Joseph Haas, M.D.

2430 Estancia Blvd
Suite 104
Clearwater, Florida 33761

PATIENT NAME: ______________________ HOME PHONE: ______________

ADDRESS: ______________________ CELL PHONE: ______________

CITY: ______________ ST: ____ ZIP CODE: ______________

PATIENT DATE OF BIRTH: ______________ PHARMACY NUMBER: ______________

EMPLOYER: ______________ SOCIAL SECURITY NUMBER: ______________

SPOUSE OR RELATIVE NAME: ______________ HOME/CELL PHONE: ______________

REFERRING DOCTOR: ______________ PHONE NUMBER: ______________

INSURANCE NAME: ______________ POLICY NUMBER: ______________

PLEASE NOTE:
IF YOU ARE A SELF PAY PATIENT PLEASE NOTE THAT PAYMENT IS EXPECTED IN ADVANCE OF YOUR INITIAL APPOINTMENT. ALL OTHER PATIENTS WITH A CO-PAY OR CO-INSURANCE YOUR PAYMENT IS DUE AT TIME OF SERVICE. WE WILL FILE ALL MEDICARE AND SECONDARY INSURANCE CLAIMS.

THERE IS A $36.00 CHARGE FOR ALL RETURNED CHECKS/CHARGE BACKS. PAYMENTS MADE WITH A DEBIT OR CREDIT CARD WILL INCUR ADDITIONAL FEES (3%)

CHARGES MAY OCCUR FOR MISSED/RESCHEDULED/CANCELLED APPOINTMENTS WITHOUT 48 HOURS (2 FULL BUSINESS DAYS) NOTICE, MESSAGES LEFT ON THE VOICE MAIL IS NOT A SUFFICIENT FORM OF CANCELLATION. THIS CHARGE WILL BE THE SAME FEE YOU OR YOUR INSURANCE WOULD HAVE PAID FOR THAT APPOINTMENT.

THERE WILL BE A CHARGE TO YOU (OR YOUR INSURANCE COMPANY IF ALLOWED) FOR TELEPHONE SESSIONS IN WHICH PSYCHOTHERAPY OR MEDICATION MANAGEMENT OCCURS.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO JOSEPH HAAS, M.D., FOR MEDICAL SERVICES PROVIDED BY HIM.

I ALSO AGREE TO PAY FOR ANY BALANCE NOT COVERED BY MY INSURANCE THAT I AM LEGALLY RESPONIBLE FOR, AND IN THE EVENT MY ACCOUNT DEFAULTS, I AUTHORIZE JOSEPH HAAS, M.D. TO CHARGE MY CREDIT CARD PROVIDED BELOW FOR ANY BALANCE DUE

CREDIT CARD # ______________________ EXP DATE: __________

NAME AS IT APPREARS ON CARD: ______________________ BILLING ZIPCODE: ______

SIGNATURE OF PATIENT OR GUARDIAN: ______________________________

DATE: ______________ DRIVERS LICENSE: ______________________

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY
&
EMERGENCY MEDICAL CARE AND RELEASE OF INFORMATION

ASSIGNMENT OF INSURANCE BENEFITS: For services rendered by JOSEPH HAAS MD, I assign the benefits due to me under my insurance company to reimburse JOSEPH HAAS MD for these services, I agree that if these benefits are insufficient to cover the entire bill or the illness/injury is not covered by my insurance, I will be responsible for payment of the entire bill or any balance.

FINANCIAL RESPONSIBILITY: I agree to pay JOSEPH HAAS, MD all balances due and not payable by insurance on my account from the beginning date to the ending date of treatment. I further agree to pay all costs of any balance, including attorney's fees, and any collection fees. I further agree to allow my charge card to be debited for any balance due. I also agree to pay Dr. Haas a returned check fee of $36.00 per return and/or $36.00 per credit card chargeback.

CANCELLATION POLICY: I understand that there will be a fee charged to the responsible party if a scheduled appointment is not cancelled a full 48 (business hours) in advance, except in cases of an emergency. Messages left on the voice mail are not a sufficient form of cancellation. This charge will be the same fee you or your insurance would have paid for the appointment. I also understand that insurance benefits do not apply to this fee and that the charges incurred are the sole responsibility of the patient or responsible party and agree to this fee if the cancellation policy is not followed.

AUTHORIZATION FOR RELEASE OF INFORMATION: I give permission to JOSEPH HAAS MD to release information as needed, including psychiatric, psychological, or drug and alcohol treatment information to all insurance companies and its representatives for the processing of my claims, if requested.

EMERGENCY MEDICAL CARE: In the event of an accident in which emergency medical care or treatment is needed, I authorize Dr. Joseph Haas, MD to arrange for the care of treatment necessary for my emergency condition. I further authorize the treatment facility or medical personnel to provide emergency medical care and treatment and agree to be responsible for medical costs as a result of such emergency treatment.

RIGHTS OF INDIVIDUALS IN TREATMENT: I have read and understand the basic rights of treatment with Dr. Joseph Haas. These rights include:
a) The right to be informed of the various steps and activities involved in receiving treatment.
b) The right to confidentiality under federal and state laws relating to the receipt of services.
c) The right to humane care and protection from harm abuse or neglect.
d) The right to make an informed decision, whether to accept or refuse treatment.
e) The right to contact and consult with counsel and select practitioners of my own choice at my own expense.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS. NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO ME AS TO THE RESULTS THAT MAY BE OBTAINED.

______________________________ _______________

CLIENT/PATIENT/LEGAL GUARDIAN SIGNATURE DATE

____

PRINTED NAME OF PATIENT

Electronic Communication Policy and Authorization

Out of concern for your privacy, Joseph Haas M.D. P.A. discourages the use of electronic means of communication (including texting, email, and voicemail messages) as there are limitations to ensuring confidentiality. We do NOT always use an encrypted electronic communication service. Unencrypted electronic communications carries a risk to privacy and confidentiality.

Should you choose to communicate with us electronically, we ask that you limit electronic communications to brief messages and do not include detailed, sensitive information for your protection.

By signing this and/or using electronic communication to communicate with us or by asking us to electronically communicate with you, you agree to release and hold harmless Joseph Haas M.D. P.A. from any liability associated with the privacy or security of any electronic communication.

You also agree to the following:

- Electronic correspondence is only monitored during business hours form **Monday – Friday, 9am to 5pm**, and may not be viewed in a timely manner. **If it is an urgent matter, or you require immediate medical assistance, do NOT use electronic communication to contact us. Call 911 or visit the nearest emergency clinic.**
- Any electronic communication may become part of your medical record.
- Electronic communications may be viewed by persons other than the intended recipient due to safety concerns, staff leave, and/or administrative reasons.
- If you communicate with us electronically, we will use the electronic communication address(es) you have provided us.
- If someone you have designated on your consent form as being eligible to receive information about your care communicates with us electronically, you hereby authorize us to respond to them electronically. The same stipulations that apply to communications between you and Joseph Haas M.D. P.A. will apply to communications between Joseph Haas M.D. P.A. and the designated person(s).
- If you disclose information via electronic communication that may constitute a threat to yourself or others, we will take appropriate action (including but not limited to alerting law enforcement) to ensure the safety and you and/or others and limit our liability. Your safety is our top priority.

AUTHORIZATION:

I hereby acknowledge Joseph Haas M.D. P.A. discourages the use of electronic communication as he does not always use encrypted means of electronic communication. By signing this authorization, I give Joseph Haas M.D. P.A. permission to communicate with me electronically should I choose to and am aware of the limitations and potential risks related to using electronic communication. Therefore, I understand and agree to the terms listed above and understand my use of electronic communication means my confidentiality cannot be guaranteed. I may revoke this authorization at any time.

______________________________ _______________

Signature Date

____

Printed Name

WELCOME TO THE OFFICE OF JOSEPH HAAS, M.D.
BOARD CERTIFIED CHILD ADOLESCENT AND ADULT PSYCHIATRIST & ADDICTION MEDICINE

We are pleased that you made the decision of choosing our office! Please, do not hesitate to ask our office staff any questions you might have as we would like your time with us to be as comfortable as possible. The following is a few guidelines of our office.

1. **Pharmacy Refills**

   If you need a prescription filled before your next appointment, please, do the following: 3 days prior to running out of your meds, call your pharmacy and have them fax a refill request to our office @ 727-796-7350. The prescription(s) should be ready for you at your pharmacy the next business day. If you have done the above, and the refill is not available at your pharmacy, call our office directly with your medication name, dose and quantity and it will be taken care of the next business day. Please note: there may be a charge for medication refills without an appointment. You may inquire with our office about those charges. Pt's who are on Suboxone/Subutex or any Benzodiazepines, you must call the office directly for your refill (please make sure you have your pharmacy ph # ready along with medication, strength, directions)

2. **Appointment Cancellation Policy**

Our policy is to cancel your scheduled appointment 2 full business days to avoid all charges. Leaving a voice mail is NOT sufficient; you MUST speak with the office to avoid any fees.

If you cancel or reschedule without adequate notice or simply miss/forget your appointment, you are responsible for the charge of:

A) Your co-pay, if you have insurance that will cover your missed appointment.
B) The full fee if you are self paying or if your insurance will not cover the missed appointment.

***PLEASE NOTE: It is NOT the responsibility of this office to remind you of your appointments, please be sure that you write down your appointment times (at home or work) and schedule appropriately.**

3. **Phone Sessions**

   Phone sessions may be available if it is impossible for you to be here in person. However, not all insurances cover this fee (including Medicare) you can inquire with our office as to these fees.

Thank You.

Patient/Guardian Signature______________________________

Patient/Guardian Name Printed______________________________

Date____________________

New Patient Questionnaire

1. What is the **Main** Problem you want addressed during your initial appointment/evaluation.

2. What do you expect from Dr. Haas?

3. Please Circle which statement best describes your current situation:

    A) Resources "Time, Money and Effort" are available and are not going to limit any necessary or reasonable treatment.
    B) Resources "limited" and this must be taken into account when devising a treatment plan.
    C) Resources "minimal" and therefore I am looking for the minimal amount of care needed to address the problem and gain some relief.

4. What do you expect the final outcome to be?

5. Have you been receiving recent treatment for this problem? Yes or No
    - If Yes- from whom?
    - What type of treatment did you receive?
    - How effective has it been?

JOSEPH HAAS, M.D.
MEDICATION LIST

Please list all prescriptions and over the counter medications you are currently taking.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

Drug Allergies:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Notes:

____
____
____
____
____

Print Patient Name: ____________________
Patient/Parent/Guardian Signature: ____________________
Date: ____________________

Joseph Haas, MD
2430 Estancia Blvd
Suite 104
Clearwater, Florida 33761

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,__________________________, have received a copy of this office's **Notice of Privacy Practices.**

____

Please Print Name

____

Signature (Parent or Legal Guardian must also sign if the patient is under the age of 18.)

________________________________Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Table II
The SNAP-IV Rating Scale

James M. Swanson, PhD, University of California, Irvine

Name of Child ______________________ Date __________ Age ___ Sex ___ Grade ___ Rating Period ______________

Completed by ______________________ Relation to Child: Mother ___ Father ___ Teacher ___ Other __________

Check the column which best describes this child:	Not at All	Just a Little	Pretty Much	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	___	___	___	___
2. Often has difficulty sustaining attention in tasks or play activities	___	___	___	___
3. Often does not seem to listen when spoken to directly	___	___	___	___
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	___	___	___	___
5. Often has difficulty organizing tasks and activities	___	___	___	___
6. Often avoids, dislikes, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)	___	___	___	___
7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)	___	___	___	___
8. Is often easily distracted by extraneous stimuli	___	___	___	___
9. Often forgetful in daily activities	___	___	___	___
10. Often fidgets with hands or feet, squirms in seat	___	___	___	___
11. Often leaves seat in classroom or in other situations in which remaining seated is expected	___	___	___	___
12. Often runs about or climbs excessively in situations where it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)	___	___	___	___
13. Often has difficulty playing or engaging in leisure activities quietly	___	___	___	___
14. Is always "on the go" or often acts if "driven by a motor"	___	___	___	___
15. Often talks excessively	___	___	___	___
16. Often blurts out answers to questions before the questions have been completed	___	___	___	___
17. Often has difficulty awaiting turn	___	___	___	___
18. Often interrupts or intrudes upon others (e.g., butts into conversations or games)	___	___	___	___
19. Often stares into space and reports daydreaming	___	___	___	___
20. Often appears to be low in energy level, sluggish, or drowsy	___	___	___	___
21. Often appears to be apathetic or unmotivated to engage in goal-directed activities	___	___	___	___
22. Often engages in physically dangerous activities without considering possible consequences	___	___	___	___
23. Often shifts from one uncompleted activity to another	___	___	___	___
24. Often fails to finish things he or she starts	___	___	___	___
25. Has difficulty concentrating on school work or other tasks requiring sustained attention	___	___	___	___
26. Has difficulty sticking to a play activity	___	___	___	___
27. Frequently calls out in class or in other situations when silence is expected	___	___	___	___
28. Needs a lot of supervision	___	___	___	___
29. Moves about excessively (e.g., even during sleep at home or during quiet time at school)	___	___	___	___
30. Often acts before thinking	___	___	___	___
31. Often loses temper	___	___	___	___
32. Often argues with adults	___	___	___	___
33. Often actively defies or refuses adult requests or rules	___	___	___	___
34. Often deliberately does things that annoy other people	___	___	___	___
35. Often blames others for his or her mistakes or misbehavior	___	___	___	___
36. Often touchy or easily annoyed by others	___	___	___	___
37. Is often angry and resentful	___	___	___	___
38. Is often spiteful or vindictive	___	___	___	___
39. Often swears or uses obscene language	___	___	___	___
40. Often manifests provocative behavior	___	___	___	___
41. Often shows excessive stubbornness	___	___	___	___

PARENT TO DO

National Depression Screening Day®
Child Depression Form (Ages [illegible] – 18)
(DISC-MDD-SQ)

Participant No.

(to be filled out by parent or other responsible adult)

1. Child's age _____ 2. Sex _____ 3. School level ________ 4. Your relationship to child ____________

Depression Treatment History

1. ☐ Child has never been treated for depression
2. ☐ Child is currently in treatment
3. ☐ Child has been treated in the past, but not currently
4. ☐ I feel child needs help with depression or other mental health problems

Instructions:
Below is a list of questions about feelings and behaviors children sometimes have. Answer each question thinking about how your child has been DURING THE PAST SIX MONTHS.

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1. Please answer every question to the best of your ability. Thank you for participating in National Depression Screening Day®. We hope this is helpful to you.

In the past 6 months	No	Yes
1. Were there times when [he/she]seemed to be very sad?	0	1
2. Were there times when [he/she] was grouchy or irritable, often in a bad mood, so that even little things would make [him/her] mad?	0	1
3. Has there been a time when nothing was fun for [him/her], even things that [he/she] used to like?	0	1
4. Has there been a time when [he/she] just wasn't interested in anything and seemed bored or just sat around most of the time?	0	1
5. Has there been a time when [he/she] often did not feel very much like eating?	0	1
6. Has [he/she] lost a lot of weight?	0	1
7. Has there been a time when [he/she] wanted to eat more than usual?	0	1
8. Has [he/she] gained a lot of weight?	0	1
9. Has [he/she] had more trouble sleeping than usual, that is, more trouble than usual falling asleep or staying asleep or waking up too early?	0	1
10. Has [he/she] had a time when [he/she] slept a lot more than usual?	0	1
11. Has there been a time when [he/she] definitely talked or moved around a lot less than usual?	0	1
12. Has there been a time when [he/she] was very restless, when [he/she] just had to keep walking around?	0	1
13. Has there been a time when [he/she] seemed more tired than usual, so that [he/she] sat around and didn't do much of anything?	0	1
14. Has [he/she] had a time when [he/she] seemed like [he/she] had much less energy than usual, so that it was a big effort to do anything?	0	1
15. Was there a time when [he/she] seemed to feel less good about [himself/herself] than usual and when [he/she]blamed [himself/herself] a lot for things that happened in the past?	0	1
16. Has [he/she] been more down on [himself/herself] than usual, when [he/she] said that [he/she] couldn't do anything right?	0	1
17. Was there a time when [he/she] had more trouble than usual paying attention to [his/her] school work, or keeping [his/her] mind on other things [he/she] was doing?	0	1
18. Has there been a time when [he/she] didn't seem able to concentrate or to think as clearly or as quickly as usual?	0	1
19. Has there been a time when it was harder than usual for [him/her] to make up [his/her] mind about things or make decisions?	0	1
20. Did [he/she] talk more than usual about death or dying?	0	1
21. Did [he/she] say [he/she] was thinking about suicide or killing [himself/herself]?	0	1
22. Has [he/she] tried to kill [himself/herself] in the last 6 months? [actually did something to try to commit suicide, not just talked about it]		
23. Has [he/she] EVER in [his/her] WHOLE LIFE tried to kill [himself/herself]?	0	1

Screening Recommendation: to be filled out by screener.

☐ No follow-up ☐ Outpatient referral ☐ Inpatient referral ☐ Do you consider this an emergency? ☐ Yes ☐ No

☐ Referred back to current provider

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CHILDREN'S DEPRESSION INVENTORY CDI

NAME: DATE:

[redacted]ER:

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group, pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently.

Fill in the circle ☞ ○ next to the sentence that you pick for your answer.

Here is an example of how this form works. Try it. Fill in the circle next to the sentence that describes you best.

Example:

○ I read books all the time.
○ I read books once in a while.
○ I never read books.

...and here is a filled-in circle! ✏ ●

☞ REMEMBER, PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

1. ○ I AM SAD ONCE IN A WHILE.
   ○ I AM SAD MANY TIMES.
   ○ I AM SAD ALL THE TIME.

2. ○ NOTHING WILL EVER WORK OUT FOR ME.
   ○ I AM NOT SURE IF THINGS WILL WORK OUT FOR ME.
   ○ THINGS WILL WORK OUT FOR ME O.K..

3. ○ I DO MOST THINGS O.K..
   ○ I DO MANY THINGS WRONG.
   ○ I DO EVERYTHING WRONG.

4. ○ I HAVE FUN IN MANY THINGS.
   ○ I HAVE FUN IN SOME THINGS.
   ○ NOTHING IS FUN AT ALL.

5. ○ I AM BAD ALL THE TIME.
   ○ I AM BAD MANY TIMES.
   ○ I AM BAD ONCE IN A WHILE.

6. ○ I THINK ABOUT BAD THINGS HAPPENING TO ME ONCE IN A WHILE.
   ○ I WORRY THAT BAD THINGS WILL HAPPEN TO ME.
   ○ I AM SURE THAT TERRIBLE THINGS WILL HAPPEN TO ME.

7. ○ I HATE MYSELF.
   ○ I DO NOT LIKE MYSELF.
   ○ I LIKE MYSELF.

8. ○ ALL BAD THINGS ARE MY FAULT.
   ○ MANY BAD THINGS ARE MY FAULT.
   ○ BAD THINGS ARE NOT USUALLY MY FAULT.

9. ○ I DO NOT THINK ABOUT KILLING MYSELF.
   ○ I THINK ABOUT KILLING MYSELF BUT I WOULD NOT DO IT.
   ○ I WANT TO KILL MYSELF.

10. ○ I FEEL LIKE CRYING EVERYDAY.
    ○ I FEEL LIKE CRYING MANY DAYS.
    ○ I FEEL LIKE CRYING ONCE IN A WHILE.

☞ REMEMBER, PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

11.
- ○ THINGS BOTHER ME ALL THE TIME.
- ○ THINGS BOTHER ME MANY TIMES.
- ○ THINGS BOTHER ME ONCE IN A WHILE.

12.
- ○ I LIKE BEING WITH PEOPLE.
- ○ I DO NOT LIKE BEING WITH PEOPLE MANY TIMES.
- ○ I DO NOT WANT TO BE WITH PEOPLE AT ALL.

13.
- ○ I CANNOT MAKE UP MY MIND ABOUT THINGS.
- ○ IT IS HARD TO MAKE UP MY MIND ABOUT THINGS.
- ○ I MAKE UP MY MIND ABOUT THINGS EASILY.

14.
- ○ I LOOK O.K..
- ○ THERE ARE SOME BAD THINGS ABOUT MY LOOKS.
- ○ I LOOK UGLY.

15.
- ○ I HAVE TO PUSH MYSELF ALL THE TIME TO DO MY SCHOOLWORK.
- ○ I HAVE TO PUSH MYSELF MANY TIMES TO DO MY SCHOOLWORK.
- ○ DOING SCHOOLWORK IS NOT A BIG PROBLEM.

16.
- ○ I HAVE TROUBLE SLEEPING EVERY NIGHT.
- ○ I HAVE TROUBLE SLEEPING MANY NIGHTS.
- ○ I SLEEP PRETTY WELL.

17.
- ○ I AM TIRED ONCE IN A WHILE.
- ○ I AM TIRED MANY DAYS.
- ○ I AM TIRED ALL THE TIME.

18.
- ○ MOST DAYS I DO NOT FEEL LIKE EATING.
- ○ MANY DAYS I DO NOT FEEL LIKE EATING.
- ○ I EAT PRETTY WELL.

19.
- ○ I DO NOT WORRY ABOUT ACHES AND PAINS.
- ○ I WORRY ABOUT ACHES AND PAINS MANY TIMES.
- ○ I WORRY ABOUT ACHES AND PAINS ALL THE TIME.

20.
- ○ I DO NOT FEEL ALONE.
- ○ I FEEL ALONE MANY TIMES.
- ○ I FEEL ALONE ALL THE TIME.

☞ REMEMBER, PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

21. ○ I NEVER HAVE FUN AT SCHOOL.
    ○ I HAVE FUN AT SCHOOL ONLY ONCE IN A WHILE.
    ○ I HAVE FUN AT SCHOOL MANY TIMES.

22. ○ I HAVE PLENTY OF FRIENDS.
    ○ I HAVE SOME FRIENDS BUT I WISH I HAD MORE.
    ○ I DO NOT HAVE ANY FRIENDS.

23. ○ MY SCHOOL WORK IS ALRIGHT.
    ○ MY SCHOOL WORK IS NOT AS GOOD AS BEFORE.
    ○ I DO VERY BADLY IN SUBJECTS I USED TO BE GOOD IN.

24. ○ I CAN NEVER BE AS GOOD AS OTHER KIDS.
    ○ I CAN BE AS GOOD AS OTHER KIDS IF I WANT TO.
    ○ I AM JUST AS GOOD AS OTHER KIDS.

25. ○ NOBODY REALLY LOVES ME.
    ○ I AM NOT SURE IF ANYBODY LOVES ME.
    ○ I AM SURE THAT SOMEBODY LOVES ME.

26. ○ I USUALLY DO WHAT I AM TOLD.
    ○ I DO NOT DO WHAT I AM TOLD MANY TIMES.
    ○ I NEVER DO WHAT I AM TOLD.

27. ○ I GET ALONG WITH PEOPLE.
    ○ I GET INTO FIGHTS MANY TIMES.
    ○ I GET INTO FIGHTS ALL THE TIME.

SUM:___________

ADMINISTRATION: 0 INDIVIDUAL
(Circle one) 1 GROUP

Kovacs, M. & Beck, A.T. (1977).

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Version:
7/77 with format changes 8/79 and 3/92

"WHAT I THINK AND FEEL"

(RCMAS)

Cecil R. Reynolds, Ph.D. and Bert O. Richmond, Ed.D.

Published by

Name: ______________________ Today's Date: __________

Age: __________ Sex (circle one): Girl Boy Grade: __________

School: ______________ Teacher's Name (Optional): __________

DIRECTIONS

Here are some sentences that tell how some people think and feel about themselves. Read each sentence carefully. Circle the word "Yes" if you think it is true about you. Circle the word "No" if you think it is *not* true about you. Answer every question even if some are hard to decide. Do not circle both "Yes" and "No" for the same sentence.

There are no right or wrong answers. Only you can tell us how you think and feel about yourself. Remember, after you read each sentence, ask yourself "Is it true about me?" If it is, circle "Yes." If it is not, circle "No."

	Raw Score	Percentile	*T*-Score or Scaled Score
Total:	____	____	____
I:	____	____	____
II:	____	____	____
III:	____	____	____
L:	____	____	____

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4 5 6 7 8 9
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DIRECTIONS: Here are some sentences about how you may have been feeling for the past two weeks or so. Read each sentence and decide how often you feel this way. Decide if you feel this way: *Almost never, Sometimes, A lot of the time*, or *All the time*. Fill in the circle under the answer that best describes how you really feel. There are no right or wrong answers. Just choose the answer that tells how you have been feeling for the past two weeks.

EXAMPLE

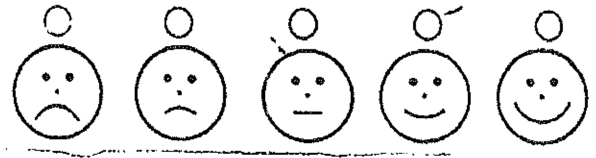
	Almost never	Sometimes	A lot of the time	All the time
I feel like watching TV.	○	○	○	○

	Almost never	Sometimes	A lot of the time	All the time
1. I feel happy.	○	○	○	○
2. I worry about school.	○	○	○	○
3. I feel lonely.	○	○	○	○
4. I feel my parents don't like me.	○	○	○	○
5. I feel important.	○	○	○	○
6. I feel like hiding from people.	○	○	○	○
7. I feel sad.	○	○	○	○
8. I feel like crying.	○	○	○	○
9. I feel that no one cares about me.	○	○	○	○
10. I feel like playing with other kids.	○	○	○	○
11. I feel sick.	○	○	○	○
12. I feel loved.	○	○	○	○

GO ON TO THE NEXT PAGE

	Almost never	Sometimes	A lot of the time	All the time
13. I feel like running away.	○	○	○	○
14. I feel like hurting myself.	○	○	○	○
15. I feel that other kids don't like me.	○	○	○	○
16. I feel upset about things.	○	○	○	○
17. I feel life is not fair.	○	○	○	○
18. I feel tired.	○	○	○	○
19. I feel I am bad.	○	○	○	○
20. I feel I am no good.	○	○	○	○
21. I have trouble paying attention in class.	○	○	○	○
22. I feel sorry for myself.	○	○	○	○
23. I feel like talking to other kids.	○	○	○	○
24. I have trouble sleeping.	○	○	○	○
25. I feel like having fun.	○	○	○	○
26. I feel worried.	○	○	○	○
27. I get stomach aches.	○	○	○	○
28. I feel bored.	○	○	○	○
29. I feel like nothing I do helps anymore.	○	○	○	○

30. Fill in the circle over the face that shows how you feel.



1. I have trouble making up my mind .... Yes No
2. I get nervous when things do not go the right way for me .... Yes No
3. Others seem to do things easier than I can .... Yes No
4. I like everyone I know .... Yes No
5. Often I have trouble getting my breath .... Yes No
6. I worry a lot of the time .... Yes No
7. I am afraid of a lot of things .... Yes No
8. I am always kind .... Yes No
9. I get mad easily .... Yes No
10. I worry about what my parents will say to me .... Yes No
11. I feel that others do not like the way I do things .... Yes No
12. I always have good manners .... Yes No
13. It is hard for me to get to sleep at night .... Yes No
14. I worry about what other people think about me .... Yes No
15. I feel alone even when there are people with me .... Yes No
16. I am always good .... Yes No
17. Often I feel sick in my stomach .... Yes No
18. My feelings get hurt easily .... Yes No
19. My hands feel sweaty .... Yes No
20. I am always nice to everyone .... Yes No
21. I am tired a lot .... Yes No
22. I worry about what is going to happen .... Yes No
23. Other people are happier than I .... Yes No
24. I tell the truth every single time .... Yes No
25. I have bad dreams .... Yes No
26. My feelings get hurt easily when I am fussed at .... Yes No
27. I feel someone will tell me I do things the wrong way .... Yes No
28. I never get angry .... Yes No
29. I wake up scared some of the time .... Yes No
30. I worry when I go to bed at night .... Yes No
31. It is hard for me to keep my mind on my schoolwork .... Yes No
32. I never say things I shouldn't .... Yes No
33. I wiggle in my seat a lot .... Yes No
34. I am nervous .... Yes No
35. A lot of people are against me .... Yes No
36. I never lie .... Yes No
37. I often worry about something bad happening to me .... Yes No

Attention all Insurance Patients of Dr. Joseph Haas, M.D.

If you miss/cancel/no show/or reschedule an appointment **without a full 48 business hours' notice** for an appointment with Dr. Haas, OR if you have requested to have your session over the telephone; you are being notified that your insurance's official policy is to NOT pay for appointments that patient's do not physically attend. Our new policy will require you to leave a $250.00 retainer to cover the appointment.

This retainer will be held as a credit balance on your account until your treatment with Dr. Haas is completed and will be returned to you afterwards unless you have a co-pay balance exceeding it to Dr. Haas.

Attention all insurance patients: This is to notify you that your insurance carrier does not pay for the specific urine drug screen that we perform that is required for your treatment. Therefore there will be a fee of $40.00 for all urine drug screens that are performed in the office in addition to your normal co-pay. Please Note: ALL NEW PATIENTS are REQUIRED to do a urine screening on the first visit.

We thank you in advance for your cooperation to this matter.

Sincerely,

Joseph Haas MD

Patient Name: ______________________________

Patient Signature: __________________________