CARI FOOTE, M.A., LPC, LMFT & ASSOCIATES, PLLC

606 Avenue J
Marble Falls, TX 78654
830-693-0530

www.professionalcounseling.us
TIN: 51-0668504
NPI: 1720251606

925 N Goliad Street
Rockwall, TX 75087
214-548-1220

Client and Financial Information and Agreement to Pay for Professional Services

Today's date: ________________________________

A. Identification

Client's name: ____ Date of birth: _______________ Age: ________

Nicknames or aliases:__________________________________Social Security: ___________________________________

Home street address:____Apt. # ________________________

City: _____________________________________ State: ___________________ Zip: ________________________

Home/evening phone:__________________________Cell:_______________________ Work: ___________________

E-mail address:____Preferred form of communication: _______________

Employer:____Occupation: __________________________________

Address of Employer: ____

Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Partner ☐ Other ______________

Legal Gender for Insurance Purposes ☐ Male ☐ Female Preferred Pronouns ____________________________

If client is a dependent for insurance purposes, enter the following information for the insured parent or spouse:

Insured's name: ____ Date of birth: _______________ Age: ________

Nicknames of aliases:__________________________________Social Security: ___________________________________

Home street address:____Apt. # ________________________

City:_______________________________________ State:____________________ Zip:____________________________

Home/evening phone: _________________________ Cell: ____________________ Work: _______________________

Employer:____Occupation: _____________________________________

Address of Employer: ____

Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Partner ☐ Other _______________

If applicable, enter the following information about the dependents **other parent or client's spouse:**

Name: ____ Date of birth: _______________ Age: _________

Nicknames of aliases:__________________________________Relationship to client: ______________________________

Home street address:____Apt. # _________________________

City:_______________________________________ State:____________________ Zip:____________________________

Home/evening phone: _________________________ Cell: ____________________ Work: _______________________

Emergency Contact:

Name: ____ Relationship to client: ___________________________

Home street address:____Apt. # _________________________

City:_______________________________________ State:____________________ Zip:___________________________

Home/evening phone: _________________________ Cell: ____________________ Work: ______________________

Please list everyone living in the home with the client:

Name | Age | Relationship

____

____

____

Please list any medications, vitamins or supplements that you are currently taking:

____

Please list any medical conditions that you have:

____

B. Referral: Who gave you my name to call?

Name:____Phone: ______________________

How did this person explain how I might be of help to you? ________________________________

____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name:_____________________________________Phone: ____________________

Address: ____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? □ Yes □ No (if you indicate "yes" I will not make any contact until you complete a release of information.)

D. Insurance Coverage: If you are covered by insurance for psychological services, please fill in the applicable information below if known.

Name of subscriber or policy holder : ____

Name of Insurance Co. or HMO: ____

Identification/ policy #:________________________________Group #: _________________________

Deductible________________Out of Pocket Limit_________________Co-pay amount: ______________

E. If you do not have insurance, how will you pay for services from this office? ________________

F. Release to insurance company: I give this office permission to release any information obtained during examinations or treatment of this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee.

____

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G. Agreement to Pay for Professional Services and Cancellation Policies:

I request that Cari Foote & Associates, PLLC provide professional services to me or to________________________________, who is my_____________________. I agree that I am responsible for services provided by this therapist to me (or this client) at the fee of $ 100.00 per 55 minute session (or agreed rate of _____________) although other persons or insurance companies may make payments on my (or this client's) account at the insurance companies contracted rate. As of date signed below I am covered under _________________________________ Insurance company and they have quoted my coverage with this therapist to be ____ and my out of pocket for each ongoing appointment is___________________. ***I am responsible for notifying the therapist immediately if my insurance changes or I am responsible for any insurance charges that later become uncollectible from the insurance company due to late filing limits set by the insurance company***.

I understand that that if I must cancel an appointment, I must do so 24 hours in advance of the appointment. If I do not, I understand that I am financially responsible for the missed appointment at the full session rate if my insurance company allows the therapist to bill for this. I understand that my insurance company or EAP is not financially responsible for missed appointments. I also understand that accounts that are past due more than 30 days must be paid in full or payment arrangements made. **If payment efforts are not made at that time, 35% will be added to the balance & accounts will be forwarded to a collection agency.**

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or in writing; that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

A. Assignment of Benefits:

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

____ _____________
Signature of client (or person acting for client) Date

____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ _____________
Signature of therapist Date

___ Copy accepted by client ___Copy kept by therapist

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Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Receive nondiscriminatory treatment with sensitivity to differences of race, age, gender, ethnic origin, language, disability, sexual orientation, political and religious beliefs.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse to answer any question or give any information you choose not to answer or give.
- To have the right to confidentiality, except in the cases of 1) distinct danger to yourself or others, 2) when children, elderly or disabled adults are abused, neglected or in danger, or 3) by order of the court.
- Know if your therapist will discuss your case with others (for instance, supervisors, consultants, or students).
- Ask that the therapist inform you of your progress and to participate in the development of a treatment plan.
- To decide to not enter into therapy with me. If you wish, I will provide you with names of other good therapists.
- You have the right to end therapy at any time. The only thing you will have to do is to pay for any treatments you have already had. You may, of course, have problems with other people or agencies if you end therapy – for example, if you have been sent for therapy by a court.
- Report immoral and illegal behavior by a therapist.

In the case that you may wish to verify my license or file a complaint you may do so with the Texas Behavioral Health Executive Council at www.bhec.texas.gov and 1-800-821-3205. A copy of my ethical guidelines is always available to you upon your request.

I have reviewed my rights with my therapist and have received a copy of them.

________________________________ ________________________
Client Signature Date

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What You Should Know about Private Health Information, Confidentiality in Therapy and My Privacy Practices

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state and the federal Health Insurance Portability & Accountability Act of 1996 (HIPAA) prevent me from telling anyone else what you tell me or that you are even my client, unless you give me written permission.

Your health information is protected by HIPPA. Protected health information is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.

Your health information is protected in our HIPPA compliant practice management system and locked offices and filing cabinets. Emails are considered protected health information and are a part of your file. Emails to you are encrypted when sent from your provider but are not encrypted when received by you unless your email in encrypted. Text messages are not encrypted or protected and it is highly recommended that very limited information be communicated by text. Protected Health Information that is in your possession is your responsibility to protect.

HIPPA rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else without your permission.

There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. **When you or other persons are in physical danger,** the law requires me to tell others about it. Specifically:

    a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
    b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
    c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
    d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person, I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding,** you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

   a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
   b. In cases where your emotional or mental condition is important information for a court's decision.
   c. During a malpractice case or an investigation of me or another therapist by a professional group.
   d. In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
   e. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

3. There are a few other things you must know about confidentiality and your treatment:

   a. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist may be available to help my clients. I must give him or her some information about my clients, like you.
   b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

4. Children and families create some special confidentiality questions.

   a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to *general* information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others' actions put them or others in any danger.
   b. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.
   c. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.
   d. If you and your spouse have a custody dispute, or a court custody hearing is coming up, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
   e. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
   f. At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 6b, below.)

5. Here is what you need to know about confidentiality **in regard to insurance and money matters:**

   a. If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or managed care organizations ask for much information about you and your symptoms, as well as a detailed treatment plan.
   b. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information at the insurer's office. You cannot be required to release more information just to get payments.
   c. If you have been sent to me by your employer's Employee Assistance Program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.

d. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

6. Finally, here are a few other points:

   a. If you want me to send information about our therapy to someone else, you must sign a “release-of-records” form. I have copies you can see, so you will know what is involved.
   b. Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

Your signature here shows that you have read, discussed with the therapist, understand, and agree to abide by the points presented above. Your signature also acknowledges that you have received a copy the Privacy Practices of this office which contains a complete description of the uses and disclosures of your health information.

____ ____________
Signature of client (or person acting for client) Date

____
Printed name

____ ____________
Signature of client Date

____
Printed name

____ ____________
Signature of therapist Date

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Information and Informed Consent for Telehealth Treatment

Telehealth is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

I understand that Telehealth services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the Telehealth sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to Telehealth, and that no information obtained in the use of Telehealth that identifies me will be disclosed to other entities without my written consent except as required by law. I further understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to Telehealth services.

I understand that Telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. If the telehealth internet connection is disrupted, the therapist will call me.

I understand that I or my therapist may discontinue the Telehealth sessions at any time if it is felt that the video technology or physical setting in which I'm in is not adequate for a therapeutic environment. I also understand that I or my therapist may discontinue the Telehealth sessions at any time if it is felt that telehealth is not appropriate for my clinical situation. My therapist will make appropriate referrals as indicated.

I will authenticate my location and identity as requested or required by my therapist for my safety, therapist compliance with state regulations about practice location and insurance authentication requirements.

I understand that if there is an emergency during a Telehealth session, then my therapist may call emergency services and/ or my emergency contact.

I understand that emails and text messages are a part of my medical record and are protected health information. I also understand that email from my therapist is encrypted when sent to me, but encryption and protection when received or sent by me is determined by my technology, email accounts and my actions. I also understand that text messages are never encrypted when sent or received by myself or my therapist.

I understand a "no show" or late cancel fee policy I signed and agreed to in my intake paperwork applies to telehealth sessions.

I understand my telehealth sessions will take place on the Kareo HIPPA compliant platform and that I will be texted and/or emailed links that I can use to connect on my computer and cell phone.

I hereby give my informed consent for the use of Telehealth in my care.

____ ____________________
Client Signature (or person acting for client) Date

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Adult Checklist of Concerns

Name____ Date: __________________

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." **Where there are multiple choices, please underline or circle those that apply to you**. You may also add a note or detail in the space next to the concerns checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse to self by others – physical, sexual, emotional abuse
- ☐ Abuse to others – physical, sexual, emotional, cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration; distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use – prescription medications over-the-counter medications, street drugs
- ☐ Eating problems – overeating, under eating, appetite, vomiting (see also "Weight and diet issues)
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Fertility issues
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Flashbacks (pictures, smells, sounds, physical sensations)
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores – quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking

- ☐ Legal Matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict in family, distance/coldness, infidelity/affairs, remarriage, different expectations,
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Phobia
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, with relatives, or at work)
- ☐ School problems (see also "Career concerns …)
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Self-harming behavior
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse)
- ☐ Scary ideas, or pictures in your head
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems – too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts or attempts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ History of Trauma – to self or as a witness (including accidents)
- ☐ Witness of physical, sexual or emotional abuse
- ☐ Weight and diet issues
- ☐ Withdrawal, isolation
- ☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

- ☐ ____
- ☐ ____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

____

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Client Name________________________________ Date ___________________

Depression Screening Scale
Center for Epidemiologic Studies Depression (CES-D)

During the past week	RARELY or NONE of the time	SOME or a LITTLE of the Time	OCCASIONAL LY Or a MODERATE amount of the time	MOST or ALL of the Time
	0-1 days	1-2 days	3-4 days	5-7 days
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get "going."				

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Chemical Use Survey

Name:____Date: ____________________

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and/or other chemicals that can affect you psychologically. So please answer these questions fully.

A. What have you used?

1. Think about any and all chemicals you have used, and indicate how much you used (amount) and how often. Then indicate all the effects it had on you (mental, physical, family, legal, etc.).

			Over the last 30 days		
Chemical	Age Started	Last Use	Amount and how often	Effects/consequences	See question 3, below
Caffeine					
Tobacco (smoked or chewed)					
Alcohol					
Marijuana/THC					
Cocaine/crack (snorted, injected, or smoked)					
Inhalants					
LSD					
Unprescribed use of Prescribed pills					
Others: Specify					

2. Write "P" above next to your primary drug of choice if any.
3. For each chemical you currently use, what causes you to stop? Enter one or moreof these letters in the lastcolumn above: A = The money runs out. B = The substance runs out. C = Personal choice. D = Unconsciousness. E = Achieved my purpose F = Other reasons: ______________________________
4. What are or were your sources of money for buying the above chemicals? ________________________

B. Which of these have you had? ☐ None ☐ Blackouts ☐ Bad reactions ☐ Withdrawal symptoms

☐ Overdoses ☐ Detoxification in a hospital ☐ Other problems ______________________________

C. Family patterns of chemical use.

Please describe the chemical(s) used by family members.

Family Member	Name	Chemical	Age started	Last Use	Over the last 30 days	
					Amount and how often	Effects
Father						
Mother						
Brothers/ Sisters						
Spouse/ partner						
Other relatives						

Please add any other information you think is important: ____

____

D. Treatment for chemical use

Dates	Agency/ Provider	Type of Program	Voluntary Yes/No	Length of Treatment	Methods Used	Aftercare	Effect of Treatment

E. Self-description of use

1. Would you say you ☐ are a social drinker ☐ are a heavy drinker ☐ have alcoholism or ☐ have a drinking problem? Or how would you describe your use? ______________________

2. Would you say you ☐ have used drugs to self medicate ☐ are a recreational drug user ☐ have an addiction or ☐ have a drug problem? Or how would you describe your use? ______________

F. Other

Has your drinking/drug use caused you any spiritual problems? ______________________________

Has your drinking/drug use caused any relationship problems? ______________________________

Has your drinking/drug use caused any family problems? ______________________________

Has your drinking/drug use caused any legal problems? ______________________________

Has your drinking/drug use caused any work/school problems? ______________________________

Signed:______________________________________ Date: ______________________

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The mood disorder questionnaire

PATIENT ______________________ SCORE ______________ DATE ______________

1. ***Has there ever been a period of time when you were not your usual self and...***

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○ *yes*	○ *no*
...you were so irritable that you shouted at people or started fights or arguments?	○ *yes*	○ *no*
...you felt much more self-confident than usual?	○ *yes*	○ *no*
...you got much less sleep than usual and found you didn't really miss it?	○ *yes*	○ *no*
...you were much more talkative or spoke much faster than usual?	○ *yes*	○ *no*
...thoughts raced through your head or you couldn't slow your mind down?	○ *yes*	○ *no*
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○ *yes*	○ *no*
...you had much more energy than usual?	○ *yes*	○ *no*
...you were much more active or did many more things than usual?	○ *yes*	○ *no*
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○ *yes*	○ *no*
...you were much more interested in sex than usual?	○ *yes*	○ *no*
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○ *yes*	○ *no*
...spending money got you or your family into trouble?	○ *yes*	○ *no*

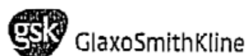
2. ***If you checked YES to more than one of the above, have several of these ever happened during the same period of time?*** ○ *yes* ○ *no*

3. ***How much of a problem did any of these cause you — like being unable to work; having family, money or legal troubles, getting into arguments or fights?***
Please select one response only.

○ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem

—Adapted with permission from Robert M. A. Hirschfeld, MD.

Compliments of



Caffeine Consumption Questionnaire

			Average number of ounces/doses/tablets per day	Average total per day
Beverages				
Coffee (6 oz.)	125mg	X	_______	_______
Decaf Coffee (6 oz.)	5 mg	X	_______	_______
Espresso (1 oz.)	50 mg	X	_______	_______
Tea (6 oz.) Green	35 mg	X	_______	_______
Tea (6 oz) Black	50 mg	X	_______	_______
Cocoa (6 oz.)	15 mg	X	_______	_______
Energy drinks (12 oz.)	*equivalent 200 mg	X	_______	_______
Caffeinated Soft Drinks (12 oz.)	40-60 mg	X	_______	_______
Chocolate candy bar	20 mg	X	_______	_______
Over-the-Counter Medications				
Anacin	32 mg	X	_______	_______
Appetite-control pills	100-200 mg	X	_______	_______
Dristan	16 mg	X	_______	_______
Excedrine	65 mg	X	_______	_______
Midol	132mg	X	_______	_______
NoDoz	200mg	X	_______	_______
Triaminicin	30 mg	X	_______	_______
Vanquish	33 mg	X	_______	_______
Vivarin	200 mg	X	_______	_______
Prescription Medications				
Cafergot	100 mg	X	_______	_______
Fiorinal	40 mg	X	_______	_______

TOTAL MG. CAFFEINEPER DAY _______

*Caffeine content of energy drinks vary. They also include a number of stimulating herbs.

> 250 milligrams a day, if taken after noon, *may* interfere with deep sleep

® John Preston (2015)