Blue Mountain Neuropsychological Associates, PS (Blue Mountain Psychology)
1624 W. Dean Ave., Spokane, WA 99201
Phone: (509) 939-6863; Fax: (509) 464-6463
DrLontz@BlueMountainPsychology.com

Please complete all pages prior to your first appointment. Thank you.

ADULT CLIENT/PATIENT/EXAMINEE INFORMATION

Today's date: ___/___/_____	**Patient Name:** _____ **First** **Last** **Middle**	**Date of birth (DOB):** ___/___/_____
Patient's address:		Marital status:
Employer name:	Job title:	Employer address:
Patient's home phone: ( )	Patient's work phone: ( )	Patient's cell phone: ( )
Email address:		
Preferred contact#: ☐Home, ☐Work, ☐Cell	Patient's SSN: _____-_____-_____	Previous patient: ☐Yes Dates:_____ ☐No
Patient's race:	Patient's ethnicity:	☐Male ☐Female ☐_____
Reason for referral (reason and/or diagnosis required):		
Emergency contact name:	Emergency contact phone number: ( )	
Patient's Primary Care Provider (PCP):	PCP address:	PCP phone: ( )
Referral source:	Other professionals involved in patient's care for current services:	
Allergies:	Current medications:	

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Is referral auto related?	If so, date of injury: ___/___/_____	
Is referral work related?	If so, date of injury: ___/___/_____	
Does patient have a legal guardian?:	Name of legal guardian:	
Phone number of legal guardian: ( )	Address of legal guardian:	

****Please bring your insurance card to the first appointment (*include a copy if submitting this form electronically*)****

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INSURANCE INFORMATION

A copy of the patient's insurance card does not replace this page. Please complete as much information as possible including a phone number for the insurance company. Thank you.

Today's Date: __/__/____	**Patient Name:** _____ **First Last Middle**	**Patient Date of Birth:** __/__/___
Primary insurance carrier:	Insurance phone#: ( )	Claims mailing address:
Member#:	Group ID#:	
Subscriber name: _____ First Last Middle	Subscriber's Date of Birth: ___/___/_____	Subscriber employer:
Date verified (**Staff only**): ___/___/_____	Contact person:	Call notes:
Secondary insurance:	Insurance phone#: ( )	Claims mailing address:
Contract #:	Group#:	
Subscriber name (if different): _____ First Last Middle	Subscriber's Date of Birth: ___/___/_____	Subscriber employer:
Date verified (**Staff only**): ___/___/_____	Contact person:	Call notes:
Other insurance (e.g., auto):	Insurance phone#: ( )	Claims mailing address:
Contract #:	Group#:	
Subscriber name (if different): _____ First Last Middle	Subscriber's Date of Birth: ___/___/_____	Subscriber employer:
Date verified (**Staff only**): __/__/____	Contact person:	Call notes:

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Client/Patient/Examinee Name: _____ Date: _____

This practice is located in a professional office building where noise must be kept to a minimum and unruly behavior is not allowed. Children must be accompanied by an adult at all times in this building.

Parents/Guardians are responsible for all children under their care. Please arrange for childcare of siblings and other children if needed, and take your child (children) out of the building if he or she becomes unruly or too noisy at any time (e.g., while in the waiting room).

We apologize for any inconvenience. Thank you for your understanding, and for helping us assure quality care of all individuals.

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Client/Patient/Examinee Name: _____ Date: _____

Disclosures

Consent to treatment

1) You (the **Client/Patient/Examinee**) have a right to refuse treatment and all other services offered by **Blue Mountain Neuropsychological Associates, PS** hereafter referred to as **BMNA (also known as Blue Mountain Psychology)**
2) The **Client/Patient/Examinee** has responsibility to choose the provider and treatment modality that best suits their needs
3) The theoretical orientation used by BMNA staff is an eclectic one
4) I hereby consent to receiving services from BMNA

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Client/Patient/Examinee Name: _____

Notice of Privacy Practices Acknowledgement
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
PAGE ONE OF THREE

Confidentiality

1) Your (the patient's) confidential health care information cannot be disclosed to any other person without written authorization from you (the patient) or a legal representative
2) You have a right to receive an accounting of disclosures of health care information made by a health care provider or a health care facility in the six years before the date on which the accounting is requested, except for disclosures:
    a. To carry out treatment, payment, and health care operations;
    b. To the patient of health care information about him or her;
    c. Incident to a use or disclosure that is otherwise permitted or required;
    d. Pursuant to an authorization where the patient authorized the disclosure of health care information about himself or herself;
    e. Of directory information;
    f. To persons involved in the patient's care;
    g. For national security or intelligence purposes if an accounting of disclosures is not permitted by law;
    h. To correctional institutions or law enforcement officials if an accounting of disclosures is not permitted by law; and,
    i. Of a limited data set that excludes direct identifiers of the patient or of relatives, employers, or household members of the patient
3) In the case of suspected neglect or abuse of a child or elderly person, information may be disclosed without your consent
4) In the case of potential harm to self, others, or property, information may be disclosed to others without your consent
5) Please see RCW 70.02.050 for information about possible disclosure without patient authorization
6) I hereby authorize BMNA to release medical and financial information pertaining to services rendered to third party insurance carrier(s) for charges incurred during my receipt of BMNA services
7) I hereby authorize disclosure of any information that BMNA deems necessary to provide me with proper treatment or other services

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Notice of Privacy Practices Acknowledgement
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PAGE TWO OF THREE

NOTICE

You have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if they pay out-of-pocket in full for the healthcare service. You have the right to be notified if there is breach of your unsecured PHI. You must sign an authorization before BMNA can release your PHI for any uses and disclosures not described in this Privacy Notice.
Breach Notification Addendum to Policies & Procedures: 1. When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the breach notification Overview, the Practice will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. The Practice will keep a written record of that Risk Assessment. 2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview. 3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS. 4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.
This practice will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice: 1. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. 2. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence. 3. Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services. 4. Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) the risk assessment of this practice fails to determine that there is a low probability that your PHI has been compromised.

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Notice of Privacy Practices Acknowledgement
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
PAGE THREE OF THREE

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting an authorized representative of Blue Mountain Neuropsychological Associates, PS (BMNA).

Records are maintained for at least eight years beyond the date of service. Records for minor children are maintained at least until the **Client/Patient/Examinee** becomes 24 years of age, or for eight years, whichever is longer.

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: _____ **Date:** ___/___/_____

Signature of guardian (if applicable): _____ **Date:** ___/___/_____

Staff signature: _____ **Date:** ___/___/_____

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Client/Patient/Examinee Name: _____

Financial Obligations
PAGE ONE OF TWO

Duplicating or searching for records

1) A charge of $1.24 per page will be charged for the first 30 pages; 94 cents per page will be charged for all other pages (WAC 246-08-400 & RCW 70.02.010[38]).
2) There is a $28 clerical fee for searching and handling of records.
3) Reviewing/editing/preparing/authenticating records assessed at $325 for *any portion* of each hour.

Charges for clinical services

1) "Hourly" rate for services received is $325 for *any portion of* each hour ("hourly" is typically defined as a period of 45-50 minutes).
    a. Hourly rate for Master's-level provider is $170 for *any portion of* each hour.
2) Intake appointments assessed at $490.
    a. Intake appointments by Master's-level provider assessed at $255.
3) **Consistent with standard fees, the following apply:**

Psychological &/or Forensic Psychological Evaluation	**$1,625** (50% is retained if cancelled ≤ 7 days before appointment).
Neuropsychological &/or Forensic Neuropsychological Evaluation	**$3,250** (50% is retained if cancelled ≤ 7 days before appointment).
Travel	**$325** for *any portion of* each hour.
Consultation	**$425** for *any portion of* each hour.
Deposition	**$1,625** for *any portion of* the first hour, **plus $715** for *any portion of* each additional hour. **All fees are due in advance & non-refundable, even with a *cancellation or no-show*, unless alternate arrangements have been agreed upon.**
Live Testimony (including telephonic, video-teleconference, and any other formats)	**Minimum charge of $7,150** (covers *up to* 4 hours of testimony); additional charge of **$715** for *any portion of* each hour beyond the initial 4-hour block of testimony (*charges begin at the arranged start time, and last until my departure*). **All fees are due in advance & non-refundable, even with a *cancellation or no-show*, unless alternate arrangements have been agreed upon.**

Insurance is not billed for any Forensic/Legal/Parenting Competency Evaluations

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Financial Obligations
PAGE TWO OF TWO

1) If you have insurance that is accepted by BMNA, your insurance carrier will be billed for amounts due
    a. You are fully responsible for any amounts rejected or otherwise not covered by your insurance company
    b. If BMNA has not secured payment from your insurance company within 90 days of billing, you will be responsible for the bill
2) Reports may be withheld until balance is paid in full
3) I hereby authorize that the benefits payable be directly paid to BMNA by third party carrier(s)

Failure to show for scheduled appointments

1) Failure to show (*no*-show) for scheduled appointments, or cancelling a scheduled appointment less than 48 hours in advance, will result in a charge of **$425** per occurrence
    a. **Clients/Patients/Examinees** who present greater than 15 minutes late for a scheduled appointment will be considered a *no-show* and billed accordingly
    b. This charge cannot be billed to your insurance provider
    c. All outstanding charges must be paid before additional appointments will be scheduled
2) Copayments, deductibles, and other out-of-pocket expenses are due at time of appointment unless other arrangements have been made
3) Cash, check, and credit cards (**4%** transaction fee applies) are acceptable forms of payment
    a. There is a **$30** fee on each returned check
    b. If your account is delinquent for 90 or more days, services may be discontinued and your account may be forwarded to a collection agency
        i. An interest charge of **1.2%** per month will be applied to all outstanding balances
        ii. You are responsible for all collection costs and applicable attorney fees
4) You are responsible for notifying BMNA of any changes to your insurance carrier or coverage

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____
(if 13+ years old)

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Disclosure Authorization
Release of Information

(Complete this form if you know that BMNA staff will need to communicate with the client's/patient's/examinee's family physician, transportation services, family members, or others involved in their care)

Client/Patient/Examinee Name: _____ Today's Date: _____
DOB: _____

I authorize Blue Mountain Neuropsychological Associates, PS to exchange (i.e., **release and/or receive**) my confidential medical/health information with the following entity or entities:

_____
_____

The following types of information will be disclosed:

__All available records
__Diagnoses
__Treatment plans
__Other (please describe): _____

This disclosure authorization will expire on: ___/___/_____
Additional information regarding expiration of this authorization: _____

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

Disclosures to financial institutions or employers for purposes other than payment shall expire after 90 days unless renewed by the patient. Disclosures to the department of corrections (DOC), while the patient is under supervision of DOC, expires at end of the supervision term or end of required treatment. Please see RCW 70.02.050 for information about possible disclosure without patient authorization.

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Client/Patient/Examinee Name: _____ Date: _____

Use of data for research and clinical demonstration

I authorize Blue Mountain Neuropsychological Associates, PS to use confidential information that is gathered about me or my dependent (if patient is a child) while providing professional services. Such information may be used in research studies and for purposes of clinical demonstration (e.g., training students and other professionals) to help advance scientific practices. **My personal information will be kept confidential and anonymous**:

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Permission to Audio/Video Record (if applicable)

Client/Patient/Examinee Name: _____ Date: _____

I _____ authorize Blue Mountain Neuropsychological Associates, PS to audio and/or video record communications as part of rendering professional services.

This authorization will expire on: ___/___/_____
Additional information regarding expiration of this authorization: _____

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Release of Claims

Client/Patient/Examinee Name: _____ Date: _____

In consideration of services provided by Blue Mountain Neuropsychological Associates, PS (BMNA), Blue Mountain Psychology, or Dr. Jameson C. Lontz, the client/patient/examinee as well as his/her delegate whose signature is below this paragraph releases and waives any and all claims they might possibly have against BMNA, its affiliates, or Dr. Jameson C. Lontz, whether aware of them or not. In legal terms, this means that the client/patient/examinee and his/her delegate whose signature is below this paragraph completely releases and forever discharges BMNA, its affiliates, Dr. Jameson C. Lontz, and respective directors, officers, agents, representatives, owners, employees, past and present, from all claims, demands, rights, actions, obligations, and causes of action of any and every kind, nature, and character, known or unknown, arising from or in any way connected to all actions, omissions, and conduct during the receipt of services by BMNA, its affiliates, or Dr. Jameson C. Lontz.

Signing this form basically means you understand that services provided here are driven by available psychological information and other scientific data. Signing this form also means you acknowledge that if for some reason the evaluation and report are not favorable or to your liking, then you would not hold BMNA or Dr. Lontz liable.

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Client/Patient/Examinee Name: _____ Date: _____

Informed Consent for Teleneuropsychological (Telehealth) Services, if applicable
PAGE ONE OF TWO

Prior to starting audio-/video-/tele-conferencing (telepsychology/telehealth) services, we discussed and agreed to the following:

- There are potential benefits and risks of receiving services in this way (e.g. limits to your confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology (telehealth) services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your appointment, you must notify the provider in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult (18 or older), we need the permission of your parent or legal guardian (and their contact information) for you to participate in these sessions.
- You must confirm with your insurance company that these telepsychology (telehealth) sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist (or other provider), I may determine that due to certain circumstances, telepsychology (telehealth) is no longer appropriate and that we will terminate appropriately, or resume our sessions in-person.
- Due to Coronavirus (COVID-19) pandemic precautions, this evaluation reflects reduced exposure to the patient/client/examinee in terms of cognitive testing and documentation limited to essential psychological and neuropsychological issues: Although such tele-based assessment techniques have been shown to be reliable and valid (e.g., Cullum et al., 2014), you hereby acknowledge that there are limitations of objective neuro/psychological assessment when receiving services in this way.

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Informed Consent for Teleneuropsychological (Telehealth) Services, if applicable
PAGE TWO OF TWO

Your preferred phone number: _____
Emergency contact Name: _____
Emergency contact phone number: _____
Address of the emergency room closest to your location: _____

Please sign and date below to acknowledge receipt of this document

Signature of Client/Patient/Examinee: _____ Date: ___/___/_____

Signature of guardian (if applicable): _____ Date: ___/___/_____

Staff signature: _____ Date: ___/___/_____

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Please complete all sections prior to first appointment

Client/Patient/Examinee Name: _____ Birthdate: _____ Today's date: _____

Social History

Where were you born & raised? Who raised you? _____

Describe your parents and your relationship with them currently (if living) as well as while growing up. How were (are) your parents employed? Any problems with either parent? _____
_____

Do you recall ever being the victim of neglect or abuse (physical, sexual, emotional/verbal)? ___
_____

Other traumatic experiences: _____

Do you have any brothers or sisters? Where are you in the birth order? How many siblings, and how is your relationship with each of them? _____
How are your siblings employed? _____

Family history of mental illness, neurological problems, and substance abuse: _____
_____

What is your educational history (i.e., how far did you go in school, and what year did you graduate)? _____
Grade point average: _____
Concerns with your learning (compared to peers): _____
Any special education services: _____
Were you ever suspended from school, and what for? _____
While growing up, were you involved with any extracurricular activities (e.g., sports; clubs)? __
_____

What type of work do you do? If unemployed, when did you last work, and what type of work did you do? _____
_____

Military experience: _____
Combat deployments: _____
Marital status and relationship history? _____
_____

Ages and genders of your children (if applicable): _____
How are your relationships with your children/grandchildren? _____
_____

Who currently lives in your home? _____

Spiritual history (e.g., church, racial, ethnic, and other cultural factors that affect your presenting concerns): _____

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Who are the most supportive people in your life? _____

What do you do for fun? _____

Medical & Developmental Histories
Birth complications: _____
Were you carried full-term? If not, how many weeks? _____
Childhood illnesses (e.g., excessive ear infections; breathing problems; slowed development)? __

Age at which you did the following:

Sit without help_____
Crawl_____
Walk _____
Show a clear hand preference_____
Fasten buttons, work zippers_____
Build with blocks_____
Sit still for t.v. or stories_____
Play with puzzles_____
Draw pictures_____
Play with other children_____
Say single words meaningfully_____
Combine two or more words_____
Use sentences_____
Other developmental concerns: _____

Head injuries: _____
Surgeries (inc. years): _____
Current and past illnesses or conditions that you have not mentioned: _____

How you cope with stress: _____
How you express anger: _____

Mark any of the following that are current areas of concern for you:

☐Sleep
☐Diet
☐Libido
☐Energy level
☐Weight
☐Concentration
☐Leisure
☐Relationships
☐School functioning

Substance (Drug) History
All current **medications**, over the counter and prescribed (continue on back of last page if necessary): _____
_____

Previous medications: _____
Are you seeing any other doctors? If so, what for? Date of last physical exam: _____
_____

Are you a smoker? If so, how many per day? _____
Other tobacco products you use (e.g., *e-cigarette or other vaping*): _____

Did your mother use tobacco, alcohol, marijuana or other recreational substances, any medications, or any illegal drugs during pregnancy? If so, how often, and how much? _____
_____

How often do you now drink alcohol, use marijuana, or use any other *recreational* substances? How much per occasion? _____
_____

Have you ever used illegal drugs to get high, sleep better, lose weight, or change your mood? Which drugs, how often, when in your life were you using the most, and how long did that period last? _____
_____

Have you ever taken prescription medication in a way other than directed by a doctor? _____
_____

How many coffees, sodas, energy drinks, or other caffeinated beverages do you drink in a day? _
_____

Legal History

Have you ever been arrested (during childhood, adolescence, or adulthood)? If so, what for? Were you convicted? What sentences did you receive? _____
_____

Psychological & Psychiatric History

Have you ever been in therapy/counseling before? If so, with whom, how long, and what were the reasons? _____

Have you ever been a patient in a psychiatric hospital? If so, where, how long, and what were the reasons? _____
_____

When was the last time you thought about hurting or killing yourself, or someone else? _____
_____

Nature of Referral

What are the reasons you are here? _____
_____

How long have you had these concerns? _____
Who referred you here? _____

Treatment Goals and Expectations

What are you hoping to gain from receiving services here? _____
_____

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For each sentence, please circle the *one* word (*None, Mild, Moderate, Severe, or Extreme*) that best tells about you in the past *30 days.*

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

36-item version, self-administered

Patient Name: _____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Date:** _____

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include **diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.** Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only **one** response.

	Numeric scores assigned to each of the items:	1	2	3	4	5	*Clinician Use Only* Raw Item Score	Raw Domain Score	Average Domain Score
	In the last 30 days, how much difficulty did you have in:								
	Understanding and communicating								
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.3	Analyzing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do		___/30	___/5
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do			
	Getting around								
D2.1	Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do		___/25	___/5
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.5	Walking a long distance, such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do			
	Self-care								
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do		___/20	___/5
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do			
	Getting along with people								
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do		___/25	___/5
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do			

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Numeric scores assigned to each of the items:		1	2	3	4	5	Clinician Use Only: Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did you have in:									
Life activities—Household									
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.3	Getting all of the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do		20	5
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do			
Life activities—School/Work									
If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.									
Because of your health condition, in the past 30 days, how much difficulty did you have in:									
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.7	Getting all of the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do		20	5
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do			
Participation in society									
In the past 30 days:									
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.2	How much of a problem did you have because of barriers or hindrances around you?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.4	How much time did you spend on your health condition or its consequences?	None	Some	Moderate	A Lot	Extreme or cannot do		40	5
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do			
						General Disability Score (Total):		180	5