Erin F. McKowen, MSW, LCSW
Baton Rouge Christian Counseling Center
763 North Blvd., B.R., LA 70802
www.brchristiancounseling.com
(225)387-2287

WELCOME LETTER

I am looking forward to meeting with you and would like to go over some necessary details to set you up for your upcoming appointment(s).

HOW TO SCHEDULE: Go to www.brchristiancounseling.com and click on the drop down "COUNSELING". Then click on "Counselors" and then on "Erin McKowen". There is a link on my bio that leads you to a page to be set up as a new client and be able to schedule your future appointments. You will not be able to schedule your initial appointment on-line, but you will be able to schedule future appointments if you choose to do so. Follow the directions to set up your account. Make sure to fill out the section labeled Biographical information. In addition, you will need print out and sign the attached forms.

FORMS: Print out the attached forms and bring them to your first appointment.

CONFIRMATION: On the registration Form (on line) you can elect to have your appointments confirmed through text , email, or automated phone call. Whether an appointment is confirmed or not, you are ultimately responsible for remembering your appointments and will be charged for any missed appointments.

INSURANCE: I am an in network provider for a few insurance companies. I will file claims for you for these particular companies. It is your responsibility to document accurate insurance information so that I can file your claims. If you plan to use insurance, please fill in all the insurance information (on-line) when you register. Please call your insurance company if you have any confusion on your coverage, as mental health benefits are usually different from medical benefits. If there is any discrepancy, I will use the information on the EOB (explanation of benefits) from your insurance company.

GETTING HERE: See our website for a map and here are directions: My office is in the First Presbyterian Church campus at 763 North Boulevard in downtown Baton Rouge. The church takes up a whole city block and is bordered by North Boulevard (grass down the middle) & Convention and 7th & 8th Streets. We are in the red brick building closest to the Interstate. ***Either park at a meter on 8th Street and enter via the 8th Street door OR park in the big parking lot on Convention and enter via the Chapel door.*** Buzz the Counseling Center for someone to unlock the door. When the door is unlocked a light will go off. Go on up to the third floor via the stairs or elevator. **You may want to allow extra time to find for your first session, especially given Baton Rouge's traffic! Printing out the directions in this email and/or from our website can be helpful**.

ERIN F. MCKOWEN, LCSW
Baton Rouge Christian Counseling Center
763 North Boulevard, Baton Rouge, La. 70802
(225) 387-2287, Fax (225) 383-2722

DECLARATION OF PRACTICES AND PROCEDURES

I am pleased that we will be working together, and I am committed to helping individuals and families who contact me for professional counseling services. Please read over the following to obtain a better idea of my qualifications and our office policy & procedures. Once you have reviewed these first two pages, PLEASE SIGN AND DATE.

1. Counseling Relationship. It is my desire to promote a warm and trusting atmosphere in which you feel free to examine patterns of relating to others and behaviors, thoughts or moods that are causing you concern. I am eclectic in my counseling approach which means that I use a variety of theoretical approaches in an attempt to match the client. I act as a guide to assist you in reaching your goals, and I look forward to working beside you to make the changes necessary to accomplish those goals.
Your first session involves information gathering and becoming acquainted. I will obtain historical information from you and review the events that brought you to see me. Feel free to ask any questions that you may have. The nature of your need will be discussed, and recommendations made concerning future appointments or outside referrals if I am unable to provide the appropriate service. A physical examination is recommended if you have not had one in the last year. I also ask that you document any medications that you may be taking.

2. Qualifications. I earned a Master of Social Work degree from Louisiana State University in 1994 and am a Licensed Clinical Social Worker (La. License #3939). Initially, I obtained an undergraduate degree in Accounting from the University of Texas in 1985 and subsequently went on to get my CPA. After several years in this career, I chose to follow my passion of becoming a counselor.

3. Session Times and Fees. Counseling sessions are 50 -55 minutes in duration with the remaining five-ten minutes used for rescheduling, payment, and other related business. Fees are due at the time of service rendered. My initial evaluation fee is $135.00; my fee for each individual session is $102.00 and family sessions are $110. There will be a charge for telephone consultations, excessive phone calls and some emergency situations. Cash, credit card or personal checks are acceptable for payment. Except for Managed Care clients, third party payments are not accepted, but a receipt can be obtained for reimbursement purposes from your insurance carrier. THE FINAL OBLIGATION FOR PAYMENT LIES WITH THE CLIENT, NOT THE INSURANCE OR MANAGED CARE COMPANY. Fees are subject to change. There will be a $25 NSF charge on all returned checks.

4. Cancellation. If you must cancel a session, the office must be notified at least 24 hours in advance or you will be responsible for the FULL SESSION FEE OF $102.00/$110.00. If the office is not open and you need to cancel, you can cancel on-line on the Therapy Appointment website or you can leave a message on our voice mail at **(225) 387-2287** and the time will be registered. **We aim to confirm appointments, but do not always have ample staff to do so. Responsibility for remembering appointments and clarifying appointment time discrepancies rests with the client.**

5. Code of Conduct. I am required by Louisiana law to adhere to a Code of Conduct which is determined by the Louisiana State Board of Certified Social Work Examiners.

6. Privileged Communication/Confidentiality. Confidentiality and privileged communication remain rights of all people involved in counseling, according to the State of Louisiana. I will need written consent in order to share

confidential information with a third party (i.e., other doctors, counselors, etc.). There may be cases where a judge may order that your counselor testify or produce counseling records. Please inform me immediately if you are involved in any litigation so we can discuss the potential risks. Certain types of litigation may lead to a court ordered release of information without your consent.

As I participate in peer supervision, I may share general, non-descriptive information (no names, etc.) in order to aid in therapy. Also note that if you are using third party insurers, such as health insurance policies, your signature at the bottom of this page allows me and my insurance coordinator to obtain and share information necessary to obtain health care benefits.

State law requires that I report to the appropriate authorities suspected cases if an individual intends to take harmful, dangerous, or criminal action against another person or against him/herself. It is the counselor's responsibility to warn appropriate individuals of such intentions. Additionally, any suspicion of child or elder abuse in any form MUST be reported. Individuals warned may include one or more of the following:
a) the person or the family who is likely to suffer the results of harmful behavior; b) the family or friend(s) of the person who intends to harm himself or someone else; c) law enforcement officials; d) the coroner.

7. Potential Counseling Risks. As a result of mental health counseling, the client may realize that he/she has additional issues which may not have surfaced prior to the onset of the counseling relationship. Also, there is a possible risk in couples and/or family counseling of one person changing and placing additional strain on the other relationship(s), especially if the other(s) involved refuse(s) to grow.

8. Emergency Situations. In case of emergency, call 911, The Crisis Intervention Center (The Phone) at (225) 924-3900, a psychiatric hospital, and/or go to the nearest emergency room, if warranted.

9. Telephone/Video Appointments: are available for quarantine and/or emergency situations. It is your responsibility to determine if your insurance will cover such charges. Separate instructions/guidelines/releases will be obtained by the client in order to receive these services (included in this packet or available upon request). The fees are the same as my reasonable and customary fees as stated in declaration # 3. It is expected that you will respect my privacy in this matter. (see declaration #3 for fees). There may also be a charge for excessive emails and texts.

10. Client Responsibilities. The client is expected to follow billing, scheduling and office procedures. In a case where I am working with another health professional on your behalf, written permission must be obtained from you, the client, in order for both professionals to collaborate. It is suggested that the client have a complete physical examination if he/she has not had one within the past year. Also, the client agrees to list on the attached form any medications he/she is taking.

11. My policy, and the policy of BRCCC, is to securely store the client's credit card number for payment purposes. It is used for the initial session, for subsequent sessions, for any "no shows", and for appointments not cancelled with at least 24 hours of notice.

I have read and understand the above information. I hereby sign in agreement and authorize the provider to release any necessary information to obtain assignment, of health care benefits for the above services and to release information to my primary care physician, as needed.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Signature: _____ Date: _____

Erin McKowen, LCSW, MSW

BATON ROUGE CHRISTIAN COUNSELING CENTER

...a ministry of First Presbyterian Church

DX CODE: _____

Counselor: Erin McKowen, MSW, LCSW

TO HELP WITH YOUR FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.
PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Date:_____ Birth Date:_____

Name:_____(if a couple, please each fill out forms)

Address:_____City/St_____ Zip:_____

Your Phone #'s: (Home)_____, (Work)_____

(Cell):_____

Email Address:_____

Your Employment/Job Title:_____

Person responsible for your bill, if different than above:
Name/Address:_____
If using Insurance, **(you also need to fill out the Insurance Questions Form**)
Name of Ins. Co.:_____

ANY CHURCH MEMBERSHIP:_____

Briefly describe your **spiritual life**:_____

Last year of school completed: _____or **GED** College: 1 2 3 4 Degree: _____ Other: _____

Single_____Married_____Separated_____Divorced_____Remarried_____Widowed_____

Total number of prior marriages for you_____for your spouse/partner_____

Spouse's name:_____Age of spouse:_____ #of yrs. married_____

Spouse's employment:_____

WHO REFERRED YOU TO US? _____

Is it ok to call your home & leave message: Yes____ No____; At your work: Yes____ No____

Person to contact in case of an **emergency (name/phone): _____**

BRIEFLY describe your reason for seeking counseling: _____
_____

Do you have children? _____ Yes_____ No If yes:

First Name	Age	Sex	Relationship to you (biological/step/adopted/foster)	Live in your home?

Your Parents':(Father) Age: ____ or ____ Deceased (Mother) Age:____ or ____Deceased

Number of **Brothers:** _____ Number of **Sisters:**_____

Has anyone in your family ever had **counseling** before? If so, for what? _____

_____

Any history of **drug/alcohol abuse** for self, father, mother, siblings? _____ Yes _____ No

If yes, please describe:_____

_____

Any history of **physical** or **sexual abuse** to you or your brothers / sisters? _____Yes _____No

If yes, please describe:_____

_____

Do you use **alcohol** or **nonprescription drugs?** _____Yes _____No
If yes, describe frequency and type:

_____

Have you ever experienced any **sexual difficulties:** _____Yes _____No If yes, describe?

_____

Have you ever had **counseling** before? _____Yes _____No
If yes, describe and list counselor, rough number of sessions, any psychiatric hospitalizations:

Describe any **major changes** that have occurred to you or your family in the last few years? (moves, changes in number of family members, marital status, situation, or income)

_____

_____

List any **major health problems** for which you have received treatment for in the last 24 months:

_____

_____

Primary Care Physician: _____ Phone:_____

Are you taking any **prescription drugs** at this time? _____Yes _____No

If yes, what type, for what purpose, and who prescribed?

_____

_____

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:		
Nervousness	**Depression**	**Fear**
Shyness	**Sexual Problems**	**Suicidal Thoughts**
Separation	**Divorce**	**Finances**
Drug Use	**Alcohol Use**	**Friends**
Anger	**Self-Control**	**Unhappiness**
Sleep	**Stress**	**Work**
Relaxation	**Headaches**	**Tiredness**
Legal Matters	**Memory**	**Ambition**
Energy	**Insomnia**	**Making Decisions**
Loneliness	**Inferiority Feelings**	**Concentration**
Education	**Career Choices**	**Health Problems**
Temper	**Nightmares**	**Marriage**
Children	**Appetite**	**Stomach Problems**

Baton Rouge Christian Counseling Center

Phone (225) 387-2287
Fax (225) 383-2722

763 North Boulevard
Baton Rouge, LA 70802

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003 a federal regulation, commonly known as the "HIPAA Privacy Rule", requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Baton Rouge Christian Counseling Center may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the "*Notice of Privacy Practices*" may change over time, and that I have a right to obtain any revised Privacy Notices, if requested.

I also understand that I have the right to request BRCCC to restrict how my health information is used or disclosed. BRCCC does not have to agree to my request for the restriction, but if BRCCC does agree, BRCCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that BRCCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Baton Rouge Christian Counseling Center ● 763 North BLVD ● Baton Rouge, LA 70802 ● (225) 387-2287

INFORMED CONSENT FOR IN-PERSON THERAPY DURING THE COVID-19 CRISIS

Decision to Meet Face-to-Face

If we mutually decide to meet in person (Face-to-Face, hereinafter - F2F) for some or all future counseling sessions, precautions must be in place to mitigate the COVID-19 pandemic. This document contains information about those precautions and guidelines to safely meet F2F. Your signature(s) below indicates that you understand and agree to undertake these actions concerning all F2F appointments. Please read this carefully and let me know if you have any questions.

If we mutually decide to meet in person (F2F) and there is a subsequent resurgence of the pandemic, or subsequent changes in local, state, or federal guidelines, or if other health concerns arise, I may require that we meet via teletherapy. If you decide at any time that you would prefer teletherapy, I will respect that decision, provided it is clinically appropriate.

Also be mindful that if your therapist files for reimbursement for any teletherapy services, such reimbursement is determined by insurance companies and applicable law. You are responsible for payment whether services are provided via teletherapy sessions or F2F, and whether insurance companies reimburse or not.

Risks of Opting for In-Person F2F Services

Although there are potential benefits for in-person F2F counseling, there are also risks. You understand that by attending F2F sessions, you would be assuming the risk of exposure to the coronavirus, or other public health risks, and that this risk may increase if you travel by public transportation, cab, or ridesharing service.

In consideration of the services of Baton Rouge Christian Counseling Center (hereinafter BRCCC) and my therapist, I hereby agree to release, indemnify, defend and discharge both BRCCC and my therapist, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

I have been offered by BRCCC and my therapist to conduct the therapy session remotely via Zoom or other online means, however, I desire a face to face therapy session. I am aware of the risk of infection with COVID 19 and I understand that such risk simply cannot be eliminated without completely avoiding a face to face therapy session.

I expressly agree and promise to accept and assume the risk of infection with COVID 19 existing in a F2F therapy session. My participation in a F2F therapy session at BRCCC and with my therapist is purely voluntary, and I elect to participate in spite of the risks.

Your Responsibility to Minimize Your Exposure

To obtain counseling in person (F2F), and signing this document, you will take the following precautions which will help keep all of us (you, me, our families, my staff, and other clients) safer from exposure, sickness and possible death. Failure to adhere to these safeguards, may result in our starting or returning to a teletherapy arrangement.

- If you reasonably believe that you have recently been exposed to, are infected with, or have symptoms of the coronavirus, you will cancel your F2F appointment or proceed using teletherapy.
- You will wait in your car or outside until no earlier than 5 minutes before your appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will wear a mask in all areas of the office (I, and my staff will too). Clients agree to:
    - bring their own face mask that covers their nose and mouth,
    - wear the face mask upon entering the building,
    - continue to wear the face mask until entering the counseling session, (face masks are not required during the counseling session, unless your therapist deems them necessary), and
    - wear a face mask after the session while exiting the building.
- You will adhere to the safe distancing precautions we have set up in the waiting areas and offices.
- You will keep a distance of 6 feet from all other persons and there will be no physical contact (i.e. no shaking hands) with me, other clients, or with my staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- You will not bring guests and/or non-client children to BRCCC.
- You will take steps between F2F appointments to minimize your exposure to COVID-19.
- If you have a job, other responsibilities, or activities that put you in close contact with others infected with COVID, you will notify me immediately.

- If a resident of your home tests positive for the coronavirus infection, you will notify me immediately. Continuing treatments will be conducted via teletherapy until quarantine is over.
- To minimize contact with support staff, you will do all scheduling of appointments either online through the Therapy Appointment software, or over the phone with support staff.
- To minimize the exchange and handling of payment(s), you will have your credit card information on file with BRCCC at least one day prior to the counseling session.

I reserve the right to change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, you will be notified about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I are Sick

You understand that I am committed to keeping you, me, my staff, all clients, and all of our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by teletherapy as appropriate.

If I, or my staff, test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I am required to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature(s) below shows that you agree to and will abide with these terms and conditions. By signing this document, I acknowledge that I waive my right to maintain a lawsuit against BRCCC and my therapist on the basis of any claim that I released herein. I also agree to pay BRCCC and my therapist attorneys' fees and costs in enforcing this agreement.

_____ _____

Client Date

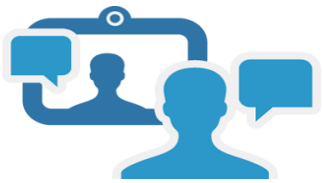
_____ _____

Client (if couple, both sign) Date

_____ _____

Therapist Date

Written incorporating sample-informed-consent-form-1 from APA-1
Dee Adams, PhD, LPC, LMFT; LCC
Director BRCCC
May 18, 2020



ERIN MCKOWEN, MSW, LCSW

Baton Rouge Christian Counseling Center | 763 North Boulevard, Baton Rouge, LA 70802 | (225) 387-2287

INFORMED CONSENT FOR TELETHERAPY (VIDEO) COUNSELING

Prior to starting video-counseling services, we discussed and agreed to the following:

- There are potential benefits and risks for video-conferencing that differ from in-person sessions.
- Confidentiality still applies and no one will record the session without the permission of the other person.
- You will need a webcam or a smartphone/tablet for the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions during the session.
- The same 24-hour cancellation rules apply to video counseling.
- We need a back-up plan (e.g., phone number where you can be reached) in case we have technical difficulties. If we get disconnected, I will continue to try to reach you. If we both initiate, we will miss each other.

  Back-up phone number: (_____) _____

- 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.

  Emergency Contact Name: _____

  Emergency Contact Number: (_____) _____

  Closest ER:_____

- As your counselor, I may determine that due to certain circumstances, video counseling is no longer appropriate and that we should resume our sessions in-person.

PLEASE READ AND SIGN AND RETURN THE TELEMENTAL HEALTH AGREEMENT AS FOLLOWS:

As your client in teletherapy, I understand the limits of liability for Digital Communication, Telemental Health and Teletherapy. At the beginning of each session, I agree to disclose my current location and allow my therapist to assess for safety, security, and comfort in my environment. The virtual teletherapy sessions will be conducted through Doxy.me, a HIPAA compliant teletherapy platform, and my Patient Health Information (PHI) will be protected within the limitations of Doxy.me and the environment in which the services are utilized.

Email and Text Messaging: The client should be aware that they have the right to refuse digital communications with the therapist; however, this could limit communication channels and immediacy of access to reach each other in the counseling relationship. The client understands that the use of digital technology, email, text messages, online video conferencing services, software, and/or platforms may not meet HIPAA compliance standards; therefore, I understand that my therapist will protect my information to the best of their ability within the limitations of the digital and physical environment.

There is confidentiality risk involved for both parties in utilizing digital technology Communication. I understand the risk involved in digital communication and I hereby authorize my therapist to communicate with me utilizing digital technology on the internet.

Please initial here if you agree to the teletherapy policy outlined above: _____

Client's Signature(s): _____ Date: _____

Client's Signature(s): _____ Date: _____

Client's Signature(s): _____ Date: _____

Print Name: _____

Counselor's Signature: _____ Date: _____

Erin McKowen, MSW, LCSW

Policy for Cancellations & "No Shows"

ERIN F. MCKOWEN LCSW, MSW

Baton Rouge Christian Counseling Center
763 North Boulevard, Baton Rouge, LA 70802
(225) 387-2287 *(24 hour voice mail)*

I, ____, agree to have my/our
Print Name(s)
MasterCard or Visa charged the **FEE OF $50 for first appointment and the FULL FEE of $102 for all successive appointments:**

1) for any session not cancelled with ***at least*** 24 hour notice, and/or
2) for any appointment I/we neglect to appear ("no show")
3) for any balance owed 30 days past due.

____ ___________________
Signature Date

~~~~~~

BRCCC's policy is that payment is due at the time of the session.

Confirmation of appointments is provided as a courtesy when there is ample staff to do so.
Keeping the appointment is the responsibility of the client.

All new or returning clients will need to have a credit card number on file before scheduling their first or a new appointment.

Credit cards numbers will be securely locked and kept confidentially along with other client data. My policy, and the policy of BRCCC, is to securely store the client's credit card number for payment purposes. It is used for the initial session, for subsequent sessions, for any "no shows", and for appointments not cancelled with at least 24 hours of notice.

PLEASE FILL IN THE INFORMATION BELOW		
CARD TYPE MasterCard ☐ **MASTERCARD** VISA ☐ **VISA** DISCOVER NETWORK ☐ **DISCOVER**		
CARD NUMBER:	**SECURITY CODE:**	**ZIP CODE:**
CARDHOLDER NAME:	**EXP DATE:**	
SIGNATURE:	**AMOUNT: Maximum $102.00 for missed appointments or ANY balance due past 30 days**	
~~~~~~

Burns Anxiety Inventory * (Revised)

Instructions: Put a check (√) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

	0 – not at all	1 - Somewhat	2 - Moderately	3 – A Lot	4 - Extremely
Anxious Thoughts and Feelings					
1. Feeling anxious					
2. Feeling nervous					
3. Feeling frightened					
4. Feeling scared					
5. Worrying about things					
6. Feeling that you can't stop worrying					
7. Feeling tense, agitated or on edge					
8. Feeling stressed					
9. Feeling "uptight"					
10. Thoughts that something frightening will happen					
11. Feeling alarmed or in danger					
12. Feeling insecure					
Anxious Physical Symptoms					
13. Feeling dizzy, lightheaded or off balance					
14. Rubbery, or "jelly" legs					
15. Feeling like you are choking					
16. A lump in the throat					
17. Feeling short of breath or difficulty breathing					
18. Skipping, racing or pounding of the heart					
19. Pain or tightness in the chest					
20. Restlessness or jumpiness					
21. Tight, tense muscles					
22. Trembling or shaking					
23. Numbness or tingling					
24. Butterflies or discomfort in the stomach					
25. Sweating or hot flashes					
Please total your score on items 1 to 25 here➔					

_____ _____

NAME **DATE**

Burns Depression Checklist *
(Revised)

Instructions: Put a check (√) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

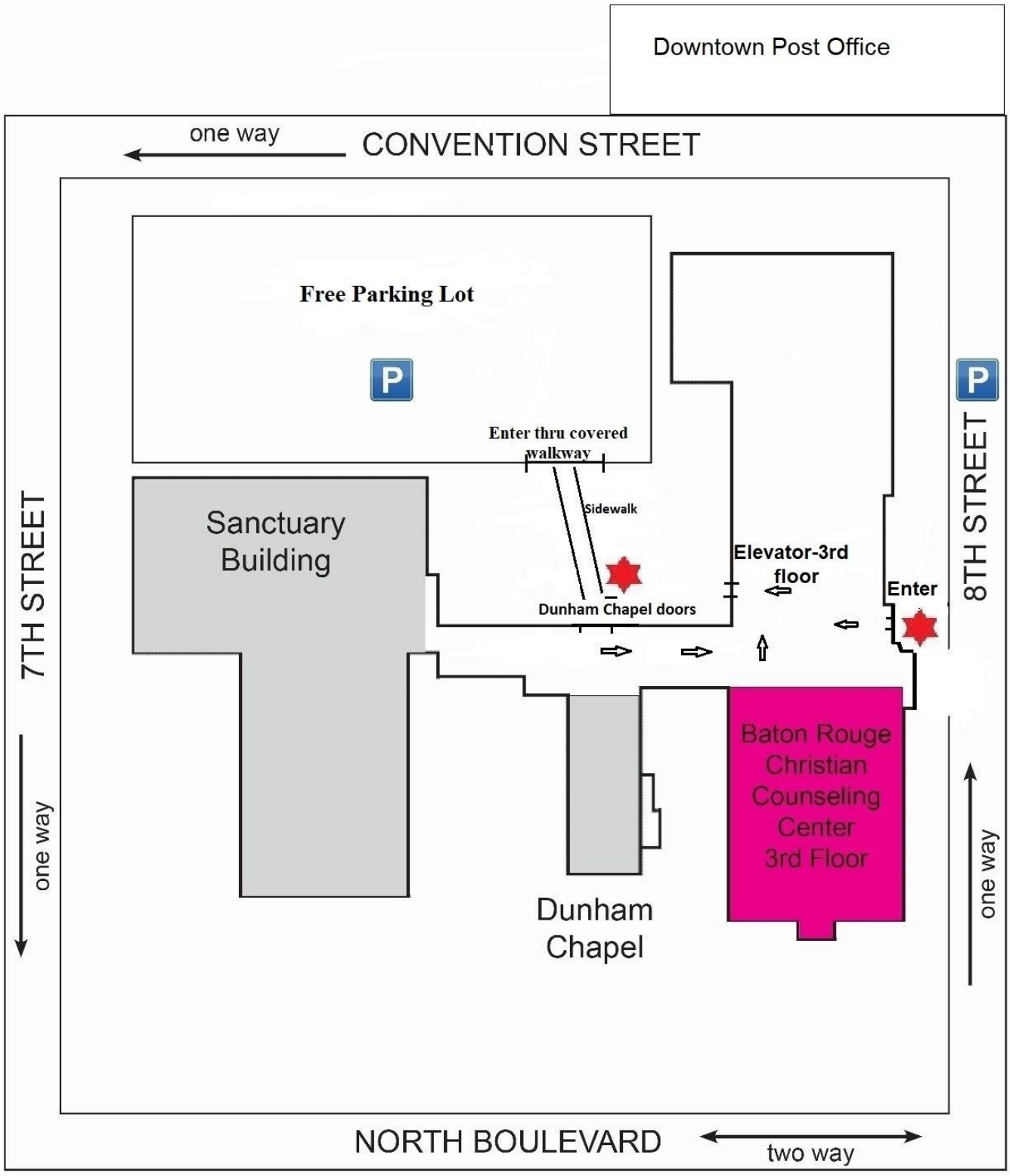
	0 – not at all	1 - Somewhat	2 - Moderately	3 – A Lot	4 - Extremely
Thoughts and Feelings					
1. Feeling sad or down in the dumps					
2. Feeling unhappy or blue					
3. Crying spells or tearfulness					
4. Feeling discouraged					
5. Feeling hopeless					
6. Low self-esteem					
7. Feeling worthless or inadequate					
8. Guilt or shame					
9. Criticizing yourself or blaming yourself					
10. Difficulty making decisions					
Activities or Personal Relationships					
11. Loss of interest in family, friends or colleagues					
12. Loneliness					
13. Spending less time with family or friends					
14. Loss of motivation					
15. Loss of interest in work or other activities					
16. Avoiding work or other activities					
17. Loss of pleasure or satisfaction in life					
Physical Symptoms					
18. Feeling tired					
19. Difficulty sleeping or sleeping too much					
20. Decreased or increased appetite					
21. Loss of interest in sex					
22. Worrying about your health					
Physical Symptoms**					
23. Do you have any suicidal thoughts?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					
Please total your score on items 1 to 25 here➔					

_____ _____

NAME **DATE**

****Anyone with suicidal urges should seek help from a mental health professional.**

Map of BRCCC



Enter at either the 8th Street entrance or the Convention Street Chapel. Buzz appropriate box.

P Parking available in the Convention St. lot (free) or on 8th Street.