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Client Information

Client Name: First _____ Middle _____ Last _____ Gender: _____

SSN: _____ DOB: _____ Age: _____ How did you first hear about us: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell: _____ Cell Carrier: _____ (for apt reminders)

Email: _____ Employer: _____ Phone: _____

Religion: _____ Single | Married | Separated | Divorced

Emergency Contact: _____ Relationship: _____ Phone: _____

Spouse/Partner/Parent Name:_____ Their DOB: _____

Divorced Spouse/Parent Name: _____ Their DOB: _____

Primary Insured Name: First _____ Middle _____ Last _____ Gender: ___

Insured Policy # _____ Group #: _____

Insured DOB: _____Insurance Company: _____

Secondary Insurance Company Name: _____

List all current **PRESCRIPTIONS and/or MEDICAL CONDITIONS**?

Prescription and/or Condition	Month/Year it Started/Stopped	Comments

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

**Proof of guardianship is required for all minors with guardians.

***If Guardian is different from parent: Name: _____ Phone: _____

Address: _____ City: _____State: _____ Zip: _____

Social Security Number (if responsible for billing): _____

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Client Authorization for Release of Protected Health Information

Client Name (First / Middle / Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number*: _____ DOB: _____ Phone:_____

* Providing your Social Security Number is voluntary but necessary to accurately identify your medical records.

1. I authorize the following health care provider or facility **TO RECEIVE & DISCLOSE** my patient information:
   Life Stone Counseling Centers, 613 East Fort Union Blvd Ste 104 Midvale, UT 84047, phone: 801-984-1717
2. I authorize the following person or organization **TO RECEIVE & DISCLOSE** my patient information:
   [Court, Judge, Probation/Parole Officer, Attorney, Medical Provider, Therapist, Clergy, Family, Friend, Employer]
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
3. Please disclose the following information: Assessment, Treatment, Compliance, Completion and Referral.
4. Discloser may occur to: Obtain Information, Provide Updates, Facilitate Court Process, and Provide Referral.
5. I understand that sanctions may be applied if I revoke my consent.
6. If applicable, I understand that based on the information I have designated above, the disclosure Life Stone makes pursuant to this authorization may include information regarding my participation in mental health treatment. I understand that mental health treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164.
7. If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
8. I understand that Life Stone will not condition treatment, payment enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used under this authorization. Fees may apply.
9. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Life Stone/Medical Records, 613 East Fort Union Blvd Ste 104 Midvale, UT 84047. I understand my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 1 year from the date below.

I have read the above, understand it, and hereby give my consent to the above-mentioned receipt & disclosure.

_____ _____
Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

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Rights & Notice of Privacy Practices

Client Name (First / Middle / Last): _____

Life Stone's written policy for consumer rights and privacy includes the following:

1. Clients have the right to be treated with dignity and equality without discrimination according to race, religion, gender, sexual orientation or physical handicap.
2. Clients have a right to privacy. It is the responsibility of everyone who is working for Life Stone to protect information in the records from being made available to anyone who is not specifically authorized to have access to that information.
3. Clients have the right to treatment in a safe treatment environment; free from abuse, neglect, mistreatment and exploitation.
4. Every effort will be made to have clients conform to program and treatment rules and expectations, including being warned regarding inappropriate behavior, asked to leave the setting if necessary, and including the use of law enforcement if further assistance is necessary. Clients may be involuntarily terminated for lack of compliance with treatment program expectations. Clients may be re-admitted upon re-application and re-evaluation by program staff.
5. Clients have the right and responsibility to participate in their treatment as determined by assessment and evaluation, which will be conducted on an ongoing basis during the course of treatment. Clients will have the opportunity to continue in treatment by following all the rules and program expectations.
6. Clients have a right to make complaints about their treatment. Clients are encouraged to take complaints first to their therapist, counselor, or case manager and thereafter to owners if the complaint is not addressed correctly.
7. Clients with a smoking addiction may continue to smoke at the center during designated breaks and in designated outdoor locations. Clients are not allowed to smoke during group, individual therapy or any indoor location at the Center. All applicable restrictions and guidelines of the Utah Clean Air Act must be followed.

Client Expectations

As a participant at Life Stone, I agree to the following:

- I agree to give 24 hours notice when cancelling an appointment. I understand that if prior notice is not given, Life Stone reserves the right to charge for time reserved.
- I agree to not engage in physical, sexual or other intimate behaviors with other Life Stone group members or staff. Fraternization with other Life Stone group members may be forbidden, as determined by the Treatment Team.
- I agree to refrain from any and all violent, threatening or aggressive behavior while on the premises. This includes use of profanity and all weapons. Such behavior may result in my being asked to leave the premises and/or being arrested.
- I agree that while I am at Life Stone, to demonstrate personal integrity and self-respect, I will dress in clothes that are modest, non-offensive and non-distracting to staff and other group members. Clothing cannot be revealing. Shorts and skirts must be mid-thigh when seated.
- If you are in a life and death emergency situation, dial 911 for assistance or go immediately to your local emergency medical facility.
- I agree to keep the names and information revealed by other clients confidential during group or family sessions.
- I understand Life Stone may disclose all knowledge of illegal behaviors not related to consented parties and/or law enforcement agency.

I certify I have READ, UNDERSTOOD and SIGNED this Notice of Privacy Practices and Client Expectations. I may request a copy of this Notice. I understand the failure to comply with any of these items listed above may result in termination of services

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

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Consent for Treatment & Financial Responsibility

Client Name (First / Middle / Last): _____

CONSENT FOR TREATMENT:
I acknowledge that I have received, have read (or have had read to me), and understand the information about the Life Stone services. I have had all my questions answered fully. I do hereby seek and consent to take part in the services provided by this organization and hold this organization harmless for any or all treatments. I agree to play an active role in my treatment. We reserve the rights to refuse and/or discontinue service at any time and for any reason.

I understand that no promises have been made to me as to the results of treatment or of any procedures or services provided by this agency and/or service providers at this agency. While psychotherapy cannot insure the successful resolution of issues you face, it is our experience that most people can gain benefit from the therapeutic process.

I understand that Life Stone is not a medical facility. Clients should have regular medical evaluations to identify any health or medical needs. Clients must inform Life Stone of any health or medical conditions that may be relevant to the services provided at Life Stone.

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in our offices. If I am participating in an electronic service, I understand that I must be in the state of Utah to receive these services. If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact; this allows you to maintain your privacy.

FINANCIAL RESPONSIBILITY:
I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged the full self-pay rate for that appointment. Insurance will not pay for these fees.

I understand that I will be responsible for the cost of all services provided. Full payment is due at the time of service; I understand that I will be paying my bill at the time of service even if I have insurance coverage. I am aware that an agent of my insurance company or other third-party payer may be billed and/or given information about the type(s), costs, date(s), & providers of any services or treatments I receive. I understand that I will be financially responsible for any legal requirements requested on the client's behalf at $150.00 per hour.

Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims. If your insurance company rejects your claim, you are responsible to pay the balance in full upon receipt of your statement. I understand that if payment is not received for my services, the therapist may discontinue my treatment. We may charge for paperwork requests that we judge to be beyond basic. Life Stone is NOT contracted with Medicaid or Medicare facility, and will not bill services to these entities.

RETURNED CHECKS: A $35.00 handling charge is applied to all returned checks.

DELINQUENT ACCOUNTS: All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay all collection costs. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account., including wireless telephone numbers which could result in charges to you. We may also contact you by send text messages or e-mail, using any email address you provide us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of Patient or Patient Representative* Date
*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

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No Show/Cancellation Policy

To ensure that we are able to provide appropriate and consistent services for both you and your family, we ask that you make every effort to attend all scheduled appointments. Please take a moment to review the guidelines we have put into place to ensure that you get the most out of your experience with Life Stone Counseling Centers.

- It is our strict policy to stay on time for all scheduled appointments. We ask that you please arrive ten minutes prior to your appointment, to allow time for check-in and any needed paperwork.

- If you are more than 15 minutes late, your appointment will more than likely need to be rescheduled due to conflicting appointments and a No-Show will be recorded for that day. If you are aware that you are going to be late, please call the office as soon as possible and let us know.

- If you are unable to attend a scheduled appointment, we require that you directly notify our office staff (not your therapist) of your intended absence at least 24 hours in advance at (801) 984-1717. You may leave a message if calling outside of business hours.

- If you do not cancel within 24 hours or do not show for your scheduled appointment, you will be charged $100.00 fee (a $50 fee applies for those scheduled with our Master Level Interns).
  PLEASE NOTE: Insurance does not cover the cost of No-Shows or Late Cancellations. These are your responsibility.

- A No-Show or Late Cancellation may result in the removal of all future scheduled appointments. You will need to call to resume and/or reschedule your appointments.

- Life Stone is happy to offer repeating appointments to clients when possible. Please note, it is still your responsibility to call and cancel these with 24 hours.

In the event that I experience an event that results in a Late Cancellation/No-Show, I give Life Stone permission to charge my credit card for the associated fee. My credit card information is as follows:

Card Type: Visa MasterCard Discover American Express Other: _____

Card #:_____ Expiration: _____ Security Code: _____

My Signature below shows that I understand and agree to adhere to the No-Show/Late Cancellation Policy. I also agree to the charge of my credit card provided for fees associated with this policy.

_____ _____

Signature of Patient or Patient Representative* Date

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*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

Arbitration Agreement

Client Name (First / Middle / Last): _____

Article 1. Dispute Resolution
By signing this agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2. Definitions

A. The terms "we," "parties" or "us" means you, (the Patient), and the Provider.
B. The term "Claim" means one or more Actions defined in the Utah Health care Malpractice Act (Utah Code 78-14-3 (15). Each party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.
D. The term "Patient" or "you" means you and any person who makes a Claim for care given to you, such as your heirs, your spouse, children, parents or legal representatives.

Article 3. Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any and all Claims by the following:
   a. Working directly with each other to try and find a solution that resolves the Claim; OR
   b. Using non-binding mediation (each of us will bear one-half of the costs); OR
   c. Using binding arbitration as described in this Agreement.
B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and cots of our own attorney.
C. Arbitration-Final Resolution. If working with the Provider or using non-binding mediation dos not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4. How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving this Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
   a. Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
   b. Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

Client Initials _____

E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Jointed may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Jointed Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5. Liability and Damages May be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel e selected for considering damages. However, if a second panel is selected, the Jointly –Selected Arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6. Venue/Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre-litigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7. Term/Rescission/Termination

A. Term. This Agreement is binding on both of us for one year form the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date of the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this Agreement (see Article 4(E).
C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises wile it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8. Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9. Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10. Receipt of Copy I may receive a copy of this document by request.

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

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Adverse Childhood Experiences (ACE) Study

About the Study: What Everyone Should Know

Over 17,000 Kaiser Permanente members voluntarily participated in a study to find out about how stressful or traumatic experiences during childhood affect adult health. After all the identifying information about the patients was removed, the Centers for Disease Control and Prevention processed the information the patients provided in their questionnaires.

Here's What We Learned:

Many people experience harsh events in their childhood. 63% of the people who participated in the study had experienced at least one category of childhood trauma. Over 20% experienced 3 or more categories of trauma, which we call Adverse Childhood Experiences (ACEs).

- 11% experienced emotional abuse.
- 28% experienced physical abuse.
- 21% experienced sexual abuse.
- 15% experienced emotional neglect.
- 13% witnessed their mothers being treated violently.
- 27% grew up with someone in the household using alcohol and/or drugs.
- 19% grew up with a mentally-ill person in the household.
- 23% lost a parent due to separation or divorce.
- 5% grew up with a household member in jail or prison.

ACEs seem to account for one-half to two-thirds of the serious problems with drug use. They increase the likelihood that girls will have sex before reaching 15 years of age, and that boys or young men will be more likely to impregnate a teenage girl.

Adversity in childhood causes mental health disorders such as depression, hallucinations and post-traumatic stress disorders.

The more categories of trauma experienced in childhood, the greater the likelihood of experiencing:

- alcoholism and alcohol abuse
- chronic obstructive pulmonary disease (COPD)
- depression
- fetal death
- poor health related quality of life
- illicit drug use
- ischemic heart attack (IHD)
- liver disease
- risk for intimate partner violence
- multiple sexual partners
- sexually transmitted diseases (STDs)
- smoking
- obesity
- suicide attempts
- unintended pregnancies

If you experienced childhood trauma, you're not alone!

For more information about the ACE Study, email carolredding@acestudy,org, visit www.acestudy.org or the Center for Disease Control and Prevention at www.cdc.gov/NCCDPHO/ACE

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Adverse Childhood Experiences (ACE) Questionnaire

Answer the following questions. Enter a 1 in the slot if the answer is yes.
While you were growing up, during the first 18 years of life:

1. Did a parent or other adult in the household **often or very often**
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**
   Push, grab, slap or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were to drunk or high to take care of you or take you to the doctor if needed?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:

Often or very often pushed, grabbed, sapped or had something thrown at her?

or

Sometimes, often or very often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who ever used drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison (jail)?

Yes No If yes enter 1 _____

Now Add up your "Yes" answers: _____ This is your ACE Score.

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Dissociative Experiences Scale-II (DES-II)

Carlson, Putnam

Client Name (First / Middle / Last): _____

DIRECTIONS: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you, and circle the number to show what percentage of the time you have the experience.

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

3. Some people have the experience of finding themselves in a place and have no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

6. Some people sometimes find that they are approached by people that they do not know, who call them by another name or insist that they have met them before. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

8. Some people are told that they sometimes do not recognize friends of family members. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

10.Some people have the experience of being accused of lying when they do not think that they have lied. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

19. Some people find that they sometimes are able to ignore pain. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle the number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
Never Always

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle the number to show what percentage of the time this happens to you.

0%	10	20	30	40	50	60	70	80	90	100%
Never										Always

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle the number to show what percentage of the time this happens to you.

0%	10	20	30	40	50	60	70	80	90	100%
Never										Always

25. Some people find evidence that they have done things that they do not remember doing. Circle the number to show what percentage of the time this happens to you.

0%	10	20	30	40	50	60	70	80	90	100%
Never										Always

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle the number to show what percentage of the time this happens to you.

0%	10	20	30	40	50	60	70	80	90	100%
Never										Always

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle the number to show what percentage of the time this happens to you.

0%	10	20	30	40	50	60	70	80	90	100%
Never										Always

28. Some people sometimes feel as if they are looking at the world through a fog, so that people and objects appear far away or unclear. Circle the number to show what percentage of the time this happens to you.

0%	10	20	30	40	50	60	70	80	90	100%
Never										Always