Psychiatry High Risk Program
Psychiatry Faculty Practice, Inc.
719 Harrison St., 3rd Floor
Syracuse, NY 13210
315.464.3117 Phone
315.464.3263 FAX

Program Summary

Thank you for considering Upstate's Psychiatry High Risk Program, an innovative recovery-based suicide prevention program for youth and young adults ages 14 through 40 years, recognized by the national Suicide Prevention Resource Center as "a best practice" in suicide prevention. Common conditions of clients treated in our program include depression and anxiety, bipolar disorder, eating disorders, borderline personality disorder, PTSD, or addictive behaviors. Instead of treating repeated crises through support, advice, and symptom management in a chronic illness model, we address the underlying vulnerabilities of these conditions, so that our clients no longer feel stuck alone with overwhelming pain. Most clients describe treatment at our program as very different and more helpful than previous treatments with which they have participated.

The program is outpatient only; there is no residential or day hospital component. Treatments include evidence-based individual psychotherapy, along with medication management, family and group therapy as needed. Through addressing underlying neurocognitive and psychosocial vulnerabilities, we aim for transformative healing, building resilience for long-term recovery. Note that family therapy sessions are strongly encouraged for any teen or adult who is living with their parents.

In order for the program to be helpful to you, it is necessary to make the commitment to yourself to attend sessions on a regular basis, work towards health and recovery, actively participate in treatment, and enable open communication among all members of your care team, including your primary care provider. **Your first 4 sessions are for consultation purposes to see if the program is a good fit for your needs; therefore, keep your current therapist and psychiatrist until you are formally admitted into the program.** The first two of these sessions will involve a comprehensive psychiatric evaluation for treatment planning purposes. Please bring previous records to these sessions. We do not prescribe injectables or controlled medications in the program, except for younger teens. If you have questions, please call our Intake Coordinator Nichole at (315) 464-3117 or email her at GallaN@upstate.edu.

Please check the appropriate box:

☐ Yes ☐ No I have read the above summary and agree to the commitments outlined in the last paragraph

PLEASE COMPLETE THIS FORM AS THOROUGHLY AS POSSIBLE:

PSYCHIATRY FACULTY PRACTICE INC.
DEPARTMENT OF PSYCHIATRY
719 Harrison St, Syracuse, NY 13210
tel. 315-464-3117 fax: 315-464-3263

DATE:

REFERRED BY:

PATIENT INFORMATION

LAST	FIRST	MI	SSN	BIRTHDATE	GENDER ASSIGNED AT BIRTH MALE ☐ FEMALE ☐
ADDRESS	CITY	STATE	ZIP		GENDER IDENTITY
HOME/CELL PHONE	ALT. PHONE				MARITAL STATUS M S W D
EMAIL	EMPLOYER/SCHOOL				OCCUPATION
EMPLOYER'S ADDRESS	CITY	STATE	ZIP		START DATE
NEXT OF KIN/EMERGENCY CONTACT (Person not living with you)		RELATIONSHIP			PHONE

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY AND ADDRESS	PHONE #	COPAY
POLICY/MEMBER ID #	GROUP #	
POLICY HOLDER ADDRESS (IF DIFFERENT)	SSN DOB	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY AND ADDRESS	PHONE #	COPAY
POLICY/MEMBER ID #	GROUP #	
POLICY HOLDER ADDRESS (IF DIFFERENT)	SSN DOB	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

GUARANTOR INFORMATION (person responsible for payment): ☐ Self

LAST	FIRST	MI	☐ PARENT (IF MINOR) ☐ SPOUSE ☐ OTHER_____	BIRTHDATE
ADDRESS (IF DIFFERENT FROM PT)	CITY	STATE	ZIP	SOCIAL SECURITY #
HOME/CELL PHONE	WORK PHONE	EMPLOYER/SCHOOL	OCCUPATION	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

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HISTORY FORM

In order to best serve you, please complete all of the following:

How did you hear about the program (or who referred you)? _____

What would you most like help with? _____

Have you been diagnosed with mental health conditions? If so, which diagnoses have been given?

_____

If you currently have a psychiatrist, therapist, or counselor, what are their names and organizations?

_____

How old were you when you first saw a psychiatrist, therapist, or counselor, and for what reason?

_____

Have you ever been admitted to a psychiatric hospital? If so, when was the most recent time?

_____

Have you ever tried to harm yourself or commit suicide? If so, when was the most recent time and what was the attempt? _____

Have any family members ever been treated for mental disorders or addictions? If so, which ones and for what conditions? (include parents, siblings, children, aunts, uncles and grandparents)

_____

With whom do you currently live, or are you homeless? _____

Have you ever been arrested, or have a current legal mandate? _____

Are you currently employed? If so, where and for how long? _____

--Would you be willing to attend weekly in-person sessions, unless you live far away? ☐ Yes ☐ No
--If you live longer than 45 min drive away, would you be willing to attend in-person at least monthly and have access to internet connection, webcam/phone, and a private location at home? ☐ Yes ☐ No

Are any of these active or pending services?

☐ Yes ☐ No SPOA, Health Home Assistance, or case management?

☐ Yes ☐ No Child Protective Services (CPS) open case?

☐ Yes ☐ No Medicaid Transportation assistance needed?

☐ Yes ☐ No EIP/504 or other accommodations for school or frequent meetings (1x monthly)?

Please list all medications that you are currently taking with dosages (include supplements and over-the-counter medications): _____

_____

What medications have you taken previously for mental health?

_____

_____

Are you allergic to any medications? If so, please list the medication and the allergic reaction to it:

_____

Have you seen a primary care provider within the past 6 months? If so, what is his/her name?

_____

Have you had any major medical (non-psychiatric) illnesses or surgeries? (Please list below current and past medical problems)

_____

What is your approximate HEIGHT _____ **WEIGHT** _____

How often do you have difficulties with... (check boxes)

	Frequently	Occasionally	Does not apply
Chest pain or palpitations?			
Shortness of breath?			
Stomach pain, nausea, diarrhea, or constipation?			
Difficulties with urination or sexual functioning?			
Joint or muscle aches?			
Dizziness or headaches?			
Irregular periods? (women only)			
Double or blurry vision? (other than needing glasses)			
Problems with your ears, nose, mouth, or throat?			
Problems with your skin or hair?			
Other physical symptoms not mentioned above? (please describe):			

Please check the box for YES or NO for the following psychiatric symptoms:	**YES**	**NO**
Do you ever see things or hear things that other people don't see or hear?		
Do you ever have panic attacks?		
Do you feel uncomfortable in crowded situations, such as malls or stores?		
Do you have scary memories or dreams of things that happened to you in the past?		
Have you ever had several days in a row of feeling so good that you hardly need any sleep, you are running from one thing to another, your thoughts are racing a mile a minute, and you get big ideas in your head?		

saving and transforming lives

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Consent for Video Recordings For Clinical Care or Education Purposes

I hereby authorize the Psychiatry Faculty Practice Inc. to:

Take and use video or digital photographs/images of myself either for enhancing the quality of the clinical care provided to me or for use in medical teaching. I understand that these images may be used in various mediums and may be transmitted electronically.

By signing below, I waive any rights I may have in such photographs/images or recordings, as well as the privilege of inspecting or approving them for determining their final disposition. I hereby agree to release Upstate Medical University and Psychiatry Faculty Practice Inc. from any and all liability in connection such photographing, video recordings, etc. for which I am hereby giving my consent. In the event that I wish to revoke my permission granted herein, I understand that I must do so in writing that will be signed and dated by me

Print Individual's Name: _____

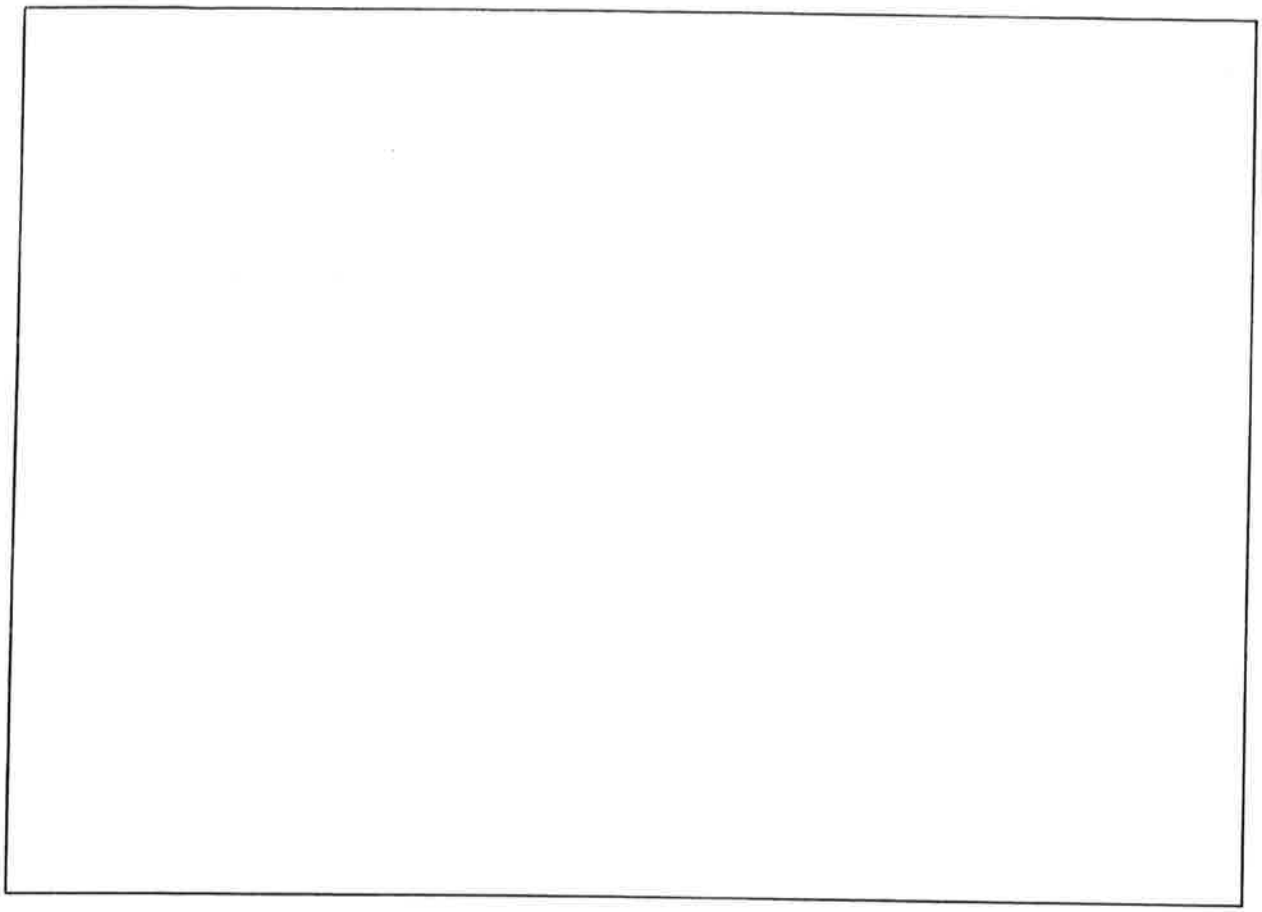
Signature: _____

Parent or Legal Guardian's Signature: _____
(Required for patients who are minors)

Date: _____

***Note that the recordings are used for purposes of peer feedback from other therapists in the Psychiatry High Risk Program after particularly challenging sessions. This feedback is important for ensuring that we are delivering to you the highest possible care. We therefore strongly encourage patients in the program to sign consent for recording to maximize their chances of success.**

Please describe a recent **CONFLICT** you had with another person in 5-10 sentences.



Safety Plan

A safety plan is a list of skills and supports that you create before a crisis so that you have it available at times when you are overwhelmed and less able to think clearly. Be sure to keep it in an easily accessible place and give copies to family and other supports so that they can help you to stay safe.

1. **Warning signs**

   What are the signs that you are doing worse or in crisis? These can be thoughts, feelings, behaviors, or types of situations.

   a.

   b.

   c.

   d.

2. **Activities and coping skills**

   What can you do by yourself to take your mind off of the problem? Ex: walking/gym, Netflix, drawing, music, reading, deep breathing, meditation.

   a.

   b.

   c.

   d.

3. **Social support**

   Who can you turn to for emotional support, distraction, or fun?

Name	Contact Information

4. **Steps to make the environment safer**

   Ex: limit access to weapons/meds/sharps, increase supervision, lockboxes

   a.

   b.

   c.

   d.

5. **Crisis Resources**

   1. **CONTACT** in Onondaga County: 315-251-0600 or dial 211
   2. **National Suicide Hotline**: Dial 988 or TEXT HELLO to 741741
   3. **Mobile Crisis**: Onondaga/Oswego County: 315-251-0800; Cortland: 607-756-3771; Cayuga: 315-253-0341; Madison: 800-721-2215

6. **In case of an emergency**, please CALL 911 or take self to ER, as well as call your therapist _____ at _____.

Borderline Evaluation of Severity over Time (Version 1.7)

Date:_____ [ ] Name:_____

FOR THE PAST MONTH...

The highest rating (5) means that the item caused extreme distress, severe difficulties with relationships, and/or kept you from getting things done. The lowest rating (1) means it caused little or no problems.

Circle the number which indicates how much the item in each row has caused distress, relationship problems, or difficulty with getting things done

A. THOUGHTS AND FEELINGS: [ ]	None/Slight	Mild	Moderate	Severe	Extreme
1. Worrying that someone important in your life is tired of you or is planning to leave you.	1	2	3	4	5
2. Major shifts in your opinions about others such as switching from believing someone is a loyal friend or partner to believing the person is untrustworthy and hurtful.	1	2	3	4	5
3. Extreme changes in how you see yourself. Shifting from feeling confident about who you are to feeling like you are evil, or that you don't even exist.	1	2	3	4	5
4. Severe mood swings several times a day. Minor events cause major shifts in mood.	1	2	3	4	5
5. Feeling paranoid or like you are losing touch with reality.	1	2	3	4	5
6. Feeling angry.	1	2	3	4	5
7. Feelings of emptiness.	1	2	3	4	5
8. Feeling suicidal.	1	2	3	4	5

B. BEHAVIORS (Negative): [ ]	None/Slight	Mild	Moderate	Severe	Extreme
9. Going to extremes to try to keep someone from leaving you.	1	2	3	4	5
10. Purposely doing something to injure yourself or making a suicide attempt.	1	2	3	4	5
11. Problems with impulsive behavior (not counting suicide attempts or injuring yourself on purpose). Examples include: over-spending, risky sexual behavior, substance abuse, reckless driving, binge eating, other_____ *(circle those that apply)*	1	2	3	4	5
12. Temper outbursts or problems with anger leading to relationship problems, physical fights, or destruction of property.	1	2	3	4	5

Circle the number below which indicates how often you used the following positive behaviors:

C. BEHAVIORS (Positive): [ ]	Almost always	Most of the time	Half of the time	Sometimes	Almost never
13. Choosing to use a positive activity in circumstances where you felt tempted to do something destructive or self-defeating.	5	4	3	2	1
14. Noticing ahead of time that something could cause you emotional difficulties and taking reasonable steps to avoid/prevent the problem.	5	4	3	2	1
15. Following through with therapy plans to which you agreed (e.g., talk therapy, "homework" assignments, coming to appointments, medications, etc.)	5	4	3	2	1

To the clinician: The total for each section (A, B, & C) should be recorded in the brackets next to the section titles above. At top of page record Composite Score = 15 + A + B - C

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use a check mark to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better of dead, or of hurting yourself.	0	1	2	3
	Add columns:	+	+	

TOTAL:

Please check YES or NO for the past month:

	YES	NO
1. Has there been a time in the past month that you wished you were dead or wished you could go to sleep and not wake up?		
2. In the past month, have you actually had any thoughts about killing yourself?		

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

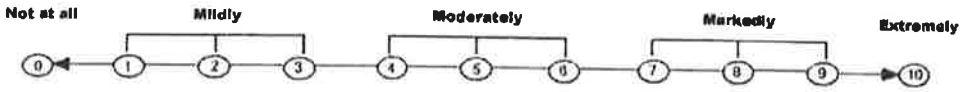
SHEEHAN DISABILITY SCALE

A BRIEF, PATIENT RATED, MEASURE OF DISABILITY AND IMPAIRMENT

Please mark ONE circle for each scale.

WORK* / SCHOOL

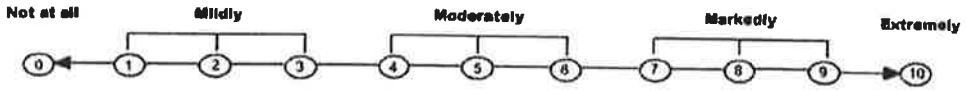
The symptoms have disrupted your work / school work:



☐ I have not worked /studied at all during the past week for reasons unrelated to the disorder.
* Work includes paid, unpaid volunteer work or training

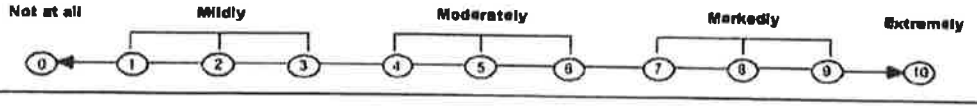
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:



DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

Interpersonal Needs Questionnaire (INQ) v.12.8.22

Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently, and mark one box ☑ indicating how you feel.		Not at all true for me			Somewhat true for me			Very true for me
1	These days, the people in my life would be better off if I were gone	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
2	These days, the people in my life would be happier without me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
3	These days, I think I am a burden on society	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
4	These days, I think my death would be a relief to the people in my life	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
5	These days, I think the people in my life wish they could be rid of me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
6	These days, I think I make things worse for the people in my life	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
7	These days, other people care for me	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
8	These days, I feel like I belong	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
9	These days, I rarely interact with people who care about me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
10	These days, I am fortunate to have many caring and supportive friends	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
11	These days, I feel disconnected from other people	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
12	These days, I often feel like an outsider in social gatherings	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
13.	These days, I feel that there are people I can turn to in times of need	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
14.	These days, I am close to other people	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
15.	These days, I have at least one satisfying interaction every day	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Self-Compassion Scale

For each of the following statements, please mark one box ☑ indicating how often over the past month you have reacted that way		Almost Never	Rarely	Sometimes	Often	Almost Always
1	When I fail at something important to me, I become consumed by feelings of inadequacy.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2	I try to be understanding and patient towards those aspects of my personality I don't like.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3	When something painful happens, I try to take a balanced view of the situation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4	When I'm feeling down, I tend to feel like most other people are probably happier than I am.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
5	I try to see my failings as part of the human condition.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6	When I'm going through a very hard time, I give myself the caring and tenderness I need.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7	When something upsets me, I try to figure out what emotions I am experiencing.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8	When I fail at something that's important to me, I tend to feel alone in my failure	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
9	When I'm feeling down, I tend to obsess and fixate on everything that's wrong	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
10	When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11	I'm disapproving and judgmental about my own flaws and inadequacies.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
12	I'm intolerant and impatient towards those aspects of my personality I don't like.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

TAS20 – Identifying Feelings

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

Circle 1 if you STRONGLY DISAGREE
Circle 2 if you MODERATELY DISAGREE
Circle 3 if you NEITHER DISAGREE NOR AGREE
Circle 4 if you MODERATELY AGREE
Circle 5 if you STRONGLY AGREE

1.	I am often confused about what emotion I am feeling.	1 2 3 4 5
2.	I have physical sensations that even doctors don't understand.	1 2 3 4 5
3.	When I am upset, I don't know if I am sad, frightened, or angry.	1 2 3 4 5
4.	I am often puzzled by sensations in my body.	1 2 3 4 5
5.	I have feelings that I can't quite identify.	1 2 3 4 5
6.	I don't know what's going on inside me.	1 2 3 4 5
7.	I often don't know why I am angry.	1 2 3 4 5

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **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** …
   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
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **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** 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 too drunk or high to take care of you or take you to the doctor if you needed it?
   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 pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over 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 used street 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?
    Yes No If yes enter 1 _____

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

Upstate Behavior Inventory-9C © Robert Gregory 3.4.20

In the PAST 30 DAYS: *(for each item, please **fill in the number of days**)*

How many days did you spend in the emergency room or CPEP? ____

How many days did you spend on a psychiatric hospital ward? ____

How many days were you paid for working (employment) or were attending school? ____

How many days did you go on eating binges during which you ate so much that you felt uncomfortably full? ____

How many days did you force yourself to vomit, exercise excessively, use laxatives, or go on strict diets? ____

How many days did you try to harm yourself by cutting, overdose, puncturing, burning, or smothering? ____

How many days did you physically harm or threaten to harm another person? ____

How many days did you have 5 or more drinks containing alcohol (wine, beer, liquor, etc.)? ____

How many days did you use an illegal drug or use a prescription medication for nonmedical reasons? (Please include marijuana and prescribed THC) ____