THE
RESCUE
MISSION OF
MIDDLE GEORGIA

WOMEN'S DIVISION
APPLICATION FORM

Rescue Mission OF MIDDLE GEORGIA

WOMEN'S DIVISION – APPLICATION

Date of Application:_____ Age_____

CLIENT INFORMATION

Last Name:_____ First Name:_____ Nickname:_____

Last Address:_____ Apt, Lot, Bldg. #:_____

City: _____ County:_____ State:_____ Zip: _____

Date of Birth:_____ Place of Birth: _____

Social Security Number: _____-___-_____ Cell Phone Number:_____

Email Address: _____

Driver's License Number: _____ Driver's License State: _____ Any DUI's? _____

Do you have a picture ID? ( ) No ( ) Yes

Do you have a birth certificate? ( ) No ( ) Yes

Entry Point: ( ) Walk-In ( ) Court-Ordered ( ) Referral _____

List dates you have previously stayed here: _____

Next of Kin:

Name: _____ Phone:_____ Relationship:_____

Emergency Contact Information:

Name:_____ Address:_____

City: _____ County:_____ State:_____ Zip: _____

Relationship:_____

Home Phone:_____ Work Phone: _____

Cell Phone:_____

Physical characteristics: Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Ethnicity:
( ) Hispanic/Latino
( ) American Indian or Alaska Native
( ) Asian
( ) Black or African American
( ) Native Hawaiian or Pacific Islander
( ) White
( ) Two or More
( ) Other or Don't Know

Veteran:
( ) No
( ) Yes

FOR OFFICE USE ONLY
Date of Admission: _____
Date of Graduation: _____
Date of Dismissal: _____

FAMILY STATUS

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Do you have children? Y N Do you have custody of your children? Y N

Do you have an open CPS (Child Protection Services) case? Y N

Case Manager's name: _____

Case Manager's phone number: _____

	Child's FULL name	Date of Birth	Age	Child's Father's Name
1.				
2.				
3.				
4.				
5.				

Children, NOT living with you:

	Child's FULL name	Age	City & State of residence	Child's Father's Name	Guardian's Name
1.					
2.					
3.					
4.					
5.					
6.					

List any serious family relationship problems:

_____

_____

_____

HOUSING INFORMATION

Housing Status: ( ) Literally Homeless
( ) Imminently Losing Housing
( ) Unstably Housed and At-Risk of Losing Housing
( ) Stably Housed

How long have you been homeless?_____
How many times have you been homeless in the past 3 years?_____

Prior Night's Residence:

( ) Emergency shelter, including hotel or motel paid for with emergency shelter voucher
( ) Transitional housing for homeless persons
( ) Permanent housing for formerly homeless persons
( ) Psychiatric hospital or other psychiatric facility
( ) Substance abuse treatment facility or detox center
( ) Hospital (non-psychiatric)
( ) Jail, prison or juvenile detention facility
( ) Rental, no ongoing housing subsidy
( ) Owned, no ongoing housing subsidy
( ) Rental, with ongoing housing subsidy
( ) Owned, with ongoing housing subsidy
( ) Staying or living with a family member
( ) Staying or living with a friend
( ) Hotel or motel paid for without emergency shelter voucher
( ) Foster care home or foster care group home
( ) Place not meant for habitation (e.g. vehicle, abandoned building, bus station, etc.)
( ) Safe haven
( ) Other _____

Length of Stay in Prior Night's Residence:

( ) One week or less
( ) More than one week, but less than one month
( ) One to three months
( ) More than three months, but less than a year
( ) One year or longer

SPIRITUAL

How would you best describe your relationship with God? _____
Are you saved? ( ) Yes ( ) No
Religion: _____ Denomination: _____

HEALTH AND WELLNESS

General Health Status: ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

Medical Problems: ( ) No
( ) Yes, Please describe all medical problems _____

_____

_____

Disabling Conditions: ( ) No
( ) Yes, Please describe _____

_____

_____

Are you currently receiving any medical treatment? ( ) No
( ) Yes-All the treatment I need
( ) Yes-Some treatment, but I need more

Please list any medications you are taking or should be taking: _____

_____

_____

Who is financing your medical needs? _____

Have you been treated for any mental health problems (including bipolar disorder, Schizophrenia, depression, etc)?

( ) No
( ) Yes, When? _____

Please list diagnosis(es) and any medications prescribed for mental health problems: _____

Have you committed any suicidal action in the last five years? ( ) No
( ) Yes, describe _____

_____

Do you have ANY Known Allergies? (Y / N) Medical _____ Food _____

Are you a smoker? ( ) No
( ) Yes

Date of last TB test: _____ **Do you have TB?** ( ) No ( ) Yes ( ) Don't know

Date of last HIV test: _____ **Do you have HIV?** ( ) No ( ) Yes ( ) Don't know

Other Conditions:

( ) Illiterate or marginally literate
( ) HIV/AIDS related
( ) Tuberculosis
( ) Developmental disability
( ) Domestic violence victim, When? _____

ADDICTION

Do you have any addictions? ( ) No
( ) Yes-to drugs
( ) Yes-to alcohol
( ) Yes-to drugs and alcohol

List drug(s) and/or alcohol(s) of choice: _____

_____

Age started: _____ **How often did you use/drink?** _____

Date of last use: _____ **Longest period of sobriety:** _____

Have you ever been to an alcohol or drug rehabilitation center before?
( ) No
( ) Yes – List where, when and for how long: _____

_____

CRIMINAL BACKGROUND

Do you have any convictions? ( ) No
( ) Yes – list offense(s) and date(s): _____

_____

Have you ever been incarcerated? ( ) No
( ) Yes – list facility(ies) and date(s): _____

_____

Probation/parole officer (if applicable): Name: _____

Telephone Number: _____ Address: _____

Court cases pending: _____

Have you ever been convicted of a violent crime?
( ) No
( ) Yes – describe crime and when committed:

_____

Did you file a tax return last year? ( )No ( ) Yes

Do you have copy of the return? ( )No ( ) Yes

Vehicle:

Do you own a vehicle? Y N Is it in your possession? Y N

If you answered yes to either question,

Year_____ Make _____ Model _____ State, License/Tag #_____

Is this vehicle paid for? Y N If No, Finance Company name: _____

Monthly car payment: $ _____ Is your vehicle insured? Y N

Insurance Company: _____ Policy Number: _____

FINANCIAL INFORMATION

Have you received income from any source within the past 30 days? ( ) No
( ) Yes – describe below

Source	No	Yes	Amount	Date Started	Date Ended
Earned Income (Employment Income)					
Unemployment Insurance					
Supplemental Security Income (SSI)					
Social Security Disability Income (SSDI)					
Veteran Disability Payment					
Private Disability Insurance					
Workers Compensation					
Temporary Assistance for Needy Families					
General Assistance					
Retirement income from SS					
Veteran's Pension					
Pension from former job					
Child Support					
Alimony or other spousal support					
Other Source, Describe:					

Total Monthly Income: _____

Have you received any non-cash benefits from any source within the past 30 days?

( ) No
( ) Yes – describe below

Source	**No**	**Yes**	**Gateway ID**	**Password**
Food Stamps, Value: $ Date Benefits Load:				
Medicaid Health Insurance Program				
Medicare Health Insurance				
Veterans Administration (VA) Medical Services				
Other Source, Describe:				

Do you have any outstanding bills? ( ) No
( ) Yes – describe Below

Creditor	Monthly Payment	Due Date	Amount Past Due	Date of Last Payment

EDUCATION/WORK EXPERIENCE

Level of school completed:

( ) None
( ) Nursery School to 4th Grade
( ) 5th Grade to 6th Grade
( ) 7th Grade to 8th Grade
( ) 9th Grade
( ) 10th Grade
( ) 11th Grade
( ) 12th Grade, No Diploma
( ) High School Diploma
( ) GED
( ) Post-Secondary School (College, Technical School, etc.)

If you were enrolled in post-secondary education, what degree(s) have you earned?

( ) None
( ) Associates Degree
( ) Bachelors Degree
( ) Masters Degree
( ) Doctorate Degree
( ) Other Graduate/Professional Degree
( ) Certificate of Advanced Training or Skilled Artisan

Name of school(s): _____ Date(s) of graduation: _____

Degree(s) or certificate(s): _____

Are you currently in school or working on any degree or certificate? ( ) No
( ) Yes

Name of school: _____ Expected date of graduation:_____

Degree(s) or certificate(s): _____

Have you received any vocational training or apprenticeship certificates?

( ) No
( ) Yes – List _____

_____

JOB HISTORY

Employer	Position	Date Started	Date Ended

Please list any other skills or work experience: _____

_____

_____

NEEDS AND EXPECTATIONS

What do you see as the chief problem(s) in your life that you wish to resolve? _____

_____

What things have you done in an effort to resolve your problems? _____

_____

What are your expectations of the Rescue Mission of Middle Georgia (RMMG)? _____

_____

Do you feel that you are open to whatever the biblical solution might be to your problems? _____

_____

Is there any other information that you believe would be helpful to the RMMG?

_____

_____

Are you able to and do you commit to a minimum of one year of uninterrupted program at the RMMG? If no, why not? _____

_____

If applicable, have you obtained written permission from any legal supervision you may have (child support, probation, etc.) granting you permission to complete our life recovery program? _____

_____

Do you commit to refrain from the pursuit of romantic relationships , unless already legally married, while here at the RMMG?_____

_____

Are you physically and mentally able to fully participate in **ALL** aspects of our life recovery program, including work therapy assignments, while here at the RMMG?

_____

Please LIST your three most important goals:

1._____

2._____

3._____

Briefly describe your present situation: _____

_____

_____

_____

_____

Briefly describe your abuse history: _____

_____

_____

_____

_____

_____

_____

PRESENT Abuser's Information:

Last Name:_____ First Name:_____ Nickname:_____

Last Known Address:_____ City:_____ ST:____ Zip: _____

Phone Number:_____ Date of Birth:___/___/___

Social Security Number:_____ - ____ - _____

Place of Employment: _____

Height:_____ Weight:_____ Ethnicity:_____Hair Color:_____ Eye Color: _____

Identifying Physical Marks (birthmarks, scars, tattoos): _____

_____

What is the abuser's relationship to you (husband, boyfriend, etc.)? _____

How long have you had the relationship with the abuser?_____ When did the abuse start?_____

Frequency of abuse:_____ As a result of the abuse, have you ever sought medical treatment? Y N

If so, when?_____ Hospital?_____

Did you tell the medical practitioner you were hurt by your abuser? Y N

Have you ever notified law enforcement officials concerning the abuse? Y N If yes, when?_____

How many times of times notified law enforcement? _____

How many times has the abuser been arrested for abuse?_____

Prior to this, how many times have you left the abuser?_____ , and for how long?_____

Is the abuser the father of your children? Y N

Describe his relationship with your children: _____

_____

Describe his family background: _____

_____

_____

PRIOR Abuser's Information:

Last Name:_____ First Name:_____ Nickname:_____

Last Known Address:_____ City:_____ ST:____ Zip: _____

Phone Number:_____ Date of Birth:___/___/___

Social Security Number:_____ - ____ - _____

Place of Employment: _____

Height:_____ Weight:_____ Ethnicity:_____Hair Color:_____ Eye Color: _____

Identifying Physical Marks (birthmarks, scars, tattoos): _____

_____

What is the abuser's relationship to you (husband, boyfriend, etc.)? _____

How long have you had the relationship with the abuser?_____ When did the abuse start?_____

Frequency of abuse:_____ As a result of the abuse, have you ever sought medical treatment? Y N

If so, when?_____ Hospital?_____

Did you tell the medical practitioner you were hurt by your abuser? Y N

Have you ever notified law enforcement officials concerning the abuse? Y N If yes, when?_____

How many times of times notified law enforcement? _____

How many times has the abuser been arrested for abuse?_____

Prior to this, how many times have you left the abuser?_____ , and for how long?_____

Is the abuser the father of your children? Y N

Describe his relationship with your children: _____

_____

Describe his family background: _____

_____

_____

PERSONAL INVENTORY CHECK LIST

You are welcome to bring personal clothing with you as a client at the Rescue Mission of Middle Georgia. If you are unable to do this or do not have such, the Rescue Mission of Middle Georgia will supply a limited number of clothing items to you while you are a client here. Also, as it states in the client acknowledgment form, the staff of the Rescue Mission of Middle Georgia reserve the right to inspect the personal belongings, including closets/drawers, sleeping area and any area deemed necessary. Due to a limited space, you will only be able to maintain the level of items listed below. Any variations must be approved by the Women's Program Director.

Allowed items are as follows per family member:

- 10 shirts & 10 T-shirts
- 10 pair of pants (this includes shorts)
- 2 jackets (winter and spring)
- 2 dresses
- 2 skirts
- 4 pair of shoes
- 1 pair of shower slippers/flip flops
- 10 pairs of underwear
- 10 pairs of socks
- 10 bras
- 3 pajama sets

1 pocketbook
1 small bag of makeup
1 hairdryer
1 hair straightener
1 small manicure kit
1 hairbrush/comb

Tank tops are counted as bras and are not allowed to be worn as a covering.

When seasons change, residents can swap winter clothes for summer clothes. This will be done through the Bargain Center or in-house inventory through the Women's Division staff only.

There is absolutely NO asking any other staff member or residents for clothing or any other items.

The following items listed are the personal hygiene/clothing items that I have brought to the Mission:

Pants: _____ Shorts: _____ Shirts:_____ Dress:_____ Skirts:_____

Shoes: Tennis _____ Dress _____ Boots _____ Flip Flops _____

Coat/Jacket: _____ Pajamas:_____

Under clothes: Socks _____ Bras: _____ Under shorts _____

Other personal items brought: _____

If a resident is caught stashing items, asking other staff or residents for clothing or any other items are found with more inventory than she is allowed, **she will be asked to leave the program immediately.**

_____ _____ _____ _____

Client Signature Date Staff Signature Date

Liability Release

I, _____ and my children staying with me, hereby release the Rescue Mission of Middle Georgia and the Rescue Mission employees and any volunteer of any responsibilities in the event of accidents, injuries, or loss to myself or my property, including, but not limited to the extracurricular/sports activities listed below.

	Child's name
1.	
2.	
3.	
4.	
5.	
6.	

I and my children, waive any claims that I may have against the Rescue Mission of Middle Georgia. I hereby assume all risks and responsibilities that the above named may incur while under the supervision of the Rescue Mission of Middle Georgia.

- Hiking trips
- Softball games & practices
- Bike program/riding bikes or scooters
- Outings
- Walking/exercising
- Riding electric bikes
- Weightlifting
- Basketball
- Playground

_____ _____

Signature Date

_____ _____

Staff Date

RELEASE OF GENERAL INFORMATION AUTHORIZATION

I, _____ understand that the nature of my treatment and residency with the Rescue Mission of Middle Georgia requires the agency to work hand in hand with professionals from outside the Rescue Mission. These others may include, but are not limited to, staff of River Edge Behavioral Health Center, the Division of Family and Children's Services, the Department of Labor, law enforcement officials, potential employers, counselors and others working with the Mission to make my journey back to the community successful. I understand that the nature of this work requires staff of the Rescue Mission of Middle Georgia to share pertinent information when necessary to keep all informed. I hereby grant permission to the Rescue Mission to share information about my records and treatment when necessary for my successful completion of my care. I also understand that all those who would be receiving information regarding my confidential records have been briefed on confidentiality and are in agreement with honoring the confidentiality of those records.

_____ _____

Signature Date

_____ _____

Staff Signature Date

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS

As part of the conditions of my residency I, _____, do hereby authorize the Rescue Mission of Middle Georgia to obtain a criminal history record, medical/mental health records, Department of Family and Children Service records and credit report pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I agree to waive all rights allowing the Rescue Mission of Middle Georgia to inquire of my present and past history with any other agencies.

_____
Print Full Name

_____
Date of Birth

_____	_____	_____
Sex	Race	Social Security Number

_____	_____
Signature	Date

_____	_____
Staff Signature	Date

SUBSTANCE TESTING RELEASE FORM

I, _____ understand that part of my agreement to be a resident of the Rescue Mission of Middle Georgia is that I will follow the rules regarding the use of banned substances. I understand that to ensure that I am in compliance with this policy, the Rescue Mission of Middle Georgia will conduct random testing for nicotine, alcohol, illicit and prescription drugs, Kratom, synthetic cathinones, synthetic cannabinoids and any other substance that is mood or mind altering. I understand that these substances are forbidden as part of my commitment to stay at the facility.

I hereby grant the Rescue Mission of Middle Georgia permission to conduct this testing including but not limited to urine screens, hair follicle screening and blood screening, whenever and as often as they feel necessary to determine compliance with this rule.

_____ _____

Signature Date

_____ _____

Staff Signature Date

EMERGENCY CONTACT AUTHORIZATION

I, _____ understand that the Rescue Mission of Middle Georgia is dedicated to helping individuals get back on their feet and return to the community. I know that the staff always will work in a respectful and dignified way towards those coming to the agency for assistance. The Women's Division and Rescue Mission staffs believe in honoring your dignity and will not violate your confidentiality.

I also know that there are times when emergencies might arise that will cause the staff to contact my emergency contact without me being in a position to grant my verbal permission. I hereby release the staff of the Rescue Mission to contact the people designated on my application as an emergency contact when they feel it is necessary to do so.

_____ _____

Signature Date

_____ _____

Staff Signature Date

MEDICAL INFORMATION

In case of a medical emergency:

Please contact my Physician _____ Address _____

Phone _____

If hospitalization is required, I prefer:

Hospital Name _____ Address _____

Phone _____

I understand that any costs associated with my medical care or treatment is my responsibility. This includes Urgent Care / Emergency Room visits, COVID 19 testing, transportation by ambulance, and referrals to outside medical care facilities.

I understand that should I need any prescriptions for medical or mental health care, I am responsible for the cost of the prescriptions. If the Rescue Mission of Middle Georgia provides prescription assistance, I will reimburse the Mission for the full amount owed through an additional donation of my food stamps.

_____ _____

Signature Date

_____ _____

Staff Signature Date

INCOME WAIVER

I voluntarily give $125 of my food stamps to the Rescue Mission of Middle Georgia to help offset the cost of food. If I have children here in the program with me, I will give $50 per child. I will provide my food stamp card and pin number to an authorized Mission representative to purchase food on my behalf. I understand that if The Mission has to cover the cost of anything for me (such as prescription costs, etc.) I will reimburse The Mission with the equivalent amount in food stamps.

_____ _____

Signature Staff Signature

Date: _____ Date: _____

Release for Publication

During the course of your stay at the Rescue Mission of Middle Georgia, there will be occasions when you may be photographed and/or videotaped by staff, sponsors, corporate representatives, media and others. We request permission for your participation. By signing below, you may choose to grant or deny the Rescue Mission of Middle Georgia, Inc. permission to use photographs or videotapes of yourself, alone or in groups, in newspaper articles, newsletters, website, online, brochures, special fundraising activities, scrapbook, videos and photo albums for use in public understanding and support of the Rescue Mission of Middle Georgia. By granting permission below, you hereby release and hold harmless, the Rescue Mission of Middle Georgia, Inc. from any claims, judgments, or demands, which may arise from the use of the above, referenced photographs and/or videotapes.

Please initial one:

____ YES, I give permission to be photographed and/or videotaped for publication.

____ NO, I deny consent to be photographed and/or videotaped for publication.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Residents Statement of Rights & Privacy Policy

All clients; former, current or potential are to be treated with dignity and respect. Our highest priority is our clients. Therefore, each member of the staff is to ensure that clients are always safe, treated consistently with Biblical precepts and Mission values, and that the interest of the Mission, an employee, or a partnering individual or organization is not advanced at the expense of a client.

The Rescue Mission of Middle Georgia acknowledges and protects the rights of the persons we serve. All Rescue Mission of Middle Georgia's services, programs, policies, and procedures should be developed and carried out in accordance with these values. Each person served will:

- Be treated at all times with dignity, respect, honesty, and compassion.
- The Rescue Mission shall not discriminate on the basis of race, creed, age, sex or disability.
- Receive services that meet all regulatory and professional standards.
- Experience confidentiality and privacy within the context of accountability.
- Give informed consent and participate in decisions regarding service, care, or treatment.
- Have access to information in their client record.
- Be able to refuse participation in research and public relations exposure.
- Be assured that services will be delivered with awareness and respect for cultural, racial, gender, age, physical, mental, and other individual differences.
- Be treated with respect as we expose them to the love of Jesus Christ—regardless of their religious beliefs.
- Be able to express and to have a method for resolving disagreements about services or treatment received or recommended.
- Have opportunity to file a formal grievance in accordance with the Mission's Grievance Policy.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Grievance Policy

As a client of the Rescue Mission of Middle Georgia Life Recovery Program, you have the right to file a grievance if you feel you have been treated unfairly in any way. You will suffer no repercussions as a result of filing a grievance. All grievances will be addressed in a confidential manner.

If you have a grievance or recommendation, you should first discuss it with the staff member you are working with. If this is not successful, or you feel this is not an option, you should proceed with the following steps:

1. A grievance form should be completed (including the date and time of the grievance). Forms are posted and available in the lobby of the admin building.

2. Submit the grievance to the program director within 10 working days. If your grievance is with program director, your form should be submitted to the President/CEO, c/o The Rescue Mission of Middle Georgia, 6601 Zebulon Rd., Macon, GA 31220. An appointment or phone conference will be scheduled to discuss the grievance with your program director or the President/CEO.

3. If a resolution has not occurred in 10 working days, your grievance will be referred to the President/CEO. An appointment will be scheduled with you. If the problem is not resolved at this level within 10 working days, a team comprised of the CEO and a member of the Board of Directors Executive Committee will listen to the information about the incident and will mediate the grievance.

4. If filing a grievance against the President/CEO, please email the completed grievance to: susancollins@yahoo.com. A Board representative will contact you within 30 days to schedule a time to meet/discuss the issue at hand.

5. If the determination of the mediation team is still not satisfactory to you, you may contact The GARR Network, 8343 Roswell Rd #267, Atlanta, GA 30350, (470) 296-3435.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Communicable Disease Policy

There are some things you can do to STOP the spread of infectious disease. Maintaining good general health as well as the following can help stop the spread.

- Wash your hands regularly and well using soap and warm water.
- Stay in your room if you are sick and notify staff or the resident manager.
- Cover your cough and sneezes
- Clean the surfaces in your house regularly
- Sanitize all areas of your house on a regular basis

Please refer to the Communicable Disease Chart posted in your house as well.

Medication Policy

Residents may keep approved over the counter and prescribed medications. The client assumes responsibility for self-administering any medication according to the prescriber's order and manufacturer's direction for prescription medications.

Medications NOT approved:

- No nighttime medications (ex. Nyquil, Tylenol PM,)
- No Cordicidin HBP medications or any other DXM (dextromethorphan) medication
- No mouthwash containing alcohol
- No prescription pain medications
- No prescription barbiturates or benzodiazepines
- No muscle relaxer or tranquilizers

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Please list ONLY FIVE expected family visitors AND their relation to you:

1. Name: _____ Relation: _____

2. Name: _____ Relation: _____

3. Name: _____ Relation: _____

4. Name: _____ Relation: _____

5. Name: _____ Relation: _____

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Duke Anxiety –Depression Scale (DUKE-AD)

Instructions: Here are some questions about your health and feelings. Please read each question carefully and check your best answer. You should answer the questions in your own way. There are no right or wrong answers.

	Yes, describes me exactly	Somewhat describes me	Doesn't describe me at all
1. I give up too easily……..	_____ 2	_____ 1	_____0
2. I have difficulty concentrating……	_____ 2	_____1	_____0
3. I am comfortable being around people….	_____ 0	_____ 1	_____2

During the past week:
How much trouble have you had with:

	None	Some	A lot
4. Sleeping……	_____ 0	_____1	_____ 2
5. Getting tired easily……	_____ 0	_____1	_____ 2
6. Feeling depressed or sad……..	_____ 0	_____1	_____ 2
7. Nervousness…….	_____ 0	_____1	_____ 2

How to score:

1. Add the scores next to each of the blanks you checked.
2. If your total score is 5 or greater, then your symptoms of anxiety and/or depression may be excessive.

For exact scoring, multiply the total score by 7.143 to obtain the DUKE-AD score on a scale of 0 for lowest and 100 for highest symptom level.

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the screen should be considered positive if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale:
Instructions:
In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES NO

3. Were constantly on guard, watchful or easily startled?

   YES NO

4. Felt numb or detached from others, activities or your surroundings?

   YES NO