**Hello! Welcome to Tomorrow's Rainbow where we are dedicated to nurturing emotional wellness and resiliency for children, teens, and families experiencing grief, loss, and trauma.**

My name is Abby Mosher, and I am the Founding Executive Director of Tomorrow's Rainbow. After a personal tragedy changed my life, I realized that our community was missing a specialized oasis for families to heal from grief, loss, and trauma. Tomorrow's Rainbow is an emotionally safe setting where horses (big and small) and experiential services, including art and play, are combined in a natural setting to promote emotional wellness. We believe in treating every client as a unique individual and will play to your strengths in supporting you and your family.

If you choose to share you and/or your family's progress and experience with others, we welcome you to do so. Please know that should you choose to refer a potential client to work with us, all information is confidential and protected under HIPAA guidelines including all Telehealth services. Tomorrow's Rainbow does not share information with others without your consent.

Attached, you will find our new client registration package. Don't be overwhelmed by the paperwork. We are here to help! If you have any questions, we will be glad to assist you. We will reach out to you to schedule your family's intake and orientation once we receive your paperwork.

Two way communication is essential to every successful therapeutic relationship. With that said, Tomorrow's Rainbow is located on private property, and no unscheduled visits are allowed. If you have concerns or questions, please feel free to call, email, or text us. We are here to support you. I look forward to meeting you in person and sharing the Tomorrow's Rainbow experience with you!

Most sincerely,

Abby Mosher
Executive Director/CEO
Tomorrow's Rainbow, Inc.

**Tomorrow's Rainbow, Inc.**
**954.978.2390**
**4341 NW 39th Avenue**
**Coconut Creek, FL 33073**

# INTRODUCTION TO TOMORROW'S RAINBOW

Tomorrow's Rainbow is a not-for-profit organization founded by Abby Mosher in 2003 with the original mission of providing grief support groups to children, adolescents and adults. In 2019, Tomorrow's Rainbow expanded its scope of services and embarked on a new mission: ***Nurturing emotional wellness and resiliency for children, teens, and individuals experiencing grief, loss, and trauma.***

The Tomorrow's Rainbow bereavement model is a comprehensive, innovative program that combines peer facilitated grief support, equine assisted services, and expression through art and play. We utilize the world-renowned Dougy Center's model for peer facilitated grief support, which recognizes that:

- Grief is unique for each individual
- The intensity and duration of grief is different for each person
- Within each of us is the capacity to heal
- Support helps in the grief process

Our goal is to provide a safe environment in which to:

1. discover and nurture strengths, interests and talents
2. support effort toward change
3. establish consistent and stable relationships
4. improve interpersonal skills
5. enhance self-worth and empowerment
6. gain greater communication skills

The therapy program at Tomorrow's Rainbow is a formalized clinical experience that integrates all of the exciting experiential opportunities utilized in our bereavement program.

**Considerations:**
Participants must wear clothing that is suitable for being on a farm and animal-oriented environment. **Clothing and shoes will get very dirty!** Closed toe shoes are mandatory and long pants are suggested. For bereavement groups, with the exception of the teen group, parents/guardians are required to stay on the property in the designated areas.

**Attendance:**
Regular attendance is important for a successful experience at Tomorrow's Rainbow. We request that every effort be made to keep absences and tardiness to a minimum.

**Directions:**
From I-95 or the Turnpike- exit on Sample Road going West [exit 39 for I-95, exit 69 for Turnpike]. Turn Right (North) on Lyons Road. Turn Right (East) on Wiles Road. Turn at the first Right (South) on NW 39th Ave. Go to the end of the street and make a right. Pull into the first driveway on your right before the Tomorrow's Rainbow sign.

*Please keep in mind that Tomorrow's Rainbow is also a private residence. No unscheduled visits are permitted.*

**Send completed packet to:**
Tomorrow's Rainbow
4341 NW 39th Ave.
Coconut Creek, FL 33073
Fax: (754) 732-0994
Email: ashley@TomorrowsRainbow.org

*revised Jan 2022*

**Tomorrow's Rainbow, Inc.**
**954.978.2390**
**4341 NW 39th Avenue**
**Coconut Creek, FL 33073**

## REGISTRATION

Client's Name: ______________________________Date:______________________

Address: ________________________________________________________________

City: ________________________________________ Zip Code: __________________

If minor, lives with (name):______________________________________________

Relationship:______________________________________________________________

Cell Phone: ___________________________ Home Phone: _______________________

Email address (required): ________________________________________________

## HISTORY

Age: _______________ Date of Birth: ___________________ Grade: ___________________

Please give a brief life history of concerns including any grief, loss or trauma:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

List any support for grief, loss or trauma: ______________________________________

Are there any mental health diagnoses (ADHD, anxiety, depression)? __________________

__________________________________________________________________________

Current medical history including any medications taken for medical or mental health issues: __________

__________________________________________________________________________

__________________________________________________________________________

Does the client currently attend therapy? ☐ Yes ☐ No ______________________________

Is there anything else that you would like us to know? ______________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

*(use the back of the page if necessary)*

*For Staff Use Only*
Date received:________________________________ By: ___________________________

*revised Jan 2022*

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**Coconut Creek, FL 33073**

# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Client's Name: ______________________________ DOB: ______________

Address: ______________________________________________

Physician's Name: ____________________ Phone #: ______________________

Health Insurance Co: __________________ Policy #: ______________________

Allergies to Food/Animals/Etc.: ________________________________________

Allergies to Medications: ______________________________________________

Current Medications: _________________________________________________

In the event of an emergency, contact:

Name: __________________ Relationship: ____________ Phone: ____________

Name: __________________ Relationship: ____________ Phone: ____________

In the event emergency medical aid/treatment is required due to illness or injury during the participation in programs, or while on the property, I authorize Tomorrow's Rainbow, Inc., to:

1. Secure and retain medical treatment and transportation if needed; and
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

**Consent**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Signature of Client/Parent/Guardian: ______________________________ Date: __________

**Non-Consent**

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of participating in programs while on the property. In the event emergency treatment/aid is required, I wish the following procedure to take place:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Signature of Client/Parent/Guardian: ______________________________ Date: __________

**Tomorrow's Rainbow, Inc.**
**954.978.2390**
**4341 NW 39th Avenue**
**Coconut Creek, FL 33073**

## WARNING

## UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

RELEASE AND INDEMNITY AGREEMENT

In consideration of the acceptance of my participation and/or the participation of my child or ward, in any equine assisted activity and/or any activity sponsored by Tomorrow's Rainbow, Inc., Hit the Hay, Inc., and/or Abby J. Mosher, and with the understanding that a horse may be startled by sudden movement, noise or other factors, and may shy suddenly, rear, stop short, bite, buck, kick or run, especially when the program is conducted in a natural setting, as this program is, I AGREE TO ASSUME THE RISKS incidental to such participation including, but not limited to, those risks set out above, and, on my own behalf, on the behalf of my child or ward, and on behalf of my child's or ward's heirs, executors and administrators, RELEASE and forever discharge the released parties defined below, of and from all liabilities, claims, actions, damages, costs or expenses of any nature, arising out of or in any way connected with my participation and/or the participation of my child or ward in such equine assisted services and further agree to indemnify and hold each of the released parties harmless against any and all such liabilities, claims, actions, damages, costs or expenses, including, but not limited to, attorney's fees and disbursements. The released parties are Tomorrow's Rainbow, Inc., Hit the Hay, Inc., and/or Abby J. Mosher their parent, related, affiliated and subsidiary companies, and the officers, directors, employees, agents, representatives, volunteers, guests, landholders, land owners, successors and assigns of each. I understand that this release and indemnity agreement includes any claims based on the negligence, actions or inaction of any of the above released parties and covers bodily injury and property damage, whether suffered by me, my child or ward before, during or after such participation and I acknowledge that participation is not covered by workman's compensation insurance. I further authorize medical treatment for myself, child or ward, at my cost, if the need arises.

| | |
|---|---|
| ________________________________ | ________________________________ |
| Signature of Client (if adult) | Print name of Client |
| ________________________________ | ________________________________ |
| Signature of Client's Parent/Guardian (if applicable) | Date |

**Tomorrow's Rainbow, Inc.**
**954.978.2390**
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**Coconut Creek, FL 33073**

# CLIENT AUTHORIZATION FOR RELEASE OF PHOTOGRAPH/VIDEO/AUDIO/MEDIA

Client's Name: ______________________________________________________________

I hereby grant permission to use photograph(s), audio, video(s), or other likeness(es) of me or my child in a WORK presently referred to as "THE WORK." This may include, but is not limited to, newspaper and magazine articles, advertising materials, and Internet web site content including social media to be used for marketing, advertising and/or instructional purposes designed to benefit the mission of Tomorrow's Rainbow, Inc., and its clients.

The mission of Tomorrow's Rainbow, Inc., is nurturing emotional wellness and resiliency for children, teens, and families experiencing grief, loss, and trauma. Said photograph(s), media, or likeness(es) may be used in connection with the advertising and promotion of Tomorrow's Rainbow, Inc., and "THE WORK" may be published in any and all languages throughout the world.

I also acknowledge that the foregoing rights may be exercised by publishing companies, magazines, newsletters, newspapers, social media and websites. In addition, if I am receiving services by a student intern, my audio/video recordings may be utilized for supervision purposes and/or to enhance the education of student interns at Tomorrow's Rainbow.

_____________________________________________ ___________________________

Signature of Client (if over 18) Date

_____________________________________________ ___________________________

Signature of Parent/Legal Guardian (if client is under 18) Date

_________________________________________________

Address

_________________________________________________

City, State, Zip

_________________________________________________

Phone

☐ I decline to participate in the Release of Photograph/Video/Audio/Media consent.

*revised Jan 2022*

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# AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Client's Name:_______________________________________________

☐ The above referenced client does not receive therapy (do not complete this form).

I hereby give my permission for Tomorrow's Rainbow, Inc. to release to or request from the practice/agency/person(s) listed below, information contained in my or my child's health record. Information may be disclosed/requested verbally, electronically and/or in writing. I understand that my or my child's health record may contain information concerning my or my child's psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

**Name of Practice/Agency:**_______________________________________________
**Name of Person(s) and Title:** ______________________________**Phone:**______________
**Email:**____________________________________ **Fax:**______________________

*Please check one box below:*
**☐ I give permission for all records to be disclosed/requested**
**☐ I give permission for all records to be disclosed/requested EXCEPT the following:**

_______________________________________________________________

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

I am authorizing the disclosure of this health information voluntarily. I can refuse to sign, and Tomorrow's Rainbow, Inc., will not deny services. I understand that I may inspect or request a copy of the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

My signature below acknowledges that I understand that:

- I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Tomorrow's Rainbow, Inc.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information. Tomorrow's Rainbow, Inc., cannot guarantee confidentiality in these instances and will not be held liable for information re-disclosed.
- Tomorrow's Rainbow, Inc., will release only the minimum amount of information necessary to support quality client care.

*This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.*

______________________________ ______________________
Signature of Client/Parent/Guardian Date

*revised Jan 2022*

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**954.978.2390**
**4341 NW 39th Avenue**
**Coconut Creek, FL 33073**

## CLIENT DEMOGRAPHIC INQUIRY

**Client's Name:** ______________________________ Date: ____________________

To help us serve you better, please complete the following:

How many children in the home? (Circle one) 1 2 3 4 5 6 7 8

How many adults in the home? (Circle one) 1 2 3 4 5 6

**What is the total household income? (Circle one)**

a. Less than $10,000
b. $10,000 - $21,780
c. $21,781 - $29,420
d. $29,421 – $37,060
e. $37,061 - $44,700
f. $44,701 - $52,340
g. $52,341 - $59,980
h. $59,981 - $67,620
i. $67,621 - $75,260
j. over $75,261

**What is the client's race?**

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Multiracial
- ☐ Other: ____________________

**What is client's ethnicity?**

- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic
- ☐ Haitian
- ☐ Mexican American
- ☐ Spanish/Latino
- ☐ None of the above

***If client is a child, please complete the following:***

Does your child qualify for a free or reduced school lunch program? ☐ Yes ☐ No
Do you or your child receive Social Security Disability Income or Food Stamps? ☐ Yes ☐ No
Does your child receive Medicaid or Florida Healthy Kids? ☐ Yes ☐ No

*Tomorrow's Rainbow does not discriminate based on age, religion, race/ethnicity, or socio-economic status.*

*revised Dec 2022*

**Tomorrow's Rainbow, Inc.**
**954.978.2390**
**4341 NW 39th Avenue**
**Coconut Creek, FL 33073**

## Health Insurance Portability Accountability Act (HIPAA)
## Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

**LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

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There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

## CLIENT RIGHTS AND THERAPIST DUTIES

**Use and Disclosure of Protected Health Information:**

- ***For Treatment* –** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

**Patient's Rights:**

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed.

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Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

**Therapist's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.
- **Outdoor Setting:** Services at Tomorrow's Rainbow are located primarily in an outdoor setting. While we will work to keep your confidentiality, the setting has clear sightlines to other properties. The setting may have volunteers, other clients, staff or unexpected visitors which may notice that a session is occurring. Due to the nature of the setting, this may mean that people in the neighborhood, volunteers, staff, other clients or unscheduled visitors may recognize you.

**COMPLAINTS**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

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**Coconut Creek, FL 33073**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Client Name: ______________________________________________ CL________________

I hereby acknowledge that I have received a copy of Tomorrow's Rainbow's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____________________________________________ ____________________________

Signature of Client or Legal Representative Date

_____________________________________________

Printed Name of Client's Representative (if applicable)

Relationship to Client (if applicable)

□Parent or guardian of unemancipated minor
□ Court appointed guardian
□ Executor or administrator of decedent's estate
□ Power of Attorney

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, ___________________________ but acknowledgement could not be obtained because:

□ Client/Guardian refused to sign
□ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
□ Communication barriers prohibited obtaining acknowledgement (explain)

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

□ Other (specify)

_____________________________________________________________________________

_____________________________________________________________________________

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# MOOD AND FEELINGS QUESTIONNAIRE: Long Version

This form is about how your child might have been feeling or acting **recently**.

For each question, please check (✓) how s/he has been feeling or acting ***in the past two weeks***.

If a sentence was not true about your child, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about your child most of the time, check TRUE.

**Score the MFQ as follows**:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

| **To code, please use a checkmark (✓) for each statement.** | **NOT TRUE** | **SOME TIMES** | **TRUE** |
|---|---|---|---|
| 1. S/he felt miserable or unhappy. | | | |
| 2. S/he didn't enjoy anything at all. | | | |
| 3. S/he was less hungry than usual. | | | |
| 4. S/he ate more than usual. | | | |
| 5. S/he felt so tired s/he just sat around and did nothing. | | | |
| 6. S/he was moving and walking more slowly than usual. | | | |
| 7. S/he was very restless. | | | |
| 8. S/he felt s/he was no good anymore. | | | |
| 9. S/he blamed him/herself for things that weren't his/her fault. | | | |
| 10. It was hard for him/her to make up his/her mind. | | | |
| 11. S/he felt grumpy and cross with his/her parents. | | | |
| 12. S/he felt like talking less than usual. | | | |
| 13. S/he was talking more slowly than usual. | | | |
| 14. S/he cried a lot. | | | |

| | | | |
|---|---|---|---|
| 15. S/he thought there was nothing good for him/her in the future. | | | |
| 16. S/he thought that life wasn't worth living. | | | |
| 17. S/he thought about death or dying. | | | |
| 18. S/he thought his/her family would be better off without him/her. | | | |
| 19. S/he thought about killing him/herself. | | | |
| 20. S/he didn't want to see his/her friends. | | | |
| 21. S/he found it hard to think properly or concentrate. | | | |
| 22. S/he thought bad things would happen to him/her. | | | |
| 23. S/he hated him/herself. | | | |
| 24. S/he felt s/he was a bad person. | | | |
| 25. S/he thought s/he looked ugly. | | | |
| 26. S/he worried about aches and pains. | | | |
| 27. S/he felt lonely. | | | |
| 28. S/he thought nobody really loved him/her. | | | |
| 29. S/he didn't have any fun at school. | | | |
| 30. S/he thought s/he could never be as good as other kids. | | | |
| 31. S/he felt s/he did everything wrong. | | | |
| 32. S/he didn't sleep as well as s/he usually sleeps. | | | |
| 33. S/he slept a lot more than usual. | | | |
| 34. S/he wasn't as happy as usual, even when s/he was praised or rewarded. | | | |

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