INSIGHT
Center for Counseling and Recovery

973.229.3198
159 East Main Street, Suite 2
Rockaway, NJ 07866
Fax: 862.209.1106
www.insightcenterforcounseling.com

**NEW CONSUMER INFORMATION** **Today's Date:**_____

**Name**:_____ **Date of Birth**:_____

Guardian Name (If under 18):_____ Date of Birth:_____

Home Telephone No.:_____ Cell: _____ Ok to leave Msg? ☐ Yes ☐ No

Address:_____ City/State/Zip:_____

**SS#**_____ E-mail:_____

Emergency Contact:_____ Relationship:_____ Telephone:_____

**How did you hear about us?** _____

**INSURANCE INFORMATION (We will make a copy of the card)**

Subscriber's Name/Relationship:_____

**Subscriber's SS#**_____ **Subscriber's DOB**_____

Insurance Company: _____

**ID Number:**_____ **Group Number**_____

Is there secondary insurance coverage? _____

## Assignment of Benefits

I submit that all information provided to *Insight – Center for Counseling & Recovery* is accurate and current. I understand that if any information is fraudulent or coverage has lapsed, I am responsible for full fee for service. I authorize the release of any medical or other information necessary to process all claims and collect payments. I also authorize payment of all benefits and services rendered to *Insight-Center for Counseling & Recovery*.

I understand that I am financially responsible for all services that may not be recovered, including co-payments, deductibles, lab screens and denied services. *Insight-Center for Counseling & Recovery* will make all efforts possible to process claims. However, please note that there may be times when it becomes necessary for the member to communicate directly with the insurance company to negotiate coverage. All co-pay fees are due at time of service. Any cancellations or missed appointments without a 48 hour prior notification will result in session fees payable by the member. Any open balance not addressed can result in an interruption of service. Open balances not addressed after a 3 month period will be sent to collections.

_____

Signature Date

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# Office Policies

In the interest of providing you with the best possible care, please read the following and sign your name(s) below. We will be glad to discuss the policies or answer any questions you may have before you sign. Upon request, we will gladly provide a copy of this agreement for your records.

**Appointments:**
Once we have established an ongoing and set appointment time, this time is reserved for you and will not be scheduled for anyone else. Therefore, we respectfully request a minimum **48 hour notice to cancel your session.** Last minute session cancellations are difficult for us to cover. Unless there is an emergency, you will be responsible for payment of the cancelled session. As subject to availability, we will make every effort to accommodate your needs by offering a different appointment time during the same calendar week, thereby off-setting any additional charges. Keeping all this in mind, we are always sympathetic to valid and unexpected emergencies. **Late Cancellation / Missed Appointment Fee: $75.00**

**Session Fees: All fees are billed through your insurance and subject to the insurance contracted rate. Associated deductibles, co-insurance and co-pays are payable at time of service.**

**Assessment/Initial Session - $225.00**
**Individual Session - $195.00**
**Couple/Family Session - $195.00**
**Group Session - $120.00**
**Letters/Phone Calls over 15 min - $15/15 minutes**

It is office procedure to submit all insurance claims through the billing department. *Insight* is in network with many insurance plans. If *Insight* is not in-network with your current insurance plan, the billing department will still submit claims as out-of-network, however the full fee per session is due at the time of service and insurance reimbursement will be made payable to you. All deductibles are due at time of service. Insight will provide co-pay receipts directly to you for submission of any secondary insurance coverage.

**Payment:**
All co-pays are due at the time of service. Payment may be made in the form of cash, check or Health Savings Card. Checks should be made out to ***Insight* – Center for Counseling & Recovery.** Checks returned for insufficient funds will be subject to the customary $25.00 processing fee. Should any finances remain in arrears for over 90 days without a signed payment plan agreement collection proceeding will be implemented.

**Telephone Calls:**
Please note that we run concurrent sessions, therefore, we check voice messages at the end of each day. Attempts will be made to return calls within 24 hours. There is no service charge for short calls, however, a call exceeding 15 minutes will be billed at the same session rate.

**Emergencies:**
We are available for additional sessions for established ongoing patients as schedules permit. However, if you are experiencing a medical and/or psychological emergency, please call the Crisis Hotline at 973-540-0100, go to the your nearest emergency room or call 911.

I (we) have read, understand, and agree to the above policies.

Signed: _____ Date: _____

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## INFORMED CONSENT

You have chosen to receive clinical/therapeutic/counseling services from ***Insight – Center for Counseling & Recovery***. The clinicians collaborating are as follows and are licensed by the State of New Jersey in compliance with all rights and privileges for professional practice.

**Denise Michalowski**, MSW, LCSW, LCADC, ACSW, CSS - *Owner / Operator*
**Tanja Frade,** MSW, LCSW, ACSW, CSS - *Director of Clinical Services*
**Justin Wells,** MSW, LCSW, MFT, CCTP, DSL - *Director of Operations*
**Toni Ayli-Manganielo,** MA, LPC - *Youth Group Facilitator*
**Ann Ayli-Furrer,** MA, LPC
**Eileen Madden,** MA, LPC - *DBT Facilitator*
**Dianne Wagoner,** CADC - *Substance Abuse Evaluator*
**Jennifer Dechene,** M. Ed., LAC - *Intake and Assessment Coordinator*
**Diane L. Schrank,** BS - *Director of Finance*

**MSW** - Masters of Social Work
**LCSW** - Licensed Clinical Social Worker
**LCADC** - Licensed Certified Alcohol and Drug Addictions Counselor
**ACSW** - Nationally Accredited Clinical Social Worker
**CSS** - Certified Clinical Supervisor
**CCTP** - Certified Clinical Trauma Professional
**MA** - Master of Arts in Counseling
**LPC** - Licensed Professional Counselor
**CADC** - Certified Alcohol and Drug Addictions Counselor
**M. Ed.** - Master of Education in Counseling
**LAC** - Licensed Associate Counselor
**BS** - Bachelor of Science in Business Management

**Confidentiality Policy**
Your clinical record and/or specific information contained within this record will be keep confidential with the following exceptions:

- You share/present information that identifies a danger to yourself or others;
- There is reason to suspect child abuse, child neglect or domestic violence;
- There is an order by the court to release specific information;
- You have signed a Release of Information Statement that allows me to share specific information with specified parties

**Parents/Guardians**
When providing services to a minor, the clinical session remains confidential. Confidentiality is regulated by the same guidelines as stated above. Release of information forms must be signed in order to provide information outside of these parameters. Parental consent is required by all parties to treat a minor.

**Messages**
If you give us permission to leave messages or communicate via text for confirmation of scheduling and appointments please provide the following:

- Phone #: _____
- Email: _____

You have the right to request information about the services and treatment you are receiving. All copies of correspondences requested will be provided. You may also request the long form of the HIPAA regulations.

We hereby assign collection accounts to Action Collection Company for collection. We hereby authorize Action to act as our agent for the purpose of collection on unpaid accounts and give them full authority to use their discretion in the settlement of these accounts. We further authorize Action Collection Company Action to act as our agent for the purpose of instituting suit and acknowledge that representation is limited to our affirmative claim.

I have read, understand, and agree to the above policies.

Signed: _____ Date: _____

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**Please note that all session cancellations must be a minimum of 2 *business days* prior to your session time.**

**Missed sessions cannot be billed to your insurance company. Therefore, cancellation fees will be billed to *you.***

**Late Cancellation/Missed Session Fee: $75.00**

**Please understand that we do recognize exceptions such as illness and emergencies. *Insight* will *always be fair and reasonable.***

**Thank you for your understanding.**

**Denise Michalowski, LCSW/LCADC, CEO**

_____

**Name – Print**

_____

**Signature** **Date**

## Medical History

Name: _____ Date: _____ Age: _____ Gender: _____

Height: _____ Weight: _____

**FAMILY HISTORY**

Mother Living? ○ Yes ○ No If no, age when deceased _____

Father Living? ○ Yes ○ No If no, age when deceased _____

Do (Did) either have any history of major illnesses? (if yes, please explain)

_____

Do you have **allergies**? Medication(s): _____ Food: _____

Seasonal: _____ Other: _____

If yes, type of reaction: _____ Epi-pen required? ☐ Yes ☐ No

**NEUROLOGICAL:**

_____ Seizure disorders
_____ Tremors or Shakes
_____ Headaches
_____ Period of loss of consciousness
_____ Strokes
_____ History of Head Injury

**PULMONARY:**

_____ Asthma
_____ Shortness of breath (at rest or on exertion)
_____ Emphysema
_____ Pneumonia
_____ Persistent cough (6 weeks or more)

**INFECTIOUS DISEASES:**

_____ Sexually transmitted disease
_____ Tuberculosis
_____ Mononucleosis
_____ Hepatitis
_____ Swollen nodes
_____ Non-healing sores
_____ Active Strep or Staph Infection

**ENT:**

_____ Frequent ear infections
_____ Frequent sore throat
_____ Blurred vision
_____ Wear glasses/contacts

**SKIN:**

_____ Eczema
_____Acne

**GASTROINTESTINAL:**

_____ Ulcer Disease
_____ Esophageal varices
_____ Pancreatitis
_____ Persistent nausea/vomiting
_____ Difficulty swallowing
_____ Jaundice
_____ Liver disease
_____ Blood in stool or black/tar like stool
_____ Severe or persistent diarrhea
_____ Severe abdominal pain

**CARDIOVASCULAR:**

_____ History of heart attack
_____ Angina
_____ Lungs filled with fluid
_____ Irregular heartbeats
_____ High blood pressure

**OTHER:**

_____ Diabetes
_____ Weight Loss
_____ Skin or joint problems
_____ Bleeding/nose bleeds
_____ Anemia
_____ Unexplained Rashes
_____ Hypoglycemia
_____ Sweats at night
_____ Weakness
_____ Problems urinating/kidney Disease
_____ Pelvic Inflammatory Disease

Name, address, and phone number of Primary Care Physician:

_____

Permission to contact your Physician? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

**History of Surgeries:**

Type _____ Date_____

Type _____ Date_____

Please list all hospitalizations (Medical and/or Psychiatric)

| Where | When | Why |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Medical Problems: _____

Immunizations up to date? ☐ Yes ☐ No If no, please explain_____

**PAIN ASSESSMENT:**

Currently being treated for physical pain? ☐ Yes ☐ No

Describe pain:

Location _____ Frequency _____ Duration _____

Type: (throbbing, stabbing, shooting, soreness)

Intensity (1-10, ranging from 1 as least to 10 as greatest _____

Treatment _____

Provider name and phone # _____

**FEMALES ONLY:** Currently pregnant? _____ Ever been pregnant _____

Explain _____

Age of first menstrual period _____ Date of last menstrual period _____

Any problems with menstruation? _____ PMS? _____

Last GYN Exam _____

**Current Medications & Supplements**

| Medication/Supplement | Dosage | Physician | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

If you have more than fits in the spaces above, please provide us with a list on a separate sheet of paper

**Have you received any prior treatment for Substance Abuse or Mental Health?** ☐ Yes ☐ No

| Where | When | Why |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**NUTRITIONAL PRACTICES**

Please answer these questions as they relate to your nutritional health over the last six months:

1. Has your weight changed by 10 pounds or more? ○ Yes ○ No
2. Has your appetite changed? ○ Yes ○ No
3. Have you had any physical problems related to digestion? ○ Yes ○ No
4. Have you been treated for an eating disorder? ○ Yes ○ No
5. Have you had any worries about your eating habits? ○ Yes ○ No
6. Have you had any episodes of self-induced vomiting? ○ Yes ○ No
7. Have you had any episodes of compulsive over/under eating? ○ Yes ○ No
8. Do you exercise more than 2 hours a day (Other than for school sports)? ○ Yes ○ No
9. Do you have unhealthy eating habits? ○ Yes ○ No
10. Do your family or friends express concern about your dietary habits? ○ Yes ○ No

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 |
| Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems 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 | ☐ |

**BDI**

PLEASE PICK ONE STATEMENT FROM EACH GROUP THAT BEST DESCRIBES YOUR CURRENT MOOD

1. 0 I do not feel sad.
   1 I feel sad
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad and unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely

# ***Life Events Questionnaire (adapted)***

Please tick the appropriate box if any of the following 15 events have happened to you in the last year, or earlier in your life. If earlier in your life, please estimate roughly how old you were when the event or situation happened to you. Please also answer questions *A* and *B* using the boxes provided. If appropriate, do give further details.

| | Event or Situation | Happened in last year | More than 1 year ago |
|---|---|---|---|
| **1** | death of a close relative, including partner, parent or child | | |
| **2** | physical assault, mugging or rape | | |
| **3** | separation due to marital difficulties | | |
| **4** | break up of a steady relationship | | |
| **5** | serious difficulties with spouse or partner | | |
| **6** | serious problem with a close friend, neighbour or relative | | |
| **7** | bullied, teased, victimized or socially isolated | | |
| **8** | loss of job | | |
| **9** | unemployed/seeking work for more than a month | | |
| **10** | legal problems or difficulties with the police | | |
| **11** | loss of regular contact with a close relative or friend | | |
| **12** | serious illness or injury to a close relative or friend | | |
| **13** | serious illness or injury to yourself | | |
| **14** | major financial problems | | |
| **15** | other seriously upsetting events, accidents or situations | | |

| | | |
|---|---|---|
| **A** | **Do you find that memories or images of upsetting events that you have been involved in pop into your mind spontaneously?** | |
| **B** | If so what feelings do you have about these memories or images – for example sadness, guilt, anger, helplessness, anxiety, shame or maybe some other feeling? | |

# Mood Questionnaire

| **1.** Has there ever been a period of time when you were not your usual self and... | YES | NO |
|---|---|---|
| ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | ☐ | ☐ |
| ...you were so irritable that you shouted at people or started fights or arguments? | ☐ | ☐ |
| ...you felt much more self-confident than usual? | ☐ | ☐ |
| ...you got much less sleep than usual and found you didn't really miss it? | ☐ | ☐ |
| ...you were much more talkative or spoke much faster than usual? | ☐ | ☐ |
| ...thoughts raced through your head or you couldn't slow your mind down? | ☐ | ☐ |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | ☐ | ☐ |
| ...you had much more energy than usual? | ☐ | ☐ |
| ...you were much more active or did many more things than usual? | ☐ | ☐ |
| ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | ☐ | ☐ |
| ...you were much more interested in sex than usual? | ☐ | ☐ |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | ☐ | ☐ |
| …spending money got you or your family into trouble? | ☐ | ☐ |

| | | |
|---|---|---|
| **2.** If you checked YES to more than one of the above, have several of these ever happened during the same period of time? | ☐ | ☐ |

**3.** How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only.

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

# ALC/CHEM – DEP SELF ASSESSMENT

| | YES | NO |
|---|---|---|
| Do you lose time from work due to drinking/using? | | |
| Is drinking/using making your home life unhappy? | | |
| Do you drink/use because you are shy with other people? | | |
| Is your drinking/using affecting your reputation? | | |
| Have you ever felt guilt or remorse after drinking/using? | | |
| Have you ever got into financial difficulties as a result of drinking/using? | | |
| Do you turn to lower companions and an inferior environment when drinking/using? | | |
| Does your drinking/using make you careless of your family's welfare? | | |
| Has your ambition decreased since drinking/using? | | |
| Do you crave to drink/use at a definite time? | | |
| Do you want a drink/use the next morning? | | |
| Does drinking/using cause you to have difficulty in sleeping? | | |
| Has your efficiency decreased since drinking/using? | | |
| Is drinking/using jeopardizing your job or business? | | |
| Do you drink/use to escape from worries or trouble? | | |
| Do you drink/use alone? | | |
| Have you ever had a complete loss of memory as a result of drinking/using? | | |
| Has your physician ever treated you for drinking/using? | | |
| Do you drink/use to build up your self-confidence? | | |
| Have you ever been to a hospital or institution because of drinking/using? | | |

## GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Worrying too much about different things | 0 | 1 | 2 | 3 |
| Trouble relaxing | 0 | 1 | 2 | 3 |
| Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems 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.

# Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.

| **PART A** | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | | | | | |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | | | | | |
| 3. How often do you have problems remembering appointments or obligations? | | | | | |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | | | | | |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | | | | | |
| 6. How often do you feel overly active and compelled to do things, like you were driven by a motor? | | | | | |

| **PART B** | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 7. How often do you make careless mistakes when you have to work on a boring or difficult project? | | | | | |
| 8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work? | | | | | |
| 9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? | | | | | |
| 10. How often do you misplace or have difficulty finding things at home or at work? | | | | | |
| 11. How often are you distracted by activity or noise around you? | | | | | |
| 12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? | | | | | |
| 13. How often do you feel restless or fidgety? | | | | | |
| 14. How often do you have difficulty unwinding and relaxing when you have time to yourself? | | | | | |
| 15. How often do you find yourself talking too much when you are in social situations? | | | | | |
| 16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves? | | | | | |
| 17. How often do you have difficulty waiting your turn in situations when turn taking is required? | | | | | |
| 18. How often do you interrupt others when they are busy? | | | | | |