DONNA MCLEMORE WATKINS, MEd, LPC, RPT Red Clay Counseling, LLC

INFORMED WRITTEN CONSENT FOR TREATMENT POLICY STATEMENT FORM

Thank you for selecting me as your counselor. The intent of this statement is to inform you about the basic therapeutic relationship between counselor and client, to inform you of basic policies, and to help you understand our professional relationship.

Counseling Philosophy, Expectations of Clients

I believe in the capacity of people for self-efficacy. This means that you are able to personally create an improved quality of life and you are in charge of your goals and personal growth. I will work with you in achieving these personal goals. My approach to therapy involves mind, body, and spirit through the use of evidence-based practices. We will together examine issues related to your self-relationship and relationships with others.

Your decision to choose to enter counseling is a voluntary one and you may terminate at any time. If, in my professional opinion, it is in your best interest to refer you to another therapist, I will do so because of ethical standards. I will provide you with the contact information of the referral. Please note that it is impossible to guarantee any specific results regarding your counseling goals; however, we will work together to achieve the best possible results. At the end of the first session, we will decide if we want to enter into a counseling relationship. If we both agree, you will sign, date, and keep a copy of this informed consent.

Scope of Practice

I operate in an outpatient private practice consisting of traditional talk therapy, equine therapy, and other experiential therapies. I work with children, adolescents, and adults. I cannot and do not assume responsibility for client's daily functioning as an institution can. I am not an emergency facility for crisis management. I make every effort to return phone calls during office hours as quickly as possible but there may be unavoidable delays. I can be reached at 770-947-2311. IN THE EVENT OF AN EMERGENCY, you should call 911 or go to the emergency room.

Ethical Guidelines and Standards

I assure you that my services will be provided in a professional manner consistent with accepted ethical standards for licensed professional counselors.

Confidentiality

Please understand that I will keep confidential what you disclose, with the following exceptions:

1. You direct/allow me to tell someone by signing a release of information form.
2. I determine you are a danger to yourself or others.
3. I am ordered by a court to disclose information
4. You abuse a child or an elderly person.

Your signature indicates that you have reviewed this document, had your questions answered to your satisfaction and you agree to adhere to policies specified in this document.

_____ _____

Printed Name Date

_____ _____

Client Signature Guardian Signature for minor clients

Today's Date: _____

Red Clay Counseling, LLC
Patient Information and Financial Agreement

(Please Print Legibly)

PATIENT INFORMATION

Please use full legal name (no nicknames please)

Last _____ First _____ MI _____
DOB _____Age _____M/F _____SSN _____
Physical Address _____
Mailing Address _____
City _____State _____ Zip _____
County _____
Cell/Home Phone _____ E-Mail _____

PARENT/GUARDIAN (Person responsible for care and financial situations)

Last _____ First _____ MI _____
DOB _____ SSN _____ Occupation _____
Mailing Address _____
Primary Phone _____Secondary _____
Employer _____Work Phone _____
E-mail _____
Other parent/guardian _____Phone _____

Are parents separated or divorced? Yes _____ No _____
If you are not a parent, are you the legal guardian? Yes _____ No _____
Best number to confirm your appointment? _____
YOU WILL NEED TO SHOW PROOF OF CUSTODY OR GUARDIANSHIP

ADDITIONAL INFORMATION

Referring Physician or Psychiatrist (Please provide doctors full name)
Phone# Diagnosis _____
If patient has seen other mental health professionals, please include psychians name and diagnosis_____

INSURANCE INFORMATION (Please fill out completely)

Primary Insurance name _____
Insurance ID#_____
Policy Holder's Name DOB _____
SSN _____ Relation to Patient _____
Group Number _____ Employer _____
Secondary Insurance Name _____ Insurance ID# _____
Policy Holder's Name _____ DOB _____
SSN _____ Relation to Patient _____
Group Number _____ Employer_____

INSURANCE AUTHORIZATION AND ASSIGNMENT
(Please Read and Initial=lnit. each section)

Init._____ I request that all insurance benefits be paid directly to Red Clay Counseling, LLC.

Init._____You are entitled to a clear understanding of your financial obligations before services are rendered. We participate with numerous managed care plans and to the best of our ability, certify your benefits prior to being seen. It is not possible for us to know all of the individual requirements of each plan. Your employer negotiates the benefits of your plan and we have no control over how claims may or may not be processed. Each plan is different in regards to what is covered, how often and where services may be rendered. Whether you have insurance or are self-pay, we maintain that you are ultimately responsible for all charges incurred.

Init. _____ We do not file indemnity plans, non-contracted or secondary insurance carriers. We try to assist you in getting services covered; but are not responsible if they are not covered under your contract and you will be billed. It is your responsibility to ensure that a referral and/or authorization has been obtained if necessary. If we do not have a referral on file, we are happy to see you as a self-pay patient. For a self-pay patient, full payment is required at the time of service.

Init. _____ If insurance cannot be verified by date of service, we expect payment in full. We accept cash, check and credit cards. If you do not have insurance, we expect payment in full, unless prior arrangements have been made with the business office.
***Co-pays are due at time of service; if it is not paid at the time of service, we will bill you with an additional administrative fee of 15% per visit.

***There is a per page fee for any written communication, to be paid at time of completion. Once requested, this fee will apply whether you choose to utilize it or not.

***Please make all checks payable to Red Clay Counseling, LLC.

*** We charge a $35.00 returned check fee.

***__Cancellation fees and NO SHOW fees__: $65.00 -individual therapy; $70.00-family therapy, or amount equivalent to reserved time for cancellation with less than 24 hours notice.

***No-show fees are billed to you directly and are your responsibility. Insurance will not pay.

***Medical records can be obtained with signed release and applicable administrative fees at time of release. There is a fee incurred.

***This office practices Credit Bureau reporting for all delinquent balances.

*** **Court Appearance:** If Red Clay Counseling, LLC, Donna M. Watkins, M.Ed., LPC, testifies in court or is subpoenaed, client will pay $150.00 per hour of time, including, but not limited to, preparation for court, testifying, and will include time at courthouse to appear. If to be paid by another entity besides client and entity does not pay, client is responsible for full amount.

Init._____ I acknowledge understanding for above.

I have read, understand and accept the terms of this financial policy. I have been provided a copy of the Privacy Practices Notice.

Date _____
Responsible Party or Patient/Client Signature _____
Printed Name _____
Signature of Staff/Witness _____

Red Clay Counseling, LLC

Patient Confidentiality

We request all cell phones and electronic devices be turned off during sessions for further patient confidentiality. Absolutely no videotaping or recording allowed to insure patient confidentiality.

Patient confidentiality is a top priority at Red Clay Counseling, LLC. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

I acknowledge that I have been made aware of the "NOTICE OF PRIVACY PRACTICES" for Protected Health Information on the date set forth below.

In the event that I am unable to be reached, Red Clay Counseling, LLC may leave any appointment or account information in the following manner:

_____ You may leave messages on my mobile phone. Number: _____

_____ You may leave messages on my home answering machine. Number: _____

_____ You may call my work number and leave a message. Number:_____

_____ You may leave messages on my office voicemail. Number: _____

_____You may share appointment/account information with my spouse. Number: _____

_____ You may share appointment information with my children. Number: _____

_____ You may share my appointment and account information with:

Name _____ Phone Number _____ Relationship to Patient _____

Name _____ Phone Number _____Relationship to Patient _____

_____ In the event you are unable to reach me; Red Clay Counseling **may not** leave appointment information or account information with anyone but myself, including on voicemail, at the following phone number: _____

Proxy Permission Form: The following person(s) may make medical decisions and sign any appropriate documents related to my child's care in my absence.

Name of Proxy (Please print) Relationship

_____

Signature of Client or Guardian Date Relationship to Client

_____

Red Clay Counseling, LLC Medical Release

Date of Release_____

Name_____ DOB (mm/dd/yyyy)_____

Address_____

Phone Number ( )_____

I give Red Clay Counseling, LLC permission to contact the following person in case of a medical emergency:

Name_____

Phone Number ( )_____

Additionally, I give permission for Red Clay Counseling, LLC staff to contact 911 and/or emergency personnel to assist in the case of an emergency.

Please Note: Please take care when entering & exiting the property by driving slowly into the parking area, watching out for children, other cars or loose animals. Also, while taking the stairs up and down into the center, hold the hand rails and step carefully. Please hold on to small children and monitor them, while inside and outside the building to ensure that they do not exit. Parents/guardians will accompany all children under age of 10 to the downstairs restroom.

Signature of Client or Guardian:_____ Date:_____

Signature of Staff/Witness:_____ Date:_____

Red Clay Counseling, LLC
Donna M. Watkins, M.Ed., LPC

Welcome,

These are a few friendly reminders about OAKHILL and Red Clay Counseling, LLC:

*Because parking is limited, please park in the marked parking area.

*Since the waiting area is small, **please limit persons who accompany the patient being seen.**

*This is a totally, non-smoking facility, including smoking in vehicles on the property.

*Please do not bring food or drinks inside the building.

*Please do not leave your children unattended.

*Please assist little ones under the age of 6 going up and down the stairs.

*Please accompany children under the age of 10 to the restroom, located downstairs.

*Please do not wander the property without staff escort.

*Please do not feed or touch the animals without staff guidance.

*Please inform Red Clay Counseling, LLC of cancellations within 24 hours to avoid a No Show Charge.

We appreciate your understanding and respect for this sacred space.

Sincerely,

Donna M. Watkins, M.Ed., LPC

Red Clay Counseling, LLC

I, _____, have read, understand and accept the terms of the
(printed name of client or guardian if minor)

general rules and guidelines at Red Clay Counseling, LLC and Douglasville Psychotherapy Center at Oakhill, P.C. I have been provided a copy of the Rules in the new client forms package.

Date: _____

Responsible Party or Patient/Client Signature: _____

Printed Name: _____

Signature of Staff/Witness: _____

HIPAA Notice of Privacy Practices Statement

Red Clay Counseling, LLC

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy too. This Notice applies to your counselor, psychotherapist, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT for example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT for example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

WITH YOUR WRITTEN AUTHORIZATION we may use or disclose mental health information for purposes not described in this Notice only with your written authorization.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION.

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/ administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

To Receive a Copy of this Notice when you obtain care.

To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of Your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason of the request. We may deny your request for an amendment if the information

was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.

To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

To Request that We Contact you by Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future.

CONTACT INFORMATION:

If you have questions about this Notice or believe your privacy rights have been violated, you may contact:

The Secretary of the Department of Health and Human Services
Contact the Office for Civil Rights
1-866-627-7748, 1-800-537-7697 (TTY)
http://www.hhs.gov/ocr/privacy/hipaa/complaints/
Filing a complaint will not affect the services you receive at Red Clay Counseling, LLC.

By law, Red Clay Counseling, LLC is required to follow the terms in this privacy notice. Red Clay Counseling, LLC has the right to change the way your personal health information is used and given out. If Red Clay Counseling, LLC makes any changes to the way your personal health information is used and given out while you are a current client, you will get a new notice, directly or by mail, within 60 days of the change.

Red Clay Counseling, LLC

Adult Psychosocial
(Ages 18+)

Date _____
Name _____ DOB _____SS# _____
Address _____ Age _____ Sex _____
City _____ State _____ ZIP _____
Marital Status: Single _____ Married _____ Divorced _____
Home Phone _____Work _____ Cell _____
E-mail _____
Employer/School _____
Occupation _____ Position/Grade _____
Referred By:_____
May we contact referral source? _____
Legal Guardian (if minor) _____
Home Phone _____Cell Phone _____ Work _____
Please Note: You will need to provide legal documentation showing guardianship, on next visit
Notify In An Emergency _____
Relationship _____ Phone _____
Alternate Phone _____
Present Complaint/Reason for Referral _____
_____
_____
Have you ever been to counseling before? _____ If so, when? _____
Name of doctor you visited _____
Reason _____ Diagnosis _____
Length of time in counseling _____ (00/00-00/00)
List all medications taken in the past:

Medication	Dosage	Purpose	Physician	Duration

List any known allergies:_____
Household Members (other than yourself)
First Name Relationship Age
_____
_____
_____

Social History

Personal Information/Treatment Plan

One of the goals of treatment is for clients to gain a better understanding of themselves and their particular situation. The purpose of this Social History is twofold. First, completing the Social History will enable you to take a look at past and current life experiences that helped to make you who you are today. Second, the Social History will enable me to understand you better and to more effectively join with you as you navigate life's challenges.

Primary Physician _____ Psychiatrist _____

Date of Last Physical Examination / Psychiatric Evaluation _____
Current Medications and Dosage _____
_____

Physical Problems / Diagnosis (if known)
1. _____
2. _____
3. _____

Have you had a recent significant weight Gain or Loss? _____ How much?_____

Average hours of sleep per night? _____ Restless or Restful? _____

Have you been diagnosed with: HIV ___ Hepatitis C ___ HBP ___ Diabetes ___ Seizures ___
Do you use drugs or alcohol? _____ How much?_____ How Often? _____ Alone or with others? _____Alcohol or Drugs of Choice? _____
Last used? _____Does your use concern you? _____

Check Anv Of The Following That May Apply:

____Agitated	____Angry	____Anxious	____Alcohol Problem
____Hostile	____Unassertive	____Suicidal	____Eating Disorder
____Homicidal	____Panic	____Phobias	____Hallucinations
____Depressed	____Guilty	____Headaches	____Sexual Problems
____Blackouts	____Insomnia	____Drug Problems	____Fatigue Difficulty
____Nightmares	____Suspicious	____Concentration	____Eating Disorder
____Jealousy	____Flashbacks	____Vision Problems	____Stomach Trouble
____Confused	____Memory Loss	____Loss of time	____Hearing Problems
____Grief	____Job Problems	____Rebellious	____Socially Withdrawn
____No Appetite	____Dizziness	____School Problems	____Emotionally Numb
____Inferior	____Temper Issues	____Marital Problems	____Rapid Mood Change
____Amnesia	____Frequently Ill	____Very Fearful	____Problems with Parents
____Compulsive Activities	____Relationship Problems		____Recurring Unwanted Thought
____Obsessive Thoughts	____Out-of-Body Experience		____Impulsive Behavior
____Problems w/ Children	____Persistent Worry		____Problems w/ Parents

Other Complaints _____

MARRIAGE AND FAMILY:

Are you currently married? _____ Name of Spouse_____

Number of children shared w/ this spouse? _____

How long have you been married? _____ How long did you date your spouse? _____

What attracted you to your spouse? _____

_____

How do you and your spouse settle disagreements? _____

_____

What are some common areas of disagreements in your marriage? (Check all that apply, add more if needed)

____Money	____Children	____Household Task
____In-Laws	____Hobbies	____Use of Free Time
____Sex	____Socializing	____Goals, Plans
____Friends	____Trust, Jealousy	____Decision Making

Other: _____

_____

How many times have you been married? (Excluding current marriage)					
Age @ time of marriage	Length of courtship	Length of marriage	Number of Children	Current Age / Sex	Briefly Reason for divorce

List All Individuals Living In the Home:

Name Relationship Age Sex School Present grade Living at home Uses Drugs

_____

_____

_____

_____

_____

HEALTH OF FAMILY MEMBERS

List other extended family members by their relationship to the patient and/if they have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

Name: _____ Relationship: _____Type of Issue:_____

Name: _____ Relationship: _____Type of Issue:_____

Name: _____ Relationship: _____Type of Issue:_____

RECREATIONAL:

How do spend your free time? _____

_____

What hobbies did/do you enjoy? _____

Do you set time aside just for yourself? _____How often? _____Amount? _____

How often do you go out to have fun by yourself? _____With your friends? _____

With family? _____ With your spouse? _____

Do you call or keep in touch with friends, family or neighbors? _____

What was the most fun you have ever had? _____

When were you happiest? _____

What type of physical activity are you involved in? _____

_____

TREATMENT GOALS:

In looking at your current situation, in what areas would you like to improve? Please check all that apply and add more if needed.

____Anger Control	____Stress Management	____Fair Fighting
____Communication Skills	____Problem Solving	____Parenting
____Increasing Flexibility	____Assertiveness Skills	____Decision Making
____Socially Comfortable	____Financial Management	____Self Esteem

What personal goals do you have for therapy/counseling?

_____

_____

_____

_____

_____

_____

_____

_____

The Mood Disorder Questionnaire

INSTRUCTIONS: Please answer each question as best you can.	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
... 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?	O	O
... you were so irritable that you shouted at people or started fights arguments?	O	O
…you felt much more self-confident that usual?	O	O
… you got much less sleep than usual and found that you didn't really miss it?	O	O
…you were more talkative or spoke much faster than usual?	O	O
…thoughts raced through your head or you couldn't slow your mind down?	O	O
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
…you had much more energy than usual?	O	O
…you were much more active or did many more things than usual?	O	O
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle the night?	O	O
…you were much more interested in sex than usual?	O	O
…you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	O	O
…spending money got you or your family into trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O

3. How much of a problem did any of these cause you – like being able to work, having family, money or legal troubles, getting into arguments or fights?

_____No problem _____Minor problem _____Moderate problem _____Serious problem

4. Have any of your blood relatives (ie. Children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? _____

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

_____

_____

Anxiety Scale

Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by checking the column that most closely corresponds to how you've been feeling.

	Not at all	Mildly	Moderately	Severely
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of the worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding or racing	0	1	2	3
Unsteady	0	1	2	3
Terrified	0	1	2	3
Nervous	0	1	2	3
Feelings of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion or discomfort	0	1	2	3
in abdomen	0	1	2	3
Faint	0	1	2	3
Face flushed	0	1	2	3
Sweating (not due to heat)	0	1	2	3

Total _____ _____ _____

Depression Scale

Instructions: This questionnaire consists of seven groups of statements. Read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past 2 weeks, including today. Circle the number beside the statement you have picked. If several statements in one group seem to apply equally well, choose the statement with the highest number beside it.

Sadness	I do not feel sad	0
	I feel sad much of the time	1
	I am sad all the time	2
	I am so sad or unhappy that I can't stand it	3

Pessimism	I am not discouraged about my future	0
	I feel more discouraged about my future than I used to	1
	I do not expect things to work out for me	2
	I feel my future is hopeless and will only get worse	3

Past Failure	I do not feel like a failure	0
	I have failed more than I should have	1
	As I look back, I see a lot of failures	2
	I feel I am a total failure as a person	3

Self-Dislike	I feel the same about myself as ever	0
	I have lost confidence in myself	1
	I am disappointed in myself	2
	I dislike myself	3

Self-Criticism	I don't criticize or blame myself more than usual	0
	I am more critical of myself than I used to be	1
	I criticize myself for all of my faults	2
	I blame myself for everything bad that happens	3

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

Loss of Interest	I have not lost interest in other people or activities	0
	I am less interested in other people or things	1
	I have lost much of my interest in other people or things	2
	It's hard to get interested in anything	3

Total _____

Self Esteem Inventory

Answer the questions below with True (T) or False (F)

1. I usually put my best foot forward _____
2. I rarely feel embarrassed _____
3. I feel I have above average intelligence _____
4. I am quite ambitious _____
5. I can be very active _____
6. I am tenacious in matters that count _____
7. I enjoy my own company _____
8. I have strong powers of concentration _____
9. I don't feel shy or ill-at-ease with new people _____
10. When situations beyond my control go wrong, I don't blame myself _____
11. I enjoy being praised or complimented _____
12. I don't feel anxious when I have to address a group of superiors _____
13. I have fantasies of doing something great _____
14. I don't feel humiliated or hurt if someone makes a joke at my expense _____
15. I don't mind showing off my good points and getting attention for it _____
16. In general, I have lots of energy _____
17. I enjoy taking calculated risks _____
18. I am psychologically "tough" _____
19. I have a great deal of self-confidence _____
20. I can remain cool in a crisis _____
21. I have considerable powers of discernment _____
22. I am quite self-sufficient _____
23. I feel I am a persuasive person _____
24. I feel I can hold my own in any group _____
25. I can give praise easily and with sincerity _____
26. I appreciate constructive criticism _____
27. I am accepted by most people I meet _____
28. I don't feel uncomfortable in a position of authority _____
29. I feel I have a strong personality _____
30. I react quickly and well to an unexpected situation _____

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