Jerry Worthington
Counseling & Coaching

RECORD OF SERVICES

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Name: _____ **Work Phone:** _____

Home Phone: _____ **Cell Phone:** _____

	Date	Description of Services	Charge	Paid	Co-Pay Amt.	Check No. #	Credit Card	DUE from Patient Balance	Total Balance Due
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									

Jerry Worthington
Counseling & Coaching

PROGRESS NOTE

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Date:	Client:

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
PERSONAL AND FAMILY INFORMATION

Name _____ Date: _____

Address _____

Phone May we contact you at any of these #'s?

Home _____ yes _____ no _____

Cell _____ yes _____ no _____

Work _____ yes _____ no _____

Date of Birth _____ Age _____

SS# _____

Level of Education _____

Occupation/Job Title _____ How long Employed? _____

What are your interests/Hobbies? _____

Employer/School (name & address) _____

_____

Marital/Relationship Status _____

Religious /Spiritual Beliefs _____

Immediate Family Members/Significant Others

Name	Age	Gender Identity	Relationship

Who should we contact in case of emergency? (name and number) _____

Who referred you? _____

What issues do you want help with? _____

_____

_____

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
HEALTH HISTORY

Name: _____ Date: _____

Medical Family History: Heart Disease, High Blood Pressure, Stroke, Blood Disease, Cancer, Thyroid Problems, Diabetes, Liver Problems, Chronic Pain, Hearing Problems, Vision Problems, or other Chronic Illness.

Name	Age	Relationship	Illness

Personal Medical History: Heart Disease, High Blood Pressure, Stroke, Blood Disease, Cancer, Thyroid Problems, Diabetes, Liver Problems, Chronic Pain, Hearing Problems, Vision Problems, Infectious Disease i.e. H.I.V., Hepatitis, Traumatic Accidents, or any other health problem.

Illness	Date	Treatment

Allergies to Medication:

Name	Reaction

Surgeries:

What	Date	Where

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
HEALTH HISTORY

Name: _____ Date: _____

Symptom Checklist:

Neurological
- _____ Frequent headaches
- _____ Fainting or loss of consciousness
- _____ Convulsions or seizures
- _____ Weakness or paralysis
- _____ Dizziness or loss of balance

Eyes
- _____ Blurred vision
- _____ Seeing halos around lights
- _____ Seeing double
- _____ Burning eyes
- _____ Not seeing objects
- _____ Recent changes in vision

Mouth and Throat
- _____ Loss of voice
- _____ Bleeding gums
- _____ Dry mouth
- _____ Tooth decay
- _____ Pain in jaw

Ears
- _____ Hearing loss
- _____ Hearing unusual things
- _____ Ringing in the ears
- _____ Earaches
- _____ Itchy ears

Neck
- _____ Pain or Stiffness
- _____ Lumps in the neck

Heart and Lungs
- _____ Chest Pain
- _____ Shortness of breath
- _____ Night sweats
- _____ Fluttering in the chest
- _____ Chronic cough
- _____ Coughing up blood

Abdominal Problems
- _____ Loss of appetite
- _____ Trouble swallowing
- _____ Nausea of vomiting
- _____ Pain in the stomach
- _____ Change in bowel habits
- _____ Constipation
- _____ Diarrhea

Arms and Legs
- _____ Cramps in the legs
- _____ Pain in the joints
- _____ Swollen joints
- _____ Numbness in the extremities
- _____ Shooting pain in the extremities

Genital-Urinary Problems
- _____ Frequent urination
- _____ Blood in urine
- _____ Pain on urinating
- _____ Trouble getting started
- _____ Trouble stopping
- _____ Loss of bladder control

Females
- _____Last menstrual period

Pregnant __yes __no
Breast feeding __yes __no
Number of: Live births #_____
Stillborns/Miscarriages #_____
Abortions #_____
- _____ Using birth control
- _____ PMS
- _____ Post Menopausal

Male and Female
- _____ Pain in breasts
- _____ Lump in breast
- _____ Discharge from breast
- _____ Sex Drive

General
- _____ Fatigue or tiredness
- _____ Thirst
- _____ Change in appetite
- _____ Weight gain
- _____ Numerous infections
- _____ Slow healing
- _____ Hot Flashes
- _____ Problems with sleep

Are immunization records up to date __yes __no
- _____ Tetanus

Do you have other general health concerns that are not listed above? _____

_____

Psychiatric History: FAMILY: Psychiatric Problems, Suicide, Trauma.

_____

_____

_____

_____

PERSONAL: Psychiatric Problems, Suicide, Hospitalizations, Outpatient Treatment, Medications.

When _____ Where _____

_____

_____

_____

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
HEALTH HISTORY

Name: _____ Date: _____

Do you take other Prescription medications?

Name	Dose	How often?	How long?

Do you take over the counter vitamins and herbs?

Name	Dose	How often?	How long?

Do you use alcohol?

Type	Amount	Frequency	Last Use

Has your alcohol use ever been a problem for you or anyone else?

_____

_____

Do you use tobacco?

Quantity	Frequency

Do you use caffeine?

Quantity	Frequency

Do you use other substances? (i.e. marijuana, heroine)

What	Quantity	Frequency

Alternate Health care? (i.e. Acupuncture, Massage Homeopathy, Chiropractor)

What	Quantity	Frequency

Do you exercise?

What	Frequency	Duration

What do you do for relaxation? _____

_____

_____

_____

What do you usually eat in a day? _____

_____

_____

Signature _____ Date _____

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
INFORMED CONSENT

CONFIDENTIALITY STATEMENT

All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. This permission can be revoked by you at any time.

FINANCIAL AGREEMENT

Your fee per visit is $ 170.00 payable at the time of treatment. We accept cash, check, cashiers check, Visa and Mastercard.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION

NO-SHOW AND CANCELLATION POLICY

Your visit has been reserved for you. 24 hour notice is required for cancellation or you will be charged a late cancellation fee of $ 170.00 .

EMERGENCIES

We have 24-hour voice mail; if we are not available you will be given emergency numbers on your initial visit.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

Client _____ Date _____

Provider _____ Date _____

Parent or Guardian _____ Date _____

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
CLIENT'S RIGHTS

Counseling at Goodale Park is dedicated to the provision of quality coaching and counseling services. Enclosed is a statement of rights and responsibilities. Please read these sheets to facilitate your understanding of these rights and responsibilities.

Rights:

1) You have the right to be treated with respect for personal dignity, autonomy and privacy.
2) You have the right to consent to or refuse a service or treatment and to participate actively in the design of your treatment.
3) You have the right to be given explanations of treatments and services being offered.
4) You have the right to confidentiality of communications. No statement will be disclosed without permission of the client. Only issues of safety of the patient or others will override this issue.
5) You have the right to access to your records.
6) You have the right not to be discriminated against on the basis of race, creed, color, sex, sexual preference, national origin, disability and/or physical or mental handicap.
7) You have the right to know the cost of services.

Responsibilities:

1) You have the responsibility to keep appointments or provide twenty-four hour notice prior to any cancellation to avoid being charged full fee for the scheduled appointment.
2) You have the responsibility to notify Counseling at Goodale Park of any changes in address, telephone number, insurance status and marital status.
3) You have the responsibility to meet your financial obligation in a timely manner.
4) You have the responsibility to be open, truthful and to share your needs, thoughts and past experiences that relate to your health.
5) We ask that you turn your cell phone off while in the waiting room and during your session.

Financial Agreement

The charges for counseling and coaching services are based on reasonable and customary fees charged in this area. In general, our fees are $170.00 an hour.

Payment of fees is expected at time of service.

I have reviewed the above information and consent to treatment of myself of my minor child and accept these rights and responsibilities.

Signed _____ Date _____

Relationship _____

Witness _____

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Intake Questionnaire
PRE-AUTHORIZED CREDIT CARD PAYMENT

I authorize **COUNSELING AT GOODALE PARK, Ltd.**

to keep my signature on file and to charge my credit card account for:

Recurring charges (on-going treatments) of $_____ every_____
(fee) (frequency)

**I understand I may revoke this agreement at any time by providing a request in writing.

Client's Name _____

Cardholder's Name _____

Cardholder's Address _____

City _____State _____Zip _____

❑ VISA ❑ MasterCard

Account number_____ Expiration_____ 3 digit Code_____

Signature _____

Provider agrees to only charge for services rendered or for cancellation fee if appointment is not cancelled within 24 hours.

Therapist's Signature _____Date_____

Intake Questionnaire
HIPPA

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

This notice describes how medical information about you may be used and disclosed and how you can get access to this information
Please review it carefully

To Our Clients
This is a notice to tell you how we handle your medical information. It tells how we use this information in our office, how we share it with other professionals and organizations, and how you view it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask our Privacy Officer, Kris Worthington, for more details.

Privacy Laws
The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal law requiring us to keep your **Personal Healthcare Information (PHI)** private and to give you this notice of our legal duties and our privacy practices. This notice is called the **Notice of Privacy Practices (NPP)**. We will obey the rules of this notice as long as it is in effect, but if it is changed, the new rules will apply to all the PHI we keep. If we change the NPP, we will post the new notice in our office where everyone can see. You, or anyone else, can also get a copy or our current NPP from out Privacy Office at any time.

What is Medical Information?
Each time you visit any doctor's office, therapist's office, hospital, clinic, or any other healthcare provider, information is collected about you and your physical and mental health. The information we collect (your PHI) is included in your medical or healthcare record. PHI may include, but is not limited to, the following:

- History - medical, personal, social and psychological
- Problems, complaints, symptoms or needs
- Diagnoses - the medical term for your problems or symptoms
- Treatment - from us or others, including medications
- Progress Notes - written information about how you are doing and what you tell us
- Legal matters
- Billing and insurance information

Although your health record are the physical property of the healthcare practitioner or facility that collected it, it belongs to you. You can read it, and if you want a copy, we can make one for you. We may charge you for the costs of copying and mailing.

If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to change or include this information.

Ways Your PHI Can Be Used
When healthcare providers read your information, it is legally called **use**. If the information is shared with or sent to others outside this office, this is legally called **disclosure**. Except in some special circumstances, when we use your PHI her or disclose it to others, we share only the minimum necessary PHI needed for those others to do their jobs. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed (shared).

Mainly, we will use and disclose your PHI for the routine purposes described below. Some uses require a written Authorization Form agreed to and signed by you. Other uses may legally require us to disclose without your authorization.

1. Uses and disclosures with your Consent
After you read this notice you will be asked to sign a separate **Consent Form** to allow us to use and share your PHI. Brief descriptions of the most common types of uses and disclosures requiring your consent follow.

Treatment, Payment or Healthcare Operations
In almost all cases we intend to use your PHI to provide treatment for you, arrange payment for our services, and for other business functions called healthcare operations. Together these routine services are called **Treatment Payment Operations (TPO)**.

We need information about you and your condition to provide care for you. We need you to agree to let us collect the information, to use it, and share it so that we can care for you properly. The information we collect about you goes into your healthcare records here.

Treatment - We use your medical information to provide you with Mental Health and Chemical Dependency Services. These might include therapy (individual, family, or group), testing (psychological, educational, or vocational), treatment planning, and/or measuring the benefits of our services.

We may disclose your PHI to others who provide treatment to you. This enables the various caregivers to better coordinate your treatment. We may refer you to their professionals for services that we cannot provide. We need to tell them about you, your condition, and treatments you have received. We will then include their findings and recommendations in your records here. If you receive treatment in the future from other professionals we will be able to share your PHI with them as well.

Payment - We may use your information to bill you, or your insurance, or others so that we can be paid for the services we provide. We may contact your insurance company to see what services it covers.
We may have to tell them:

- When we met
- Your diagnosis
- Treatments you have received
- Your progress
- Changes we expect

Healthcare Operations - There are a few other ways we may use or disclose your PHI for healtcare operations. For example, we may use your PHI to make improvements in the care and services we provide. We may be asked to supply some information to government health agencies so that they can study disorders and treatments and make plans for services that are needed. If we do so, your name and personal information will be removed from what we send.

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Other Healthcare Uses

Appointment Reminders - We may use and disclose medical information to reschedule or remind you of appointments for treatment or care. If you want us to call or write to you only at your home or your work, or some other location, we usually can arrange that. Just tell us.

Treatment Alternatives - We may use and disclose your PHI to locate treatment alternatives that we believe may be of help to you.

Benefits and Services - We may use and disclose your PHI to locate health-related benefits or services that may be of interest to you.

Business Associates - There are some jobs that we contract out to their businesses to do for us. These are legally called our "business associates." Examples would be a copy service that copies our health records, or a billing service that calculates, prints and mails our bills. These business associates need to receive some of our PHI to do their jobs properly. They have agreed in their contract with us to safeguard your information.

2. Uses and Disclosures with your Authorization

If we want to use your information for any purpose besides those we describe above, we need your permission on an Authorized Form. We don't expect this very often. If you do authorize us to use or disclose your PHI, you can revoke (cancel) that permission, in writing, anytime. After that time we will not use or disclose your information for the purposes that we agreed to. However, we cannot take back any information we have already disclosed with your permission or have used in this office.

3. Uses and Disclosures without your consent or authorization

The laws require us to use and disclose some of your PHI without your consent or authorization.

Here are examples of when we might have to share your information.

State, federal, or local laws require disclosure if:

- There is a suspected child abuse or neglect
- We receive a subpoena, discovery request, or other lawful process regarding a lawsuit involving you. We will only release your information after trying to contact you, about the request, consulting your lawyer, or attempting to obtain a court order to protect the information requested.

Government agencies check on us to see that we are obeying the privacy laws.

Law enforcement purposes

We may have to disclose medical information to investigate a crime or criminal if asked to do so by law enforcement officials.

Public Health activities

We may have to disclose your PHI to agencies that investigate diseases or injuries.

In case of death

We may have to disclose your PHI to coroners, medical examiners, funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

Government functions

We may have to disclose the PHI of military personnel and veterans to government benefit programs for eligibility and enrollment purposes. We may have to disclose your PHI for national security reasons. We may also have to disclose your PHI to correctional facilities (if you are an inmate), or to Workers Compensation and Disability Programs.

Prevention of a serious threat to health or safety

If we come to believe that there is a serious threat to your health, or to the health of another person or the public, we may have to disclose some of your PHI. We would only disclose to persons who could help in your treatment.

4. Disclosures you can choose

   We can share some information about you with your family or others. We will only do this with those directly involved in your care, or a person you choose, such as a close friend or clergy member. We will ask you who you want us to tell and what information you want us to share. We will honor your wishes as long as it is not against the law.

   If there is an emergency, and we cannot get your permission, we can share your information if we believe that it is what you would have wanted and/or we believe it will help you. If we do share information in an emergency, we will tell you as soon as we can.

Disclosure Records

When we disclose your PHI you can get an accounting (or list) if we have kept a record of these disclosures.

Questions or Problems

Contact your Privacy Officer by phone or in person if:

- You need more information or have questions about the above.
- You have a problem with how your PHI has been handled.
- You believe your privacy rights have been violated.

You have the right to file a complaint with us and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care in this office or take any actions again you if you file such a complaint.

Privacy Officer:
Kris Worthington
(614) 207-2690

The effective date of this notice is April 14, 2003

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Adverse Childhood Experiences
FIND YOUR ACE SCORE

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

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

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

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Authorization to Use and Disclose Your Protected Health Information

1. I am completing this form to allow the use and sharing of protected health & personal information about:
   Print Name:_____ Date of Birth:_____.
2. I authorize this person or organization: _____
   _____

A. To use or disclose the following checked information:

__ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illnesses
__ Admission and discharge summaries
__ Psychological or psychiatric evaluations, reports, assessments, treatment notes, summaries, documents with diagnoses, prognoses, recommendations, testing records, behavioral observations, checklists completed by any staff member and/or the patient, or similar documents
__ Treatment, recovery, rehabilitation, aftercare plans and other similar plans
__ Social, family, educational, and vocational histories
__ Social work assessments, occupational therapy and vocational reports and evaluations
__ Progress, Nursing, Case or similar notes
__ Evaluations and reports of consultants
__ Information about how the client's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living
__ Billing records
__ Academic and educational records, including achievement and other test results, reports or teachers' observations, and all other school or special education documents
__ HIV-related information and drug and alcohol information contained in these record unless indicated here: __ Do not release these
__ Complete copy of the medical record and the folder in which it was kept
__ Other:_____

B. To this person or organization _____
_____

C. For these dates of care:
From_____ to_____, and From_____ to_____, and
From_____ to_____.

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Authorization to Use and Disclose Your Protected Health Information

3. The information will be used/disclosed for the following purposes:

   _____

   _____.

4. I understand and agree that this authorization will be valid and in effect until _____ (Enter a date or event upon which this authorization expires). I understand that after that date or event no more of this information can be used or released to the above named person(s) or organization(s) unless I sign a new authorization.

5. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the above named person(s) or organization(s). Once the letter of revocation is received no further disclosure will be shared. However, we cannot change the fact that some information may have been shared before that date.

6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the professional or facility listed above in section 2, nor will it affect my eligibility for benefits.

7. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copying or other services. __Does not apply

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above in section 2, may be redisclosed and no longer protected by those regulations.

9. I understand that the professional or facility listed in section 2 will receive compensation for use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. __Does not apply

10. I affirm that everything in this form that was not clear to me has been explained to me and I believe that I now understand all of it.

_____ _____
Signature of client or personal representative Date

_____ _____
Printed name of client or personal representative Relationship to client

_____

_____
Description of personal representative's authority

11. __ I acknowledge that I received a copy of this form.

I, a mental health and coaching professional, have discussed the issues above with the client and/or a personal representative. My observations of the client's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____
Signature of professional Printed name of professional Date

Incomplete Sentences

Jerry Worthington,
M.C.L.C., L.I.C.D.C.-C.S.
Counseling & Coaching
1900 Polaris Pkwy., Suite 450
Columbus, OH 43240
Telephone: 614.207.2690

Name: _____ **Age:** _____ **Date:** _____

Instruction: Please complete these sentences to express your real feelings. Try to do every one. Be sure to make a complete sentence.

I like _____.

The happiest time _____.

I would like to know _____.

At home _____.

My parents _____.

I regret _____.

Men _____.

What really annoys me _____.

Most people _____.

My mother _____.

Sometimes I feel _____.

My greatest fear _____.

When I was a child _____.

My mind _____.

The future _____.

What I need most _____.

Marriage _____.

I am best when _____.

I hate _____.

I wish _____.

My father _____.

I secretly _____.

My greatest worry _____.