

Name: _____	Date of Birth: _____
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**Current Status** (single, married, divorced, etc.): \_\_\_\_\_

**Children** (ages): \_\_\_\_\_

**History of mental health diagnosis?** Self: \_\_\_\_\_

Family: \_\_\_\_\_

**History of substance abuse?** Self: \_\_\_\_\_

Family: \_\_\_\_\_

**Prior Mental Health or Chemical Dependency Treatment**

(counseling or therapy, groups, psychiatric hospitalizations, etc.):

Type of Treatment:	Provided By:	Approximate Dates/Timeframe:	Effective or helpful?

**Past Mental Health Medications:**

Medication:	Dose	When?	For how long?	Side effects?	Effective or helpful?

**Current Mental Health Medications:**

Medication:	Dose	Start Date	Side effects?	Effective or helpful?

**Current stressors/concerns** (financial, employment, relationships, medical, housing, safety, etc.):

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**Patient Health Questionnaire (PHQ9)**

Over the <u>last 2 weeks</u> , 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
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. 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	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
<b>Total</b>				
10. If you checked off any problems on this questionnaire so far, 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 <input type="radio"/>	Somewhat difficult <input type="radio"/>	Very Difficult <input type="radio"/>	Extremely Difficult <input type="radio"/>	

**Generalized Anxiety Disorder Questionnaire (GAD7)**

Over the <u>last 2 weeks</u> , 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
1. Feeling nervous, anxious or on edge	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Not being able to stop or control worrying	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Worrying too much about different things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Trouble relaxing	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Being so restless that it is hard to sit still	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Becoming easily annoyed or irritable	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Feeling afraid as if something awful might happen	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
<b>Total</b>				
8. If you checked off any problems on this questionnaire so far, 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 <input type="radio"/>	Somewhat difficult <input type="radio"/>	Very Difficult <input type="radio"/>	Extremely Difficult <input type="radio"/>	

**Drinking alcohol and/or using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.**

One drink equals	 12 oz. Beer	 5 oz. Wine	 1.5 oz. Liquor
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**In the past 12 months...**

*Place an X in one box that best describes your answer to each question.*

How often do you have a drink containing alcohol?	<input type="radio"/> Never <sub>0</sub>	<input type="radio"/> Monthly or less <sub>1</sub>	<input type="radio"/> 2-4 times a month <sub>2</sub>	<input type="radio"/> 2-3 times a week <sub>3</sub>	<input type="radio"/> 4 or more times a week <sub>4</sub>
How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="radio"/> 1 or 2 <sub>0</sub>	<input type="radio"/> 3 or 4 <sub>1</sub>	<input type="radio"/> 5 or 6 <sub>2</sub>	<input type="radio"/> 7 to 9 <sub>3</sub>	<input type="radio"/> 10 or more <sub>4</sub>
	<b>Never</b>	<b>Less than monthly</b>	<b>Monthly</b>	<b>Weekly</b>	<b>Daily or almost daily</b>
How often do you have 5 or more drinks on one occasion?	<input type="radio"/> <sub>0</sub>	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="radio"/> <sub>0</sub>	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
How often during the last year have you failed to do what was normally expected from you because of drinking?	<input type="radio"/> <sub>0</sub>	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="radio"/> <sub>0</sub>	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="radio"/> <sub>0</sub>	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
How often during the last year have you been unable to remember what happened the night before because of your drinking?	<input type="radio"/> <sub>0</sub>	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
Have you or someone else been injured because of your drinking?	<input type="radio"/> No <sub>0</sub>		<input type="radio"/> Yes, but not in the last year <sub>2</sub>		<input type="radio"/> Yes, during the last year <sub>4</sub>
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input type="radio"/> No <sub>0</sub>		<input type="radio"/> Yes, but not in the last year <sub>2</sub>		<input type="radio"/> Yes, during the last year <sub>4</sub>
Add scores by column, then across row.					

**Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.**

In the past 12 months...	Yes	No
Have you used drugs other than those required for medical reasons?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Do you abuse more than one drug at a time?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Are you unable to stop using drugs when you want to?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Have you ever had blackouts or flashbacks as a result of drug use?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Do you ever feel bad or guilty about your drug use?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Have you neglected your family because of your use of drugs?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Have you engaged in illegal activities in order to obtain drugs?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>0</sub>
<b>TOTAL</b>		

**PCL-C (Short Form)**

<b>In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:</b>	<b>YES</b>	<b>NO</b>
1) Have had nightmares about it or thought about it when you did not want to?		
2) Tried hard not to think about it, or went out of your way to avoid situations that made you think of it?		
3) Were constantly on guard, watchful, or easily startled?		
4) Felt numb or detached from others, activities, or your surroundings?		

<b>Has there ever been a period of time when you were not your usual self and...</b>		
	<b>YES</b>	<b>NO</b>
...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?		
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
<p>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.</p> <p style="text-align: center;"> <span>No Problem</span>                <span>Minor Problem</span>                <span>Moderate Problem</span>                <span>Serious Problem</span> </p>		
	<b>YES</b>	<b>NO</b>
Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		