PATIENT INFORMATION: Is Treatment Court-Ordered? YES/ NO

Last name: _____ First:_____ M.I. _____

Preferred Name:_____

Birth date: ____/____/____ Referral Source: _____

Identified Gender: _____ Sex:_____ Identified Race:_____

Marital Status: _____ If Married, Spouse's Name:_____

Address: _____ City: _____ State: _____Zip: _____

Phone: H:_____ W:_____C:_____

Email: _____

Permission to leave voicemails? YES/ NO Permission to email? YES/ NO

Appointment Reminder(s): ☐ Email ☐ Text Message ☐ Voicemail

RESPONSIBLE PARTY - If other than patient (i.e. legal guardian) ☐ Not Applicable

Last name: _____ First Name:_____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Employer's Name: _____ City: _____ State: _____

EMERGENCY CONTACT

Last name: _____First Name:_____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Employer's Name: _____ City: _____ State: _____

History Questionnaire

On the chart below, please check what symptoms you have recently experienced. Check all that apply. Please feel free to ask questions if you are unsure.

☐ Withdrawing from family/friends	☐ Don't Care/ Ambivalence	☐ Fear of Abandonment	☐ Trouble with Authority
☐ Low Energy/Fatigue	☐ Emotional Highs	☐ Nightmares	☐ Stealing
☐ Irritability	☐ Restlessness	☐ Phobias	☐ Over-Aggressiveness
☐ Hard Time Feeling Joy	☐ Hyperactivity	☐ Nervousness	☐ Physical Health Problems
☐ Depressed Mood	☐ Impulsiveness	☐ Obsessions/ Ruminations	☐ Chronic Pain
☐ Sleeping Too Much	☐ Anger/Hostility	☐ Flashbacks	☐ Eat When Not Hungry
☐ Not Sleeping	☐ Noticeable Mood Swings	☐ Avoid Memories	☐ Body Dissatisfaction
☐ Hard Time Falling Asleep	☐ Decision-Making Difficulties	☐ Periods of Disconnection from Body	☐ Starving/Binging/ Purging
☐ Crying Spells	☐ Disorganization	☐ Periods of Disconnection from Reality	☐ Sexual Problems
☐ Concentration/Focus Issues	☐ Impaired Memory	☐ Feel as if Others Are Spying on You	☐ Eat Large Quantities of Food
☐ Easily Distracted	☐ Racing Thoughts	☐ Hallucinations	☐ Hypervigilance
☐ Feeling Rejected	☐ Racing Speech	☐ Delusions	☐ Big Startle Response
☐ Low Self-Esteem	☐ Concern about Alcohol or Drugs	☐ Suicidal Thoughts	☐ Avoidance of Feelings
☐ Guilt/Shame	☐ Excessive Worry	☐ Urges to Self-Harm	☐ Trust Issues
☐ Helplessness	☐ Anxiety	☐ Desires to Harm/Kill Someone Else	☐ Gaps in Memory
☐ Hopelessness	☐ Panic Attacks	☐ Problems at Work/ School	☐ Risky Behaviors

Please list any symptoms you experience not listed above: _____

_____

How often do symptoms affect you?

☐ 1-2 days per week ☐ 3-4 days per week ☐5-6 days per week ☐Everyday

How long have you been dealing with these symptoms?_____

What makes the symptoms worse?_____

How much do symptoms interfere with work, housework, getting along with others?

On a scale of 1 (not at all) to 10 (all the time):_____

What improves symptoms?_____

When do you notice difficulty lessens or goes away?_____

Patient Health Questionnaire – 9	(Please Circle One)			
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 Everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep 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
How difficult have the above problems made it for you to do work, complete housework, or get along with other people?	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
**Adapted from Pfizer, Inc. and found at https://www.med.umich.edu/1info/FHP/practiceguides/depress/phq-9.pdf				

Have you thought of suicide within the past 30 days? ☐ Yes ☐ No

Have you ever thought about ending your life? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If Yes, when and what was the method?_____

Were you hospitalized? ☐ Yes ☐ No

If yes, when and where? _____

Have you made use of Crisis Services if feeling suicidal? ☐ Yes ☐ No

Do you harm yourself in any manner (i.e. cutting, burning)? ☐ Yes ☐ No

If yes, please explain:_____

Do you have any access to guns or weapons? ☐ Yes ☐ No

Generalized Anxiety Disorder (GAD-7) Scale	(Please Circle One)			
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 Everyday
Feeling Nervous, Anxious, or on Edge	0	1	2	3
Not 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
How difficult have the above problems made it for you to do work, complete housework, or get along with other people?	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
**Adapted from Pfizer, Inc. and found at https://med.dartmouth-hitchcock.org/documents/GAD-7-anxiety-screen.pdf				

In the following chart, please identify what experiences you have had in your life?

(Circle HX if you have a History and/or P if it is a Present issue)

Life Experiences								
Abusive Relationship	Hx	P	Financial Abuse	Hx	P	Miscarriage	Hx	P
Physical Abuse	Hx	P	Unhappy Childhood	Hx	P	Abortion	Hx	P
Emotional Abuse	Hx	P	Few Friends	Hx	P	Crime Victim	Hx	P
Sexual Abuse	Hx	P	Family Problems	Hx	P	War	Hx	P
Witnessed physical abuse	Hx	P	Rape	Hx	P	Poverty	Hx	P
Witnessed emotional abuse	Hx	P	Traumatic Brain Injury	Hx	P	Natural Disaster	Hx	P
Witnessed sexual abuse	Hx	P	Death of Close Loved One	Hx	P	Poor Academics	Hx	P

Please explain any details you wish to share about your life experiences: _____

_____

Current Family & Family of Origin

What is your current relationship status? ☐ Married ☐ Separated ☐ Single ☐ Divorced

☐ Committed Relationship ☐ Divorce Process ☐ Other: _____

What do you consider your sexual orientation to be (i.e. bisexual, heterosexual, homosexual, pansexual, etc.)_____

Do you have children? ☐ Yes ☐ No

Name	*Age*	*Living with You? Y/N*

What is the custody status of your children?

☐ Married with Joint Custody ☐ Sole Custody ☐ Joint Custody ☐ Children Over Age 18

Please list any other individuals with whom you currently reside

Name	*Age*	*Relationship*

Where did you grow up? _____

Family Members (Please List Parents, Siblings, and Anyone Else Who Resided with You)

Name	*Relationship*	*Current Status of Relationship*

Please use a couple of words or a phrase to describe your childhood:_____

_____

Brief description of your childhood development: (complications with pregnancy/delivery, significant development info, adoption, or social incidents in your life): _____

_____

_____

_____

Substance Use History & Present

Past Use:

☐ Alcohol ☐ Tobacco ☐ Caffeine ☐ Cannabis ☐ Methamphetamines (inc. ADHD meds)

☐ Narcotics ☐ Prescriptions (in unhealthy manner) ☐ Other _____

Current Use:

☐ Alcohol ☐ Tobacco ☐ Caffeine ☐ Cannabis ☐ Methamphetamines (inc. ADHD meds)

☐ Narcotics ☐ Prescriptions (in unhealthy manner) ☐ Other _____

Details of current use (how often, how much, etc.): _____

_____

Have you participated in a chemical dependency treatment program? ☐ Yes ☐ No

If Yes, Where and When? _____

Do you feel you have a problem with substances or alcohol? ☐ Yes ☐ No

Do you have family history of substance or alcohol abuse/dependence? ☐ Yes ☐ No

If Yes, Who and What Substance(s)?: _____

_____

CAGE-AID

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.	
Have you ever felt you ought to cut down on your drinking or drug use?	☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use?	☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes ☐ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?	☐ Yes ☐ No

Mental Health History

Have you ever received outpatient mental health therapy services? ☐ Yes ☐ No

If Yes, Please Describe (how many times, when, where, how long, good/bad experience): _____

_____

_____

_____

_____

_____

Do you currently work with a psychiatric prescriber? ☐ Yes ☐ No

If Yes, Name & Location: _____

Please list any Mental Health diagnoses which you have received by past treating providers: _____

_____

_____

Have you ever had inpatient Mental Health treatment and/or hospitalizations? ☐ Yes ☐ No

If Yes, Were you hospitalized by choice? ☐ Yes ☐ No

If Yes, Please Describe (how many times, when, where, how long, good/bad experience): _____

_____

_____

_____

_____

Do you have any history of Mental Health commitment? ☐ Yes ☐ No

If Yes, Please Describe (how many times, when, etc.): _____

_____

_____

_____

_____

Do you have family history of mental health struggles? ☐ Yes ☐ No

If Yes: _____

_____

Medical History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Primary Care Physician and Location: _____

Last Physical Exam: _____

Current Medical Concerns (i.e. diabetes, heart problems, immune disorders, etc.)

Condition	*Start Date*	*End Date (or Current)*	*Treatments*	*Status*

Medication	*Reason*	*Dosage*	*Prescriber*	*Effect (is it working?)*

Do you have a history of medical surgeries? ☐ Yes ☐ No

If Yes, Please Describe (how many times, for what, when, where, etc.): _____

_____

Do you have allergies to anything? ☐ Yes ☐ No

If Yes, Please Describe: _____

Do you have family history of physical health issues (i.e. diabetes, cancer, etc.)? ☐ Yes ☐ No

If Yes: _____

_____

Legal History

Are you currently involved with the legal system in any way? ☐ Yes ☐ No

If Yes, Please Describe: _____

_____

_____

Do you have any history of jail time or prison time? ☐ Yes ☐ No

If Yes, Please Describe: _____

_____

_____

Have you ever been divorced? ☐ Yes ☐ No # of marriages ending in divorce: _____

Have you ever been involved in custody disputes? ☐ Yes ☐ No ☐ Current

If Yes, Please Describe: _____

Education and Employment History

Are you currently in school? ☐ Yes ☐ No

If Yes, where, what degree, and how long do you have left? _____

_____

Highest level of education completed:

☐ Some High School ☐ High School ☐ GED ☐ Vocational ☐ Some College

☐ College Graduate ☐ Post Graduate ☐ Other: _____

Did you attend Special Education classes as a child? ☐ Yes ☐ No

If Yes, Please Describe: _____

Do you have Military history? ☐ Yes ☐ No

If Yes, What Branch? _____

Years of Service: _____

Discharge Status: ☐ Currently Still Active ☐ Honorable ☐ Dishonorable ☐ Medical

Current Employment Status: ☐ Full Time ☐ Part-Time ☐ Unemployed ☐ Disability ☐ Student

Current or Most Recent Employer: _____

Position:_____

Length of Time at Current/Most Recent Employer:_____

Work-Stressors:_____

If no longer employed, what contributed to leaving the employer? _____

_____

_____

Are finances a major stressor for you? ☐ Yes ☐ No

Spiritual/Religious & Cultural Information

Do you consider yourself Spiritual? ☐ Yes ☐ No

If Yes, Please Describe: _____

_____

Do you consider yourself religious? ☐ Yes ☐ No

If Yes, Please Describe: _____

_____

Please list any cultural considerations for which the Psychologist should be aware: _____

_____

_____

Is there anything else the psychologist should know? ☐ Yes ☐ No

If Yes, Please Describe: _____

_____

_____

_____

_____

_____

World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or Cannot Do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or Cannot Do

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days _____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days _____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days _____

**Adapted from World Health Organization at https://www.who.int/classifications/icf/WHODAS2.0_12itemsSELF.pdf