

Patient Name: _____

Date: _____

ADULT BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems: _____

Duration (months): _____

Additional Information: _____

CURRENT SYMPTOM CHECKLIST (Rate intensity currently present)

None=This symptom not present at this time • **Mild**=Impacts quality of life, but not significant impairment of day-to-day functioning • **Moderate**= Significant impact on quality of life and/or day-to-day functioning • **Severe**=Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe	Unsure		None	Mild	Moderate	Severe	Unsure
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	None	Mild	Moderate	Severe	Unsure		None	Mild	Moderate	Severe	Unsure
Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance use/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concomitant medical cond.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempts:	_____ number of times				

Date of last attempt: _____

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy? _____ Yes _____ No

If yes on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____/_____ to _____/_____/_____

Prior provider name: _____

City: _____ State: _____

Phone: _____

Diagnosis: _____

Intervention/Modality: _____

Beneficial? _____

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder? _____ Yes _____ No

If yes on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____/_____ to _____/_____/_____

Inpatient facility name: _____

City: _____ State: _____

Phone: _____

Diagnosis: _____

Intervention/Modality: _____

Beneficial? _____

Has any family member had outpatient psychotherapy? _____ Yes _____ No

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder

If yes, who/why (list all): _____

MARITAL STATUS:

- Single Married Divorced Separated Live In
Never married How long _____ how long _____ how long _____ how long _____

Spouses/Significant Others Name: _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Father

Full name: _____

Occupation: _____

Education level: _____

General health: _____

Mother

Full name: _____

Occupation: _____

Education level: _____

General health: _____

Describe childhood family experience:

- Outstanding home environment
 Normal home environment
 Chaotic home environment
 Witnessed physical/verbal/sexual abuse toward others
 Experienced physical/verbal/sexual abuse from others

Patient Name: _____

Date of Birth: _____

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

List all persons currently living in patient's household:

Name	Age	Gender	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children and age not living in same household as patient: _____

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationship:

Describe any past or current significant issues in other immediate family relationships:

Substance use history:

Family alcohol/drug abuse history:

- Mother Stepmother/live-in Grandparent(s) Spouse/significant other
- Father Stepfather Uncle(s)/Aunt(s) Siblings
- Children Other (Specify) _____

Substances used by patient:

(complete all that apply) Current Use

	First use age	Last use age	(yes/no)	Current frequency	Current amount
Alcohol	_____	_____	_____	_____	_____
Amphetamines/"speed"	_____	_____	_____	_____	_____
Barbiturates/"downers"	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____	_____
Crack cocaine	_____	_____	_____	_____	_____
Hallucinogens (e.g. LSD)	_____	_____	_____	_____	_____
Inhalants (e.g. glue, gasoline)	_____	_____	_____	_____	_____
Marijuana or hashish	_____	_____	_____	_____	_____
Nicotine/cigarettes	_____	_____	_____	_____	_____
PCP	_____	_____	_____	_____	_____
Prescription	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Consequences of substance use (check all that apply):

- Hangovers Seizures Assaults Loss of control of amount used Withdrawal symptoms Medical complications
- Blackouts Overdose Arrests Sleep Disturbance Suicidal Impulse Relationship conflicts
- Binges Job loss Tolerance changes Other _____

Patient Name:

Date of Birth:

Patient alcohol and/or drug treatment history:

- Outpatient (age[s]_____)
- 12-step program (age[s]_____)
- Other (age[s]_____) describe:_____
- Inpatient (age[s]_____)
- Stopped on own (age[s]_____)

Socio-economic history (check all that apply for patient):

Living situation:

- Housing adequate
- Homeless
- Housing overcrowded
- Dependent on other for housing
- Living companion
- Living companion dysfunctional
- Housing dangerous/deteriorating

Financial situation:

- No current financial problems
- Large indebtedness
- Poverty or below poverty income
- Impulsive spending
- Relationship conflicts over finances

Education:

- Highest grade completed _____
- College # of years _____
- Graduate School

Name of school _____

Employment:

- Employed and satisfied
- Employed but dissatisfied
- Unstable work history
- Coworker conflicts
- Supervisor conflicts
- Unemployed

Please list your most recent work history

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Social Support System:

- Supportive network
- Few friends
- No friends
- Substance-use based friends
- Distance from family of origin

Military history:

- Never in military
- Served in military-no incident
- Served in military with incident

Legal history:

- No legal problem
- Now on parole/probation
- Arrest(s) not substance-related
- Arrest(s) substance related
- Court ordered this treatment
- Describe last legal difficulty: _____
- Jail/prison ____ times
- Total time served: _____

Sexual history:

- Heterosexual orientation
- Homosexual orientation
- Bisexual orientation
- Currently sexually active
- Currently sexually satisfied
- Currently sexually dissatisfied
- Age of first sexual experience_____
- Age first pregnancy/fatherhood_____
- History of promiscuity, age_____
- History of unsafe sex, age _____

Cultural/spiritual/recreational history:

Cultural identity (e.g. ethnicity, religion):_____

	Yes	No
Currently active in community/recreation activities?	_____	_____
Formerly active in community/recreational activities?	_____	_____
Currently engage in hobbies?	_____	_____
Currently participate in spiritual activities?	_____	_____

If answered "yes" to any of the above, describe:_____

HEALTH SCREENING

Patient's Name: _____

Date: _____

Date of Birth: _____

Sex: _____ F _____ M

Allergies: _____

1. Do you have or have you ever had any of the following?
(please check yes or no)

	No	Yes	Please describe
Allergies			
Blood Disorder			
Bone or Joint Problems			
Cancer			
Diabetes			
Endocrine Disorders (e.g. thyroid)			
Epilepsy (seizures, convulsions)			
Gastrointestinal Disorders (stomach)			
Head injury			
Heart Disease			
HIV/AIDS Related Conditions			
Hypertension (high blood pressure)			
Hypoglycemia (low blood sugar)			
Liver Disease			
Lung Disease			
Physical Limitations			
Sexually Transmitted Disease (e.g. gonorrhea, syphilis)			
Other			

2. HOSPITALIZATIONS (list any operations, medical procedures, mental, drug, or alcohol abuse treatment)

Date	Procedure/treatment

3. MEDICATION currently taking (include prescription drugs; amount and frequency)

Name of Medication	Amount	Frequency	Date Started

4. MEDICAL PROCEDURES Physical exams; special test e.g. EKG, Blood Tests, X-rays, within past year

Exam/Test Performed	Date	Physician/Clinic

5. PRIMARY CARE DOCTOR

Name	Address	Phone	Date of Last Physical Exam

6. PREVIOUS MENTAL HEALTH TREATMENT

Date	Name of Provider	Address	Phone

Parent/Guardian/Patient's Signature: _____ Date: _____

Patient Name:

Date of Birth:

- Outpatient (age[s] _____)
- 12-step program (age[s] _____)
- Other (age[s] _____) describe: _____
- Inpatient (age[s] _____)
- Stopped on own (age[s] _____)

Socio-economic history (check all that apply for patient):

Living situation:

- Housing adequate
- Homeless
- Housing overcrowded
- Dependent on other for housing
- Living companion
- Living companion dysfunctional
- Housing dangerous/deteriorating

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- Relationship conflicts over finances

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- Highest grade completed _____
- College # of years _____
- Graduate School

Name of school _____

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- Employed and satisfied
- Employed but dissatisfied
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- Coworker conflicts
- Supervisor conflicts
- Unemployed

Please list your most recent work history

Occupation/Job title: _____ Employer: _____ Length of employment: _____
 Occupation/Job title: _____ Employer: _____ Length of employment: _____
 Occupation/Job title: _____ Employer: _____ Length of employment: _____
 Occupation/Job title: _____ Employer: _____ Length of employment: _____
 Occupation/Job title: _____ Employer: _____ Length of employment: _____

Social Support System:

- Supportive network
- Few friends
- No friends
- Substance-use based friends
- Distance from family of origin

Military history:

- Never in military
- Served in military-no incident
- Served in military with incident

Legal history:

- No legal problem
- Now on parole/probation
- Arrest(s) not substance-related
- Arrest(s) substance related
- Court ordered this treatment
- Describe last legal difficulty: _____
- Jail/prison _____ times
- Total time served: _____

Sexual history:

- Heterosexual orientation
- Homosexual orientation
- Bisexual orientation
- Currently sexually active
- Currently sexually satisfied
- Currently sexually dissatisfied
- Age of first sexual experience _____
- Age first pregnancy/fatherhood _____
- History of promiscuity, age _____
- History of unsafe sex, age _____

Cultural/spiritual/recreational history:

Cultural identity (e.g. ethnicity, religion): _____

	Yes	No
Currently active in community/recreation activities?	_____	_____
Formerly active in community/recreational activities?	_____	_____
Currently engage in hobbies?	_____	_____
Currently participate in spiritual activities?	_____	_____

If answered "yes" to any of the above, describe: _____

Patient Name:

Date of Birth:

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Questionnaire completed on visit date or specify date completed: _____
DD-Mon-YYYY

Only the patient (subject) should enter information onto this questionnaire.

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

1. Falling asleep:

- 0 I never took longer than 30 minutes to fall asleep.
- 1 I took at least 30 minutes to fall asleep, less than half the time (3 days or less out of the past 7 days).
- 2 I took at least 30 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).
- 3 I took more than 60 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).

2. Sleep during the night:

- 0 I didn't wake up at night.
- 1 I had a restless, light sleep, briefly waking up a few times each night.
- 2 I woke up at least once a night, but I got back to sleep easily.
- 3 I woke up more than once a night and stayed awake for 20 minutes or more, more than half the time (4 days or more out of the past 7 days).

3. Waking up too early:

- 0 Most of the time, I woke up no more than 30 minutes before my scheduled time.
- 1 More than half the time (4 days or more out of the past 7 days), I woke up more than 30 minutes before my scheduled time.
- 2 I almost always woke up at least one hour or so before my scheduled time, but I got back to sleep eventually.
- 3 I woke up at least one hour before my scheduled time, and couldn't get back to sleep.

4. Sleeping too much:

- 0 I slept no longer than 7-8 hours/night, without napping during the day.
- 1 I slept no longer than 10 hours in a 24-hour period including naps.
- 2 I slept no longer than 12 hours in a 24-hour period including naps.
- 3 I slept longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:

- 0 I didn't feel sad.
- 1 I felt sad less than half the time (3 days or less out of the past 7 days).
- 2 I felt sad more than half the time (4 days or more out of the past 7 days).
- 3 I felt sad nearly all of the time.

EPI0905.QIDSSR

Patient Name:

Date of Birth:

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)	
PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.	
Please complete either 6 or 7 (not both)	
<p>6. Decreased appetite:</p> <p><input type="checkbox"/>0 There was no change in my usual appetite.</p> <p><input type="checkbox"/>1 I ate somewhat less often or smaller amounts of food than usual.</p> <p><input type="checkbox"/>2 I ate much less than usual and only by forcing myself to eat.</p> <p><input type="checkbox"/>3 I rarely ate within a 24-hour period, and only by really forcing myself to eat or when others persuaded me to eat.</p>	<p>7. Increased appetite:</p> <p><input type="checkbox"/>0 There was no change in my usual appetite.</p> <p><input type="checkbox"/>1 I felt a need to eat more frequently than usual.</p> <p><input type="checkbox"/>2 I regularly ate more often and/or greater amounts of food than usual.</p> <p><input type="checkbox"/>3 I felt driven to overeat both at mealtime and between meals.</p>
Please complete either 8 or 9 (not both)	
<p>8. Decreased weight (within the last 14 days):</p> <p><input type="checkbox"/>0 My weight has not changed.</p> <p><input type="checkbox"/>1 I feel as if I've had a slight weight loss.</p> <p><input type="checkbox"/>2 I've lost 2 pounds (about 1 kilo) or more.</p> <p><input type="checkbox"/>3 I've lost 5 pounds (about 2 kilos) or more.</p>	<p>9. Increased weight (within the last 14 days):</p> <p><input type="checkbox"/>0 My weight has not changed.</p> <p><input type="checkbox"/>1 I feel as if I've had a slight weight gain.</p> <p><input type="checkbox"/>2 I've gained 2 pounds (about 1 kilo) or more.</p> <p><input type="checkbox"/>3 I've gained 5 pounds (about 2 kilos) or more.</p>
<p>10. Concentration/decision-making:</p> <p><input type="checkbox"/>0 There was no change in my usual ability to concentrate or make decisions.</p> <p><input type="checkbox"/>1 I occasionally felt indecisive or found that my attention wandered.</p> <p><input type="checkbox"/>2 Most of the time, I found it hard to focus or to make decisions.</p> <p><input type="checkbox"/>3 I couldn't concentrate well enough to read or I couldn't make even minor decisions.</p>	
<p>11. Perception of myself:</p> <p><input type="checkbox"/>0 I saw myself as equally worthwhile and deserving as other people.</p> <p><input type="checkbox"/>1 I put the blame on myself more than usual.</p> <p><input type="checkbox"/>2 For the most part, I believed that I caused problems for others.</p> <p><input type="checkbox"/>3 I thought almost constantly about major and minor defects in myself.</p>	
<p>12. Thoughts of my own death or suicide:</p> <p><input type="checkbox"/>0 I didn't think of suicide or death.</p> <p><input type="checkbox"/>1 I felt that life was empty or wondered if it was worth living.</p> <p><input type="checkbox"/>2 I thought of suicide or death several times for several minutes over the past 7 days.</p> <p><input type="checkbox"/>3 I thought of suicide or death several times a day in some detail, or I made specific plans for suicide or actually tried to take my life.</p>	

EPI0905.QIDSSR

Patient Name:

Date of Birth:

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

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?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="checkbox"/>	<input type="checkbox"/>

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?

No problems Minor problem Moderate problem Serious problem

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

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

FOR OFFICE CODING 0 + + +
=Total Score:

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Patient Name:

Date of Birth:

Zung Self-rating Anxiety Scale

Name: _____ Date: _____

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week**.

Circle the appropriate number for each statement.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

Score Total*:

*Score is for healthcare provider interpretation.

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

Patient Name		Today's Date					
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. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			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 A							
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?							
Part B							

PRIMARY CARE PROVIDER (PCP) COORDINATION OF CARE

This release is for the purpose of coordination of care between your provider at Union Counseling and your Primary Care Provider/ General Practitioner. **COMPLETE TOP SECTION ONLY.**

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Primary Care Provider (PCP) Name: _____

Address: _____

Phone: _____ Fax: _____

Optional Refusal (Initial):

_____ I **AM NOT** currently receiving services from a PCP or other medical practitioner

_____ I **DO NOT** want information shared with my PCP

***NOTICE:** By signing, I hereby authorize the behavioral health clinician/facility listed below to release information to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. **This consent will last one year from the date signed.** I understand that I may revoke my consent in writing at any time. I understand that my treatment is not conditional in any way on my consenting to this disclosure.*

Signature of Patient/Patient's Representative: _____ Date: _____

Print Name of Patient/Patient's Representative: _____

Relationship of Representative (parent, guardian, etc.) _____

(Please provide necessary documentation proving authority if requested)

THIS DOCUMENT IS FOR COORDINATION OF CARE ONLY FOR OUR MUTUAL PATIENT LISTED ABOVE

Should you have any further questions, please contact the office selected below.

Diagnosis: _____

Medications: _____

I recommend the following course of treatment for this patient:

THERAPY: _____ Individual _____ Family _____ Group _____ Couple

MEDICAL: _____ Medication Management _____ Substance Abuse Treatment

Provider Name: _____ Credential: _____

Provider Signature: _____ Date: _____

1311 Union Street Schenectady, NY 12308

Phone:(518)374-6263 Fax: (518)374-1778

5 Hemphill Place Malta, NY, 12020

Phone:(518)289-5072 Fax: (518)289-5225

DATE SENT _____

STAFF INITIAL _____

ADULT YEARLY APPT