Date: **Pt. Initials:** **DOB:**

Allergies:

Clinical History Form

Primary reason you are seeking care? (Can't sleep, anxiety, depression, mood swings, etc.):

How would YOU rate the overall severity level of the concern you listed above? (select one):

Mild Moderate Severe

What does it make you feel like on the inside? (On-edge, fatigued, empty, no pleasure from life anymore, scatterbrained, sad, hopeless, jittery, on high-alert, helpless, etc.?):

When did it start? (Elementary school, middle school, college, after starting a family, after using illicit drugs, etc.?):

Is it constant/persistent? Or does it come and go depending on your stressors/situation?

Was there any significant incident/stressor, that you can recall, happened around the time (within six months of the incident) you FIRST noticed the symptoms? (Parental divorce, loss of someone you were very close to, starting college or a new job, natural disaster, homelessness, abuse, being bullied, combat exposure, etc.?)

What seems to trigger it now? (Stress, lack of sleep, too much caffeine, family, big crowds, substance abuse, etc?):

Does anything make it better? (Adequate sleep, exercise, eating better, listening to music, reading, watching T.V., attending therapy, medications, etc.?):

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient Health Questionnaire (PHQ)

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 every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
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	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

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

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

NIDA- Modified ASSIST

1.

In your <u>LIFETIME</u>, which of the following substances have you ever used?	**YES**	**NO**
a. Cannabis (marijuana, pot, grass, hash, ect.)		
b. Cocaine (coke, crack, ect.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)		
d. Methamphetamine (speed, crystal meth, ice, ect.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)		
h. Street opioids (heroin, opium, ect.)		
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)		
j. Other- Specify		

2.

<u>In the past three months</u>, how often have you used the substances you mentioned (first drug, second drug, ect.)?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or almost daily**
a. **Cannabis** (marijuana, pot, grass, hash, ect.)	0	2	3	4	6
b. **Cocaine** (coke, crack, ect.)	0	2	3	4	6
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	2	3	4	6
d. **Methamphetamine** (speed, crystal meth, ice, ect.)	0	2	3	4	6
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, ect.)	0	2	3	4	6
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	2	3	4	6

g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K)	0	2	3	4	6
h. **Street opioids** (heroin, opium, ect.)	0	2	3	4	6
i. **Prescription opioids** (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	2	3	4	6
j. Other- Specify	0	2	3	4	6

3.

<u>In the past three months</u>, how often have you had a strong desire or urge to use (first drug, second drug, ect)	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or almost daily**
a. **Cannabis** (marijuana, pot, grass, hash, ect.)	0	3	4	5	6
b. **Cocaine** (coke, crack, ect.)	0	3	4	5	6
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	3	4	5	6
d. **Methamphetamine** (speed, crystal meth, ice, ect.)	0	3	4	5	6
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, ect.)	0	3	4	5	6
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	3	4	5	6
g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K)	0	3	4	5	6
h. **Street opioids** (heroin, opium, ect.)	0	3	4	5	6
i. **Prescription opioids** (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	3	4	5	6
j. Other- Specify	0	3	4	5	6

4.

During the past three months, how often has your use of (first drug, second drug, ect) led to health, social, legal, or financial problems?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or almost daily**
a. **Cannabis** (marijuana, pot, grass, hash, ect.)	0	4	5	6	7
b. **Cocaine** (coke, crack, ect.)	0	4	5	6	7
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	4	5	6	7
d. **Methamphetamine** (speed, crystal meth, ice, ect.)	0	4	5	6	7
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, ect.)	0	4	5	6	7
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	4	5	6	7
g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K)	0	4	5	6	7
h. **Street opioids** (heroin, opium, ect.)	0	4	5	6	7
i. **Prescription opioids** (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	4	5	6	7
j. Other- Specify	0	4	5	6	7

5.

During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, ect)	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or almost daily**
a. **Cannabis** (marijuana, pot, grass, hash, ect.)	0	5	6	7	8
b. **Cocaine** (coke, crack, ect.)	0	5	6	7	8

c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	5	6	7	8
d. **Methamphetamine** (speed, crystal meth, ice, ect.)	0	5	6	7	8
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, ect.)	0	5	6	7	8
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	5	6	7	8
g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K)	0	5	6	7	8
h. **Street opioids** (heroin, opium, ect.)	0	5	6	7	8
i. **Prescription opioids** (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	5	6	7	8
j. Other- Specify	0	5	6	7	8

6.

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (first drug, second drug, ect)?	**No, never**	**Yes, but not in the past 3 months**	**Yes, in the past 3 months**
a. **Cannabis** (marijuana, pot, grass, hash, ect.)	0	3	6
b. **Cocaine** (coke, crack, ect.)	0	3	6
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	3	6
d. **Methamphetamine** (speed, crystal meth, ice, ect.)	0	3	6
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, ect.)	0	3	6
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	3	6
g. **Hallucinogens** (LSD, acid, mushrooms, PCP,	0	3	6

Special K)			
h. **Street opioids** (heroin, opium, ect.)	0	3	6
i. **Prescription opioids** (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	3	6
j. Other- Specify	0	3	6

7.

Have you ever tried and failed to control, cut down, or stop using (first drug, second drug, ect)?	**No, never**	**Yes, but not in the past 3 months**	**Yes, in the past 3 months**
a. **Cannabis** (marijuana, pot, grass, hash, ect.)	0	3	6
b. **Cocaine** (coke, crack, ect.)	0	3	6
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	3	6
d. **Methamphetamine** (speed, crystal meth, ice, ect.)	0	3	6
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, ect.)	0	3	6
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	3	6
g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K)	0	3	6
h. **Street opioids** (heroin, opium, ect.)	0	3	6
i. **Prescription opioids** (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	3	6
j. Other- Specify	0	3	6

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?
   - o No, never
   - o Yes, but not within the past three months
   - o Yes, within the last three months.
     - ➢ Date of last use: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: Male Female Date:_____
If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week
Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best
describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains(e.g, head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one is around?	0	1	2	3	4	

	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory. (e.g., learning new information) or with location(e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

	24. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
	25. Problems with memory. (e.g., learning new information) or with location(e.g., finding your way home)?	0	1	2	3	4	
	26. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	27. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						

10. Combat or exposure to a war -zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life- threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Alcohol Use Disorders Identification Test (AUDIT)

Please select the answer that is correct for you.

	Never (Skip to Questions 9-10)	Monthly or less	Two to four times a month	Two to three times per week	Four or more times per week
1. How often do you have a drink containing alcohol?	○	○	○	○	○

	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	○	○	○	○	○

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	○	○	○	○	○
4. How often during the last year have you found that you were not able to stop drinking once you had started?	○	○	○	○	○
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	○	○	○	○	○
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	○	○	○	○	○
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	○	○	○	○	○
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	○	○	○	○	○

	No	Yes, but not in the last year	Yes, during the last year
9. Have you or someone else been injured as a result of your drinking?	○	○	○
10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?	○	○	○

Recovery Assessment Scale 24 -item (RAS-R)

INSTRUCTIONS: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and indicate the number (1-5) that best describes the extent to which you agree or disagree with the statement. Provide only one number for each statement and do not skip any items.

Item	Response options: 1 = strongly disagree; 2 = disagree; 3 = not sure; 4 = agree; 5 = strongly agree
1. I have a desire to succeed	
2. I have my own plan for how to stay or become well	
3. I have goals in life that I want to reach	
4. I believe that I can meet my current personal goals	
5. I have a purpose in life	
6. Even when I don't care about myself, other people do	
7. Fear doesn't stop me from living the way I want to	
8. I can handle what happens in my life	
9. I like myself	
10. If people really knew me, they would like me	
11. I have an idea of who I want to become	
12. Something good will eventually happen	
13. I'm hopeful about my future	
14. I continue to have new interests	
15. Coping with my mental illness is no longer the main focus of my life	
16. My symptoms interfere less and less with my life	
17. My symptoms seem to be a problem for shorter periods of time each time they occur	
18. I know when to ask for help	
19. I am willing to ask for help	
20. I ask for help when I need it	
21. I can handle stress	
22. I have people I can count on	
23. Even when I don't believe in myself, other people do	
24. It is important to have a variety of friends	

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

36-item version, self-administered

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.

In the past 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

In the past 30 days, how much difficulty did you have in:						
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in 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
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page …

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*** ____

This completes the questionnaire. Thank you.

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the above" for that section.

Constitutional	**Eyes**	**Ears, Nose, Mouth, and Throat**
o Chronic Pain	o Eye Pain	o Earache
o Loss of appetite	o Eye discharge	o Tinnitus (Ringing in the ear)
o Increased appetite	o Eye Redness	o Decreased hearing or hearing loss
o Unexplained weight loss	o Blurred or double vision	o Frequent ear infections
o Weight gain	o Visual changes	o Frequent nose bleeds
o Fatigue/Lethargy	o History of eye surgery	o Sinus congestion
o Unexplained fever	o Sensitivity to light	o Runny nose/post-nasal drip
o Hot or cold spells	o Scotomas (Blind spots)	o Difficulty swallowing
o Night sweats	o Retinal hemorrhage	o Frequent sore throat
o Sleeping pattern disruption	o Amaurosis fugax (feeling like a curtain is pulled over vision	o Prolonged hoarseness
o Malaise		o Pain in jaw or tooth
		o Dry mouth
o Other: _____	o Other: _____	o Other: _____
o None of the above constitutional issues	o None of the above eye issues	o None of the above Ears, Nose, Mouth, and Throat issues
Cardiovascular	**Respiratory**	**Musculoskeletal**
o Chest pain	o Pain with breathing	o Swelling in joints
o Pace maker	o Chronic cough	o Redness of joints
o Palpitations (fast or irregular heartbeat)	o Chronic shortness of breath	o Other joint pains or stiffness
o Swollen feet or hands	o Chronic wheezing or asthma	o Muscle pain or cramping
o Fainting spells	o Excessive phlegm	o Muscle weakness

	○ Coughing up blood	○ Muscle stiffness
		○ Decreased range of motion
		○ Back pain or stiffness
		○ History of fractures
		○ Past injury to spine or joints
○ Other: _____	○ Other: _____	○ Other: _____
○ None of the above cardiovascular issues	○ None of the above respiratory issues	○ None of the above musculoskeletal issues
Gastrointestinal		
○ Excessive gas or belching	○ Heartburn	○ Change in appearance of stool
○ Diarrhea	○ Difficulty swallowing solids or liquids	○ Blood in stool
○ Constipation	○ Recent loss in appetite	○ Dark/tarry stool
○ Persistent nausea/vomiting	○ Sensitivity to milk products	○ Loss of bowel control/soiling
○ Abdominal pain	○ Jaundice (yellow skin)	
○ Other: _____		○ None of the above gastrointestinal issues
Allergic/Immunologic	**Endocrine**	**Hematologic/Lymphatic**
○ Frequent infections	○ Severe menopausal symptoms	○ Blood clots
○ Hives	○ Cold or heat intolerance	○ Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
○ Anaphylactic reaction	○ Excessive appetite	○ History of blood transfusion
		○ Excessive bruising
		○ Swollen glands (neck, armpits, groin)
○ Other: _____	○ Other: _____	○ Other: _____
○ None of the above allergic/immunologic issues	○ None of the above allergic/immunologic issues	○ None of the above allergic/immunologic issues
Genitourinary (General)	**Genitourinary (Women)**	**Genitourinary (Men)**
Loss of urine control	Unusual vaginal discharge	Slow urine stream

o Painful/burning urination	o Vaginal pain, bleeding, soreness, or dryness	o Scrotal pain
o Blood in urine	o Genital sores	o Lump or mass in the testicles
o Increased frequency of urination	o Heavy or irregular periods	o Abnormal penis discharge
o Up more than twice per night to urinate	o No menses (Periods stopped)	o Trouble getting/maintaining erections
o Urine retention	o Currently pregnant	o Inability to ejaculate/orgasm
o Frequent urine infections	o Sterility/infertility	o Any other sexual or sex organ concerns
	o Any other sexual or sex organ concerns	
o Other: _____	o Other: _____	o Other: _____
o None of the above general genitourinary issues	o None of the above sex-specific genitourinary issues	o None of the above sex-specific genitourinary issues
Neurological	**Integumentary (Skin/ Breast and Hair)**	**Psychiatric**
o Paralysis	o Lesions	o In-depth review of psychiatric system appears earlier in document (to be checked by clinician only)
o Fainting spells or blackouts	o Unusual mole	o Feeling depressed
o Dizziness/Vertigo	o Easy bruising	o Difficulty concentrating
o Drowsiness	o Increased perspiration	o Phobias/unexplained fears
o Slurred speech	o Rashes	o No pleasure from life anymore
o Speech problems (other)	o Chronic dry skin	o Anxiety
o Short term memory trouble	o Itchy skin or scalp	o Insomnia
o Memory loss	o Hair or nail changes	o Excessive moodiness
o Frequent headaches	o Hair loss	o Stress
o Muscle weakness	o Breast tenderness	o Disturbing thoughts
o Numbness/tingling sensations	o Breast discharge	o Manic episodes
o Neuropathy (numbness in feet)	o Breast lump or mass	o Confusion
o Tremor in hands/shaking		o Memory loss
o Muscle spasms or tremors		o Nightmares
o Other: _____	o Other: _____	o Other: _____

○ None of the above neurological issues	○ None of the above integumentary issues	○ None of the above psychiatric issues

Stressors

Please rate the severity of stress you are experiencing related to each of the following categories.

	None	Mild	Moderate	Severe
Family				
Friends				
Relationships				
Educational				
Economic/Financial				
Occupational				
Housing				
Legal				
Health				

Substance Abuse Treatment History

Treatment Type	Yes	No	How many episodes of treatment?	Age at time of first treatment	Age at time of last treatment	Any additional information
Inpatient						
Intensive Outpatient						
Outpatient						
12-step Program						
Other						
Other						

Consequences of Substance Abuse

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply)

- o No consequences
- o Felt that you needed to cut down on your drinking
- o Been annoyed by others criticizing your drinking
- o Felt guilty about drinking
- o Needing a drink first thing in the morning
- o Increased tolerance
- o Withdrawal (shakes, sweating, nausea, rapid heart rate)
- o Seizures
- o Blackouts
- o Effects on physical health
- o Using/consuming more than intended
- o Unintentional overdose
- o DUI
- o Arrests
- o Physical fights or assaults
- o Relationship conflicts
- o Problems with money
- o Job loss or problems at work/school
- o Other (Please specify):

_____

_____

_____

Inpatient Psychiatric History

Do you have a history of inpatient psychiatric treatment?

- o Yes
- o No

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line. For the "Treatment Outcome" please list whether the outcome was feeling worse or negative result, minor improvement or no effect, partial response, significant improvement, resolved or nearly resolved your problem.

Hospital/ Facility	Was it voluntary? Yes/No	Primary reason for hospitalization.	How old were you?	Treatment Outcome	Additional Comments

Outpatient Psychiatric History

Do you have a history of outpatient psychiatric treatment?

- Yes
- No

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line. For the "Treatment Outcome" please list whether the outcome was feeling worse or negative result, minor improvement or no effect, partial response, significant improvement, resolved or nearly resolved your problem.

Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Treatment Outcome	Additional Comments

Suicide/Self-Harm History

Have you ever tried to harm or kill yourself?

- Yes
- No

If you answered "no," skip the rest of this page.

Was your intent to die?

- Yes
- No

How many times in your life has this occurred? _____

Please describe your **most severe** episode.

Date: _____

Method: _____

Consequences:_____
_____
_____
_____

Please describe your **most recent** episode.

Date: _____

Method: _____

Consequences:_____
_____
_____
_____

Violence History Assessment

Do you have any history of violent behavior?

- Yes
- No

If yes, please elaborate:

_____
_____
_____
_____
_____

Past Medical History

Who is your primary care physician? _____

Are you current taking any medications?

- Yes
- No

If yes, please list ALL meds you are currently taking.

Med	Dose	How many times per day?	When did you start this med?	Do you feel this med is helpful?

Do you have a history of any of the following health problems? (Please check all that apply)

- allergies
- anemia
- arthritis
- asthma
- back problems
- cancer
- cataracts
- chickenpox
- chronic bronchitis
- COPD
- Diabetes
- Diverticulitis
- fainting spells/ passing out
- fibromyalgia
- high cholesterol
- gall bladder disease
- gastritis/ulcer
- glaucoma
- gout
- hearing loss
- heart disease
- heart defect from birth
- heart valve problems
- hemorrhoids
- hepatitis
- hernia
- HIV
- Hypertension
- Hypotension
- IBS
- iron deficiency
- kidney disease
- kidney stones
- liver disease
- lupus
- migraine headaches
- multiple sclerosis
- obesity
- Parkinson's Disease
- Polyps
- Seizures
- sexually transmitted disease
- sleep apnea
- stroke/TIA
- low testosterone
- thyroid problems
- tuberculosis or exposure to tuberculosis

Have you a history of surgery in any of the following areas? (Please check all that apply)

- back/neck brain
- cardiac
- ear/nose/throat
- gall bladder
- hernia
- hip/knee/ankle/foo
- hysterectomy (ovaries removed)
- hysterectomy (ovaries retained)
- intestine
- kidney
- liver
- lung
- pancreas
- pelvis
- penis
- prostate
- gender affirming surgery
- shoulder/elbow/ wrist/hand
- stomach
- tonsils
- vagina
- weight loss

Psychiatric Medication History

Place a circle any medication you recall ever being on in the past, but are not currently prescribed.

Antidepressants

amitriptyline (Elavil®)

bupropion (Wellbutrin®)

clomipramine (Anafranil®)

desipramine (Norpramin®)

desvenlafaxine (Pristiq®)

doxepin (Sinequan®)

fluoxetine (Prozac®)

imipramine (Tofranil®)

levomilnacipran (Fetzima®)

nortriptyline (Pamelor®)

selegiline (Emsam®)

trazodone (Desyrel®)

venlafaxine (Effexor®)

vilazodone (Viibryd®)

vortioxetine (Trintellix®)

citalopram (Celexa®)

escitalopram (Lexapro®)

paroxetine (Paxil®)

sertraline (Zoloft®)

mirtazapine (Remeron®)

duloxetine (Cymbalta®)

fluvoxamine (Luvox®)

Anxiolytics and Hypnotics

alprazolam (Xanax®)

buspirone (BuSpar®)

clonazepam (Klonopin®)

eszopiclone (Lunesta®)

lemborexant (Dayvigo®)

suvorexant (Belsomra®)

temazepam (Restoril®)

zolpidem (Ambien®)

chlordiazepoxide (Librium®)

clorazepate (Tranxene®)

diazepam (Valium®)

lorazepam (Ativan®)

oxazepam (Serax®)

propranolol (Inderal®)

Antipsychotics

aripiprazole (Abilify®)

brexpiprazole (Rexulti®)

cariprazine (Vraylar®)

fluphenazine (Prolixin®)

iloperidone (Fanapt®)

lumateperone (Caplyta®)

lurasidone (Latuda®)

paliperidone (Invega®)

perphenazine (Trilafon®)

quetiapine (Seroquel®)

risperidone (Risperdal®)

ziprasidone (Geodon®)

asenapine (Saphris®)

chlorpromazine (Thorazine®)

haloperidol (Haldol®)

thioridazine (Mellaril®)

clozapine (Clozaril®)

olanzapine (Zyprexa®)

thiothixene (Navane®

Mood Stabilizers

carbamazepine (Tegretol®)

lamotrigine (Lamictal®)

oxcarbazepine (Trileptal®)

valproic acid/divalproex (Depakote®)

gabapentin (Neurontin®)

lithium (Eskalith®)

topiramate (Topamax®)

Stimulants/Non-Stimulants

Dexmethylphenidate (Focalin®)

methylphenidate (Ritalin®, Concerta®)

amphetamine salts (Adderall®)

dextroamphetamine (Dexedrine®)

lisdexamfetamine (Vyvanse®)

atomoxetine (Strattera®)

guanfacine (Intuniv®)

viloxazine (Qelbree®)

clonidine (Kapvay®)

Any medication not listed above:

_____

Family History

Do you have any family members with a history of psychiatric illness?

- Yes
- No

If yes, please elaborate below.

Mom: _____

Dad: _____

Sisters: _____

Brothers: _____

Aunts: _____

Uncles: _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Family Medical History

Do you have any family members with a history of medical illness? (Diabetes, High blood pressure, High Cholesterol, Heart Disease, Stroke, Hyper/Hypothyroidism, Anemia, Cancer, etc.).

- Yes
- No

If yes, please elaborate below.

Mom: _____

Dad: _____

Sisters: _____

Brothers: _____

Aunts: _____

Uncles: _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following:

- Exposure to drugs or alcohol during pregnancy
- A difficult pregnancy
- Problems with delivery
- None of these
- Other: _____

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)

- Yes
- No

Did you have any delays or difficulties in reaching the following developmental milestones?

- Walking
- Talking
- Toilet training

- Sleeping alone
- Being away from parents
- Making friends
- None of these
- Other: _____

Which options below best describe your childhood home atmosphere?

- Normal
- Supportive
- Parental fighting
- Parental violence
- Financial difficulties
- Frequent moving
- Other: _____

Which of the following challenges were experienced during your childhood?

- Tantrums
- Enuresis (bed wetting)
- Encopresis (fecal incontinence)
- Running away from home
- Fighting
- Stealing
- Property damage
- Fire setting
- Animal cruelty
- Separation anxiety
- Victim of bullying
- Engaged in bullying
- Depression
- Death of a parent/caregiver
- Parental divorce
- None of these

Which of the following best describe problems you may have had in school?

- Fighting
- School phobia
- Truancy
- Detentions
- Suspensions
- Expulsions
- School refusal
- Class failures
- Repetition of grades
- Special Education
- Remedial Classes

Did you have additional schooling outside of the standard classroom setting? (please check all that apply)

- Tutoring
- Accommodations
- Other: _____
- None of these
- Speech classes

What is your highest level of education?

- Less than high school diploma
- High school diploma or equivalency
- Some College
- Two year degree
- Four year degree
- Graduate or professional degree

General Social History

Which options below best describes your social situation?

- Supportive social network
- Few friends
- Substance-use based friends
- No friends
- Distant from family of origin
- Family conflict
- Other: _____

What is your current marital status?

- Single, never married
- Married/permanent relationship
- Divorced
- Separated
- Widowed

What is the status of your intimate relationship?

- Never been in a serious relationship
- Not currently in a relationship
- Currently in a serious relationship

What is the satisfaction level of your intimate relationship?

- Very satisfied
- Satisfied
- Somewhat satisfied
- Dissatisfied
- Not applicable

What is your sexual orientation?

- Heterosexual
- Homosexual
- Bisexual
- Other: _____

What is your current living situation?

- Rent
- Own
- Group Home/IRTS facility
- Homeless
- Foster care

Who do you currently live with? (Please check all that apply)

- Live alone
- Roommates
- Partner/Spouse
- Parent(s)
- Sibling(s)
- Children
- Other:

Do you currently participate in spiritual activities?

- Yes
- No

If yes, do you have any spiritual beliefs related to your care that I should be aware of? (Please elaborate below.)

_____
_____
_____
_____.

What is your current occupation status?

- Employed full-time
- Employed part-time
- Student
- Unemployed – seeking work
- Unemployed – not seeking work
- Disabled

Menstruation and Pregnancy History

At what age did you begin menstruation? _____

Which of these best describe your premenstrual symptoms?

- o Dysphoria
- o Cramps
- o Appetite change
- o Bloating
- o Sleep disturbance
- o None of these

Do you have a method of contraception? (check all that apply)

- o No method of contraception
- o Intrauterine (e.g., IUD)
- o Hormonal (e.g., implant, injection, "the pill," patch, hormonal vaginal contraceptive ring)
- o Barrier (e.g., diaphragm, male/female condom, spermicide)
- o Fertility Awareness-based (e.g., natural family planning)
- o Permanent (e.g., male/female sterilization, infertility)
- o Other:

Have you ever been pregnant?

- o Yes
- o No
- o If YES, how many times? _____

Have you ever given birth?

- o Yes
- o No
- o If YES, how many times? _____

Have you had any miscarriages?

- o Yes
- o No
- o If YES, how many times? _____

Have you had any abortions?

- o Yes
- o No
- o If YES, how many times? _____