INTAKE QUESTIONNAIRE (ADULT)

The following questionnaire is designed to assist you and me in developing and carrying out the type of service which seems most appropriate for you. If you don't wish to answer a question or if it doesn't apply to you, simply write the letters **NA** (Not Applicable). If you don't know or can't remember, write the letters **DK** (Don't Know). Please remember that this document, like all others in your file, is confidential and cannot be released without your written consent.

1. GENERAL INFORMATION

Full Name_____Birthdate_____Today's Date_____

Address_____ Phone Number_____

How did you hear about us?_____

Please describe your reason(s) for seeking assistance:

When did these issues become a problem?

What have you already tried? What was the result?

Do you wish to schedule Medication Management, Therapy or both?

2. MENTAL HEALTH INFORMATION

Have you ever had mental health treatment before? YES NO

If so, please list names of therapists, dates of therapy, and which agencies you've used

_____

_____

Have you ever been hospitalized for a mental health problem? YES NO

If so, please list dates and hospitals_____

_____

Have you *recently* had thoughts of killing yourself? YES NO

Have you ever made *attempts* to kill yourself? YES NO

Are you currently taking a medication for mental health reasons? YES NO

If so, please list the medication name(s) and dosage(s)_____

_____

Prescriber of medication(s)_____

Any past mental health medications?_____

Is there a history of any of the following in your family?

☐Anxiety	☐Psychosis	☐Substance abuse
☐Depression	☐ADHD	☐Suicide
☐Bipolar	☐Eating disorder	☐Psychiatric hospitalization

3. **MEDICAL/HEALTH INFORMATION**

Name of primary physician and clinic_____

Date of most recent physical exam_____

Are you wanting us to collaborate with your doctor?_____

Surgeries_____

Hospitalizations_____

Allergies_____

Head injuries_____

Are you currently suffering from any medical conditions? YES NO

If so, what conditions_____

What medications are you currently on?_____

_____

How good is your sleep each night? _____

How many hours of sleep do you get?_____

How many times a day do you eat a meal?_____

How much physical activity do you get each day?_____

4. CHEMICAL USE HISTORY

Have you ever been treated for drug or alcohol abuse? YES NO

If so, where?_____When_____

	Current Amount Used	**Past Amount Used**	**Age First Used**
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Other			

Drug of choice (if any)_____

	YES	NO
Have you ever felt like you ought to cut down on your drinking or drug use?	☐	☐
Have you ever had people annoy you by criticizing your drinking or drug use?	☐	☐
Have you ever felt bad or guilt about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?	☐	☐
Have you struggled with any other compulsive behaviors (i.e., gambling, pornography, video games)?	☐	☐

5. **CURRENT FAMILY**

Current marital status (and partner's name, if applicable): _____

Children and ages: _____

Have you been married before? YES NO If so, how many times? _____

I currently live with: _____

Have you experienced any abuse in your relationships? YES NO

6. **FAMILY OF ORIGIN**

Parent's name: _____ Age: _____

Occupation: _____ Marital status: _____

Parent's name: _____ Age: _____

Occupation: _____ Marital status: _____

Number of siblings and ages: _____

While growing up were you:

- Happy with the way you were raised? YES NO
- Treated cruelly, beaten, or mistreated? YES NO
- Sexually abused? YES NO
- Adopted? YES NO
- In foster care at any point? YES NO

Was there anything unusual about your birth? YES NO

Did your mother drink, smoke, or use drugs while pregnant with you? YES NO

Were there any medical difficulties for you when you were an infant or child? YES NO

If yes, what? _____

Did you experience any accidents causing injury to you? YES NO

If yes, what? _____

7. **OCCUPATIONAL/EDUCATIONAL/RECREATIONAL INFORMATION**

Highest grade completed/current grade_____School_____

Your adjustment to school was: ☐Excellent ☐Good ☐Fair ☐Poor

Favorite subjects_____Least favorite subjects_____

Current employer_____Number of years there_____

Previous work_____

What do you do with your free time?_____

Do you have many friends or social groups?_____

Are you a veteran? If yes, what type of discharge_____

8. LEGAL HISTORY

Have you ever been: ☐On probation ☐In jail ☐In prison ☐On parole

If so, when and why?_____

9. RELIGION/SPIRITUALITY

Religious or spiritual identity:_____

Are you actively practicing? YES NO

10. OTHER IMPORTANT INFORMATION

Is there anything else important you feel we should know about who you are?

11. **SYMPTOM REVIEW**

Please check any of the following that have applied to you in the past two weeks. Use a question mark if you're not sure.

- ☐ Weight loss without dieting
- ☐ Significant weight gain
- ☐ Cry often and easily
- ☐ Feel so good/hyper, others say I'm not myself
- ☐ I'm usually very talkative
- ☐ I've been more talkative than normal
- ☐ Speaking faster than usual
- ☐ Sleeping much less and not missing it
- ☐ Racing thoughts
- ☐ More energy than usual
- ☐ More social/outgoing than usual
- ☐ Taking risky or regrettable actions
- ☐ Problems from spending money
- ☐ More sexual than usual
- ☐ Inattentive/easily distracted
- ☐ Impulsive
- ☐ Often fidget
- ☐ Fail to finish things
- ☐ Bad memory/forget things a lot
- ☐ Bad at organizing
- ☐ Procrastinate
- ☐ Get in physical fights
- ☐ Infections
- ☐ Vision problems
- ☐ Severe headaches
- ☐ Chronic pain
- ☐ Sexual difficulties
- ☐ Hearing problems
- ☐ High blood pressure
- ☐ Seizures
- ☐ Sleep walking
- ☐ Dizziness
- ☐ Nervous habits
- ☐ Nail biting
- ☐ Skin picking
- ☐ Chronic neck/back tension or pain
- ☐ Panic attacks
- ☐ Fear of large public places
- ☐ Flashbacks
- ☐ Easily startled
- ☐ Tics
- ☐ Many physical complaints
- ☐ Quick mood changes
- ☐ Often daydreaming
- ☐ Difficulty making decisions
- ☐ Sometimes confused about who I am
- ☐ Sometimes confused about where I am
- ☐ Stubborn
- ☐ Too few friends
- ☐ Withdrawn
- ☐ Overly shy
- ☐ Tense
- ☐ Touchy
- ☐ Submissive
- ☐ Show off/center of attention
- ☐ Follower
- ☐ Easily embarrassed
- ☐ Clumsy/careless
- ☐ Odd/strange behavior
- ☐ Repeated actions I can't stop
- ☐ Repeated thoughts I can't stop
- ☐ Nightmares
- ☐ Perfectionistic
- ☐ Seeing things others don't
- ☐ Hearing things others don't
- ☐ Eat non-food items

1. Are you unable to use any parts of your home for their intended purposes? For example: cooking, using, furniture, washing dishes, sleeping in bed, etc.?

2. Have you ever been in an argument with a loved one because of the clutter in your home?

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

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.

Part A	**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 B					
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?					

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-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:						
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

In the past 30 days, how much difficulty did you have in:						
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*** ____

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
☐	☐	☐	☐

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 name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

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

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Madelia HEALTH

Authorization for Disclosure of Personal Health Information

Patient Identification	Name:_____ Date of Birth:_____ Address:_____ Phone Number_____ City/State/Zip:_____ Maiden/Previous Names/Nickname:_____
Provider (Who is releasing Information?)	Provider/Facility Name:_____ Address:_____ City/State/Zip:_____ Phone Number:_____
Disclose Information To: (Where is information to be sent?)	Name/Facility:_____Madelia Health Hospital & Clinic_____ Address:_____121 Drew Ave. SE_____ City/State/Zip:_____Madelia, MN 56062_____ ***PLEASE MAIL IF OVER 50 PAGES, DO NOT FAX *** Phone Number:___(507) 642-3255_____ Fax:__(507) 642-8010_____
Information to be Disclosed	☐ Hospital Progress Notes ☐ History & Physical ☐ Pathology Report ☐ EKG/Cardiology Reports ☐ Discharge Summary ☐ Physical Therapy Notes ☐ Radiology Reports ☐ Operative Report ☐ Outpatient Information ☐ ER Records ☐ Lab Data ☐ Consultation ☐ Patient Portal Information ☐ All Records ☐ Other (Specify)
Service Dates	Time period from:_____ to _____ Concerning:_____ (specific diagnosis or treatment, auto accident, etc.)
Purpose of Disclosure	☐ Continuing Medical Care ☐ Consult/Second Opinion ☐ Out of town move ☐ Insurance Claim ☐ Legal ☐ Personal ☐ Other (Specify)_____
Expiration Date	This authorization will expire one year from the date of signature or on_____.
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To", I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. _____ _____ Signature of patient/representative Signature Date _____ _____ _____ (Relationship to patient, if signed by representative) (Reason patient unable to sign) (Witness – optional) Please supply proof of authority to act. For minors, proof only required if other than parent.
Internal Use Only:	Info needed by:_____ Date sent:_____ Sent by:_____ ☐ Authority to act attached ☐ ID Validated Records to be: ☐ Mailed ☐ Will pick up Need to call pt when ready? ☐ Yes ☐ No Phone #:_____