



Request for Services

Name: _____
Chart #: _____

Date: _____ Who is seeking services: _____ Date of Birth: _____

Primary Language: _____ Communication Method: _____

Translator/Interpreter required? YES NO Do you need assistance with reading or writing? YES NO

How can we best assist you with reading or writing in your recovery process? _____

Do you need any assistive technology in the course of your treatment? YES NO

Identify assistive technology need(s): _____

Are you or the person wanting services currently having thoughts of suicide, thoughts to hurt self, or thoughts to hurt someone else? YES NO (If yes, STOP and return to front desk)

Social Security Number: _____ Gender: _____ Race/Ethnicity: _____ Email: _____

Physical Address: _____ County: _____

City, State, Zip: _____ Phone: _____ Alt. Phone: _____

Insurance: _____ Policy Holder: _____ Policy #: _____

Employment Status: Full Time Part Time Unemployed School/Child Retired
Living Arrangement: Own Home Family Home Friend's House Nursing Home Homeless
 Other: _____
Highest Level of Education Completed: _____ Currently Enrolled? YES NO
Who Referred You To Us? CPS Court Probation Parole School Other: _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Relationship: Parent/Guardian Other: _____

Emergency Contact Address: _____

Legal Status: Minor Minor w/Conservator (Please provide guardianship/court orders for custody)
 Adult with Guardian Adult no Guardian

Name of Responsible Person (or Guardian) if applicable: _____

Physical Address of Responsible Person/Guardian: _____

Mailing Address of Responsible Person/Guardian: _____

Phone Number of Responsible Person/Guardian: _____

Primary Care Physician: _____ Phone: _____

»List any allergies or special precautions: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

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	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off <i>any problems</i> , how <i>difficult</i> 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
<i>Add the score for each column</i>	+	+	+	
Total Score (<i>add your column scores</i>) =				

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 _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

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

Brief Resilience Scale (BRS)

Respond to each statement below by circling <u>one</u> answer per row.		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times.	1	2	3	4	5
BRS 2	I have a hard time making it through stressful events.	5	4	3	2	1
BRS 3	It does not take me long to recover from a stressful event.	1	2	3	4	5
BRS 4	It is hard for me to snap back when something bad happens.	5	4	3	2	1
BRS 5	I usually come through difficult times with little trouble.	1	2	3	4	5
BRS 6	I tend to take a long time to get over setbacks in my life.	5	4	3	2	1

Scoring: Add the value (1-5) of your responses for all six items, creating a range from 6-30. Divide the sum by the total number of questions answered (6) for your final score.

Total score: _____ / 6

My score: _____ (average)

BRS Score	Interpretation
1.00 - 2.99	Low resilience
3.00 - 4.30	Normal resilience
4.31 - 5.00	High resilience

Smith, B.W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P. and Bernard, J. (2008). The Brief Resilience Scale: Assessing the Ability to Bounce Back. *International Journal of Behavioral Medicine*, 15, 194-200.