Mental Health *Integration*

Date: _____ Patient's Name_____ Date of Birth _____

1. What are your main concerns and/or symptoms that you are dealing with at this time?
   a. Physical: _____
   b. Emotional:_____
2. What is currently causing you stress (at home, school, or work; in relationships)?

3. What **goals** do you hope to achieve with this treatment?

4. Have you been treated for mental health in the past? Complete the table below. Include any type of outpatient or inpatient treatment or therapy you received. Be sure to list all medications you have tried.

Mental Health Problem/Treatment

Psychiatric Hospitalizations? *Include date, situation, treatment provided*

Suicide attempt? *Include date, situation, treatment provided*

Prior experience with therapy? *Include dates, who provided treatment*

Current Mental Health Medications

Name and dose of Medications	Date Started	Response/Side Effects	Are you still on it?
			◯ Yes ◯ No
			◯ Yes ◯ No

			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

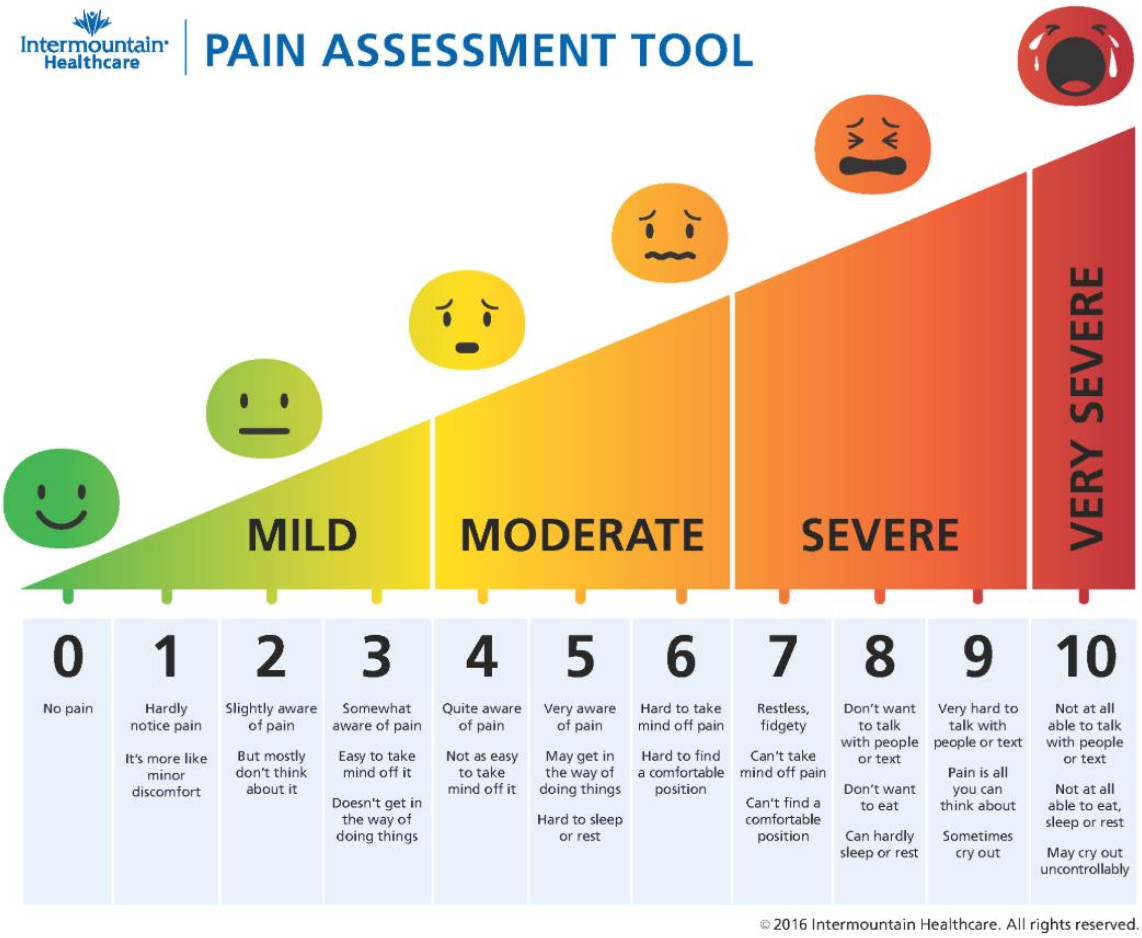
5. Physical **Review of Symptoms**. Are you currently experiencing any of the following? *(Select all that apply):*

☐ Chest Pain	☐ Shortness of Breath	☐ Tension Headache
☐ Fatigue	☐ Back Pain	☐ Migraine Headache
☐ Dizziness	☐ Stomachache	☐ Irritable Bowel Syndrome
☐ Obesity	☐ Head Injury	☐ Asthma
☐ Fibromyalgia	☐ Diabetes	☐ High Blood Pressure

6. **Chronic Pain Assessment** –

   a. Have you had **pain every day** for the last 6 months or longer? ◯ Yes ◯ No

   b. **If yes**, rate your average daily level of pain on a scale of 0-10 (using the pain scale below), with 0 being no pain and 10 being most severe. _____



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7. **Family history and critical events**

   a. **Family history of mental health diagnosis**: Do you have any biological relatives who have had behavioral, emotional, or mental problems such as depression, anxiety, bipolar disorder, ADHD, drug or alcohol use disorder, or suicide? If yes, complete the table below.

Relative (parent, sibling, child)	Behavioral, emotional, or mental problem

   b. **Critical Events**- Check if any of the following critical events have occurred in your family:

Event	Age	Comments
Parent or sibling illness		
Parental separation		
Parental divorce		
Family move		
Financial stress		
Out-of-home placement		
Death in family		
Death of close friend		
Other: _____		

8. **Access to Firearms**: Do you have access to firearms? ◯ Yes ◯ No

   a. If "Yes", **how are firearms** secured? _____

9. **Lifestyle, strengths/weaknesses, and goals:**

   a. On average, **how many days per week** do you perform moderate/vigorous exercise or physical activity? _____

   b. On average, **how many minutes** of moderate/vigorous exercise or physical activity do you perform on each of those days? _____

   c. At **what intensity** (how hard) do you usually exercise?

   ◯ Light (casual walk) ◯ Moderate (brisk walk) ◯ Vigorous (jog/run)

   d. List your strengths and weaknesses: (*What are you good at? What are somethings that are difficult for you?)*

My strengths	My weaknesses

Mental Health *Integration*

Depression Screening (PHQ-9)

Are you currently: ◯ on medication for depression ◯ not on medication for depression ◯ not sure ◯ in counseling

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	◯ 0	◯ 1	◯ 2	◯ 3
2.	Feeling down, depressed, or hopeless	◯ 0	◯ 1	◯ 2	◯ 3
3.	Trouble falling/staying asleep, 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're 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

10. 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**

In the past 2 years, have you felt depressed or sad most days, even if you felt okay sometimes?

◯ **Yes** ◯ **No**

Has there been a time in the past month when you have had serious thoughts about ending your life?

◯ **Yes** ◯ **No**

Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?

◯ **Yes** ◯ **No**

Mental Health *Integration*

Anxiety and Stress Disorder Symptoms:

Are you currently: ◯ on medication for mood regulation ◯ not on medication ◯ not sure ◯ in counseling

Over the last 2 weeks, how often have the problems below bothered you? Check the number for each item.

	How Often			
Generalized Anxiety Disorder (GAD-7)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge?	◯ 0	◯ 1	◯ 2	◯ 3
Not being able to stop or control worrying?	◯ 0	◯ 1	◯ 2	◯ 3
Worrying too much about different things?	◯ 0	◯ 1	◯ 2	◯ 3
Trouble relaxing?	◯ 0	◯ 1	◯ 2	◯ 3
Being so restless that it is hard to sit still?	◯ 0	◯ 1	◯ 2	◯ 3
Becoming easily annoyed or irritable?	◯ 0	◯ 1	◯ 2	◯ 3
Feeling afraid as if something awful might happen?	◯ 0	◯ 1	◯ 2	◯ 3

If you are experiencing any of the problems on this form, 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**

Other Symptoms	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Panic: This can include increased heart rate, increased blood pressure, chest pain or pressure, irregular breathing, getting lightheaded	◯ 0	◯ 1	◯ 2	◯ 3
Obsessions and/or compulsions: This can include repeated or persistent thoughts that they can't control (about germs, schoolwork, being perfect, neatness, safety, death); repeated behaviors or extreme routines that they can't control (such as repeated handwashing, checking locks, cleaning, personal hygiene)	◯ 0	◯ 1	◯ 2	◯ 3
Hallucinations: This can include hearing voices or seeing things that others don't hear or see.	◯ 0	◯ 1	◯ 2	◯ 3

Symptom duration: Symptoms have been of serious concern for (check the appropriate time period):

◯ 2 to 4 weeks ◯ 1 to 3 months ◯ 3 to 6 months ◯ 6 months to 1 year ◯ 1 to 2 years ◯ More than 2 years

Have 2 or more of these symptoms lasted longer than 1 year? ◯ Yes ◯ No

Mental Health *Integration*

Sleep Evaluation Questions

Do you have problems sleeping? **If no**, skip this section. **If yes, answer the following**:

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Difficulty staying asleep	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Problems waking up too early	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

How **SATISFIED/DISSATISFIED** are you with your **CURRENT sleep pattern**?

Very Satisfied	**Satisfied**	**Moderately Satisfied**	**Dissatisfied**	**Very Dissatisfied**
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	**A little**	**Somewhat**	**Much**	**Very Much Noticeable**
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

How **WORRIED/DISTRESSED** are you about your current sleep problem?

Not at all Worried	**A little**	**Somewhat**	**Much**	**Very Much Worried**
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

To what extent do you consider your sleep problems to **INTERFERE** with your daily functioning? (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) **CURRENTLY?**

Not at all Interfering	**A little**	**Somewhat**	**Much**	**Very Much Interfering**
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

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Abuse and Traumatic Events.

1. **Current events**. *Check any events below that you are **currently experiencing***:
   - ☐ Physical abuse
   - ☐ Emotional Abuse
   - ☐ Sexual Abuse
   - ☐ Emotional Neglect
   - ☐ Physical Neglect
   - ☐ Traumatic Events
   - ☐ Drug abuse in the Family
   - ☐ None of the above

2. **Past Events**. *Check any events below that you have **experienced in the past**:*
   - ☐ Physical abuse
   - ☐ Emotional Abuse
   - ☐ Sexual Abuse
   - ☐ Emotional Neglect
   - ☐ Physical Neglect
   - ☐ Traumatic Events
   - ☐ Drug abuse in the Family
   - ☐ None of the above

3. **Now, answer the following questions about the items you checked above**:
   a. Are any of the situations **occurring now?** ○ Yes ○ No
   b. Are these situations **still affecting you**? ○ Yes ○ No
   c. Do you feel in any danger or at risk because of these issues? ○ Yes ○ No
   d. Have you sought help from a professional to deal with any of these issues? ○ Yes ○ No
      - If so, who? _____

Mental Health *Integration*

ADHD Self Report Scale Symptom Checklist

For each question below, click in the box that best describes how you have felt and acted **over the past 6 months**

	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?	○	○	○	○	○
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?	○	○	○	○	○

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Eating Behaviors

Questions	Yes	No	Questions	Yes	No
Are you concerned with your eating patterns?	○	○	Does your weight affect the way you feel about yourself?	○	○
Do you ever eat in secret?	○	○	Have any members of your family suffered from an eating disorder?	○	○

Alcohol or Drug Use (NIDA)

In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol: - For men, less than or equal to 5 standard drinks* per day - For women, less than or equal to 4 standard drinks* per day	○	○	○	○	○
Tobacco products (including e-cigarettes)	○	○	○	○	○
Prescription Medications for *non-medical reasons*	○	○	○	○	○
Prescription medications in amounts greater than prescribed, for reasons other than prescribed, or if not prescribed to you	○	○	○	○	○
Illegal drugs (illicit, street drugs)	○	○	○	○	○

*Definition of a "standard drink":

- *Beer or wine cooler (5% alcohol): 12 oz*
- *Malt Liquor (7% alcohol): 8-9 oz*
- *Table wine (12% alcohol): 5 oz*
- *80-proof spirits (hard liquor) (40% alcohol): 1.5 oz*

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CIDI based Bipolar Disorder Screening Scale

Read the questions below and answer:

1. *Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.*
   a. **Have you ever had a period like this lasting several days or longer**? ◯ Yes ◯ No

2. *Have you ever had a period lasting **several days or longer** when most of the time you were so irritable or grouchy that you either stared arguments, shouted at people or hit people?* ◯ Yes ◯ No

If you answer "No" to both question 1 and 2, you may skip the rest of the questions.

People who have episodes like this often have changes in their thinking and behavior at the same time. Like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate.

3. Did you ever have any of these changes during your episodes of being excited and full or energy or very irritable or grouchy? ◯ Yes ◯ No

Think of an **episode when you had the largest number of changes** like these at the same time. During **that** episode, which of the following changes did you experience?

Questions	**Yes**	**No**
4. Were you so irritable that you either started arguments, shouted at people, or hit people?	◯	◯
5. Did you become so restless or fidgety that you paced up and down or couldn't stand still?	◯	◯
6. Did you do anything else that wasn't usual for you—like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?	◯	◯
7. Did you try to do things that were impossible to do, like taking on large amounts of work?	◯	◯
8. Did you constantly keep changing your plans or activities?	◯	◯
9. Did you find it hard to keep your mind on what you were doing?	◯	◯
10. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?	◯	◯
11. Did you sleep far less than usual and still not get tired or sleepy?	◯	◯
12. Did you spend so much more money than usual that is caused you to have financial trouble?	◯	◯