Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Adult Questionnaire

Ages 18+

Date: _____

Name: _____ **Date of Birth:** _____ **Age:** ___ **Gender:** _____

Address: _____ Primary phone: _____ Home ☐ Work ☐ Cell ☐

_____ Secondary phone: _____ ☐ ☐ ☐

Employer: _____ Occupation: _____

Marital Status: _____ Date of Marriage: _____

Previous Marriage? ☐N ☐Y Date(s) of Previous Marriage: _____

Spouse / Significant Other Information:

Name: _____ Date of Birth: _____ Age: ___ Gender: _____

Address: _____ Employer: _____

_____ Occupation: _____

Background Information:

Parents' Names:	Age	Job / Retired	Physical / Emotional / Psychological Problems
_____	_____	_____	_____
_____	_____	_____	_____

Siblings' Names:	Age	Job	Physical / Emotional / Psychological Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children's Names:	Age	Physical / Emotional / Psychological Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the reason for your visit?

How distressing is this for you? (rate 0-10: 0 - not at all, 10 - most distressing): _____

*All information on this form is considered strictly confidential within the guidelines of the clinic

How does this affect your ability to function occupationally, socially, emotionally, and spiritually?

How long have you been experiencing distress about this issue? _____

Symptoms / Issues

- ☐ Suicidal Thoughts
- ☐ Anxious, Worried
- ☐ Confused
- ☐ Depressed Moods
- ☐ Difficulty Being Alone
- ☐ Fatigued
- ☐ Guilt Feelings, Shame
- ☐ Hearing Voices / Hallucinations
- ☐ Memory / Concentration Problems
- ☐ Mood Swings
- ☐ Motivation Reduced / Absent
- ☐ Obsessive Thoughts
- ☐ Panic Attacks
- ☐ Physical Abuse
- ☐ Low Self-Esteem
- ☐ Sleep Problems
- ☐ Unusual Thoughts
- ☐ Other: _____
- ☐ Anger, Aggression, Violence
- ☐ Drug / Alcohol Use
- ☐ Eating Habits / Problems
- ☐ Lying Frequently
- ☐ Perfectionist
- ☐ Physically Abuse Self
- ☐ Shy, Uneasy with Others
- ☐ Unassertive
- ☐ Unwanted Behavior / Habits
- ☐ Withdrawn
- ☐ Employment / School Issues
- ☐ Legal Problems
- ☐ Living Arrangements
- ☐ Money Management Issues
- ☐ Parenting Issues
- ☐ Relationship / Marital Issues
- ☐ Weight Changes
  - ☐ Increase
  - ☐ Decrease

Medical / Psychological History:

Date of last physical exam: _____ Results: _____

Medical concerns in the last year: _____

Chronic illness: _____

Surgeries: _____ Disabilities: _____

Current medications and reasons prescribed:

Counseling: (current and/or previous)

Dates	Clinic / Therapist	Reason	Helpful? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatric Hospitalizations:

Dates	Hospital / MD	Reason	Helpful? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*All information on this form is considered strictly confidential within the guidelines of the clinic

Abuse Issues:

Please indicate areas of abuse that **you have experienced**:

☐ Not applicable

	Past	Current
Physical	☐	☐
Sexual	☐	☐
Verbal	☐	☐
Emotional	☐	☐

Please indicate areas of abuse **by you:**

☐ Not applicable

	Past	Current
Physical	☐	☐
Sexual	☐	☐
Verbal	☐	☐
Emotional	☐	☐

Alcohol/Substance Use: Please indicate any substances that you have used (current and/or previous)

	Type	Age at first use	How much and how often?	Last used
Nicotine:	_____	_____	_____	_____
Caffeine:	_____	_____	_____	_____
Alcohol:	_____	_____	_____	_____
Illegal/Street Drugs:	_____	_____	_____	_____
Misused Prescription Drugs:	_____	_____	_____	_____
Misused Over-the-Counter Drugs:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

In the last year, what alcohol and/or mood altering drug(s) have you used: _____

What is the maximum number of alcoholic drinks that you've had on any given day in the last year: _____

	Y	N	Not applicable
Have there been any undesirable results of your chemical abuse? (Low job/school performance, physical or relationship problems, DWI, etc.)	☐	☐	☐
Have you ever been concerned about your own chemical abuse?	☐	☐	☐
Have others expressed concern about your chemical abuse?	☐	☐	☐
Do others who are close to you abuse alcohol or drugs? If yes, who: _____	☐	☐	☐
Have you ever attended a self-help or support group? (Such as AA, NA, AlAnon, ACA)	☐	☐	☐
Are you currently attending a self-help or support group? If yes, name of group: _____	☐	☐	☐

Social History:

How many close friends do you have right now? _____

Approximately how often do you have contact with these friends? (Please select one)

☐ Daily ☐ 3-5 times per week ☐ Once a week ☐ 2 times per month ☐ Once a month

What are your hobbies / interests? _____

Current Living Situation: ☐ House ☐ Apartment ☐ Other: _____

Others Living With You: ☐ Spouse / Significant Other: _____ ☐ Children
☐ Parent(s) ☐ Sibling(s) ☐ Other(s): _____

Educational History:

Highest level of education completed: _____

Diplomas / Degrees / Certificates:	Degree	School	Year Completed	Area of Study
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

*All information on this form is considered strictly confidential within the guidelines of the clinic

Please explain any learning disabilities or problems you experienced during school:

Employment History:

Please list your last three jobs outside of the home:

Position	Responsibilities	Start Date	End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Military History: □ Not Applicable

Branch: _____ Position(s) Held: _____

Date(s) of Service: _____ Reason for Discharge: _____

Personal:

Religious / Spiritual Involvement: _____

Is religion/spirituality important to you? _____

Cultural / Ethnic Background: _____

What do you hope to gain from counseling? _____

How long do you expect to continue counseling? _____

Is there anything else you would like us to know about you?

*All information on this form is considered strictly confidential within the guidelines of the clinic

Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Name_____Date_____

The Burns Anxiety Inventory

Instructions: The following is a list of symptoms that people sometimes have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you *during the past week*:

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot

	Anxious Feelings	0	1	2	3
1.	Anxiety, nervousness, worry, or fear.				
2.	Feeling that things around you are strange, unreal or foggy.				
3.	Feeling detached from all or part of your body.				
4.	Sudden unexpected panic spells.				
5.	Apprehension or a sense of impending doom.				
6.	Feeling tense, stressed, "uptight," or on edge.				
	Subtotal from Section I				
	Anxious Thoughts	0	1	2	3
7.	Difficulty concentrating.				
8.	Racing thoughts or having your mind jump from one thing to the next.				
9.	Frightening fantasies or daydreams.				
10.	Feeling that you're on the verge of losing control.				
11.	Fears of cracking up or going crazy.				
12.	Fears of fainting or passing out.				
13.	Fears of physical illnesses or heart attacks or dying.				
14.	Concerns about looking foolish or inadequate in front of others				
15.	Fears of being alone, isolated, or abandoned.				
16.	Fears of criticism or disapproval.				
17.	Fears that something terrible is about to happen.				
	Subtotal from Section II				
	Physical Symptoms	0	1	2	3
18.	Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19.	Pain, pressure, or tightness in the chest.				
20.	Tingling or numbness in the toes or fingers.				
21.	Butterflies or discomfort in the stomach.				
22.	Constipation or diarrhea.				
23.	Restlessness or jumpiness.				
24.	Tight, tense muscles.				
25.	Sweating not brought on by heat.				
26.	A lump in the throat.				
27.	Trembling or shaking.				
28.	Rubbery or "jelly" legs.				
29.	Feeling dizzy, light-headed, or off balance.				
30.	Choking or smothering sensations or difficulty breathing.				
31.	Headaches or pains in the neck or back.				
32.	Hot flashes or cold chills.				
33.	Feeling tired, weak, or easily exhausted.				
	Subtotal from Section III				
	Combined Total				

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot

Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Name_____Date_____

The Burns Depression Checklist

Instructions: Put a check in the space to the right to indicate how much you have experienced each symptom *during the past week, including today*. Please answer all 25 items.

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot **4** = Extremely

	Thoughts and Feelings	0	1	2	3	4
1.	Feeling sad or down in the dumps					
2.	Feeling unhappy or blue					
3.	Crying spells or tearfulness					
4.	Feeling discouraged					
5.	Feeling hopeless					
6.	Low self-esteem					
7.	Feeling worthless or inadequate					
8.	Guilt or shame					
9.	Criticizing yourself or blaming others					
10.	Difficulty making decisions					
	Subtotal from Section I					
	Activities and Personal Relationships	0	1	2	3	4
11.	Loss of interest in family, friends, or colleagues					
12.	Loneliness					
13.	Spending less time with family or friends					
14.	Loss of motivation					
15.	Loss of interest in work or other activities					
16.	Avoiding work or other activities					
17.	Loss of pleasure or satisfaction in life					
	Subtotal from Section II					
	Physical Symptoms	0	1	2	3	4
18.	Feeling tired					
19.	Difficulty sleeping or sleeping too much					
20.	Decreased or increased appetite					
21.	Loss of interest in sex					
22.	Worrying about your health					
	Subtotal from Section III					
	Suicidal Urges	0	1	2	3	4
23.	Do you have any suicidal thoughts?					
24.	Would you like to end your life?					
25.	Do you have a plan for harming yourself?					
	Subtotal from Section IV					
	Combined Total					

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot **4** = Extremely

Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Patient Name: _____ D.O.B.: _____ Date: _____

GAD-7 QUESTIONNAIRE

How often during the past 2 weeks have you felt bothered by:

1. Feeling nervous, anxious, or on edge?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

2. Not being able to stop or control worrying?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

3. Worrying too much about different things?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

4. Trouble relaxing?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

5. Being so restless that it is hard to sit still?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

6. Becoming easily annoyed or irritable?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

7. Feeling afraid as if something awful might happen?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

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

Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Patient Name: _____ D.O.B.: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
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				

ADD COLUMNS FOR TOTAL SCORE _____ + _____ +_____ +_____

TOTAL SCORE: _____

NOTE: 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

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. PHQ-9 Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD® and PRIME MD TODAY® are trademarks of Pfizer Inc.

Shoreview Mental Health Center LLC

hope · · · wellness · · · peace

CURRENT WELL-BEING

1. At the present time, how upset or distressed have you been feeling?
   - ☐ Not at all distressed
   - ☐ Slightly distressed
   - ☐ Pretty distressed
   - ☐ Very distressed
   - ☐ Extremely distressed

2. At the present time, how energetic and healthy have you been feeling?
   - ☐ Not at all energetic and healthy
   - ☐ Slightly energetic and healthy
   - ☐ Pretty energetic and healthy
   - ☐ Very energetic and healthy
   - ☐ Extremely energetic and healthy

3. At the present time, how well do you feel that you are getting along emotionally and psychologically?
   - ☐ Quite poorly; I can barely
   - ☐ Fairly poorly; life is pretty tough for me at times
   - ☐ So-so; I manage to keep going with some effort
   - ☐ Fairly well; I have my ups and downs
   - ☐ Quite well; I have no important complaints
   - ☐ Very well; much the way I would like to

4. At the present time, how satisfied have you been feeling with your life?
   - ☐ Not at all satisfied
   - ☐ Slightly satisfied
   - ☐ Pretty satisfied
   - ☐ Very satisfied
   - ☐ Extremely satisfied

CURRENT LIFE FUNCTIONING

Please rate how much difficulty you are having in the following areas of your life:

		No Difficulty	Some Difficulty	A Lot of Difficulty	Extreme Difficulty
1.	Ability to perform routine tasks				
2.	Ability to maintain my personal appearance				
3.	Ability to concentrate and complete tasks				
4.	Participation in physical activities				
5.	Ability to function as an independent person				
6.	Ability to manage my finances				
7.	Being the kind of person I would like to be				
8.	Maintaining good health habits				
9.	Interactions with people at work				
10.	Performance at work or school				
11.	Developing or managing my career				
12.	Creative activities				
13.	Attending work/school or getting there on time				
14.	Interactions with my spouse/romantic partner				
15.	Interactions with my parents				
16.	Interactions with my brothers or sisters				
17.	Ability to form or sustain intimate relationships				
18.	Enjoyment of sexual activities				
19.	Carrying out family responsibilities				
20.	Interactions with friends				
21.	Participation in social activities				
22.	Planning and enjoying leisure time activities				
23.	Ability to control myself and stay out of trouble				
24.	Ability to be comfortable with people				

Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Name _____ Date: _____

WHODAS 2.0

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 give only one response.

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

		None (0)	Mild (1)	Moderate (2)	Severe (3)	Extreme or Cannot Do (4)
S1	Standing for long periods of time, such as 30 minutes?					
S2	Taking care of your household responsibilities?					
S3	Learning a new task, for example, learning how to get to a new place?					
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?					
S5	How much have you been emotionally affected by your health problems?					
	Subtotal I					
S6	Concentrating on doing something for ten minutes?					
S7	Walking a long distance such as a kilometer (or equivalent)?					
S8	Washing your whole body?					
S9	Getting dressed?					
S10	Dealing with people you do not know?					
S11	Maintaining a friendship?					
S12	Your day-to-day work?					
	Subtotal II					
	Combined Total					
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:**					

Adapted from: WHODAS 2.0 WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCHEDULE 2.0