NORTHLAND COUNSELING CENTER

ADULT HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Do you have a Health Care Directive (assumed no if blank)? _____

In an emergency notify: _____ relationship: _____ phone: _____

Primary care physician/clinic: _____ Pharmacy: _____

Brief reason for contacting NCC: _____

Referred by: _____ Current therapist: _____

MEDICAL

Date of last physical examination _____

Yes No Medication allergies -List if yes _____

Yes No Other allergies - List if yes _____

Yes No Medication side effects -Explain if yes _____

Yes No Supplemental medicinal treatment (St. John's Wort, herbs, vitamins)

Types if yes _____

Yes No Family history of thyroid problems - Explain if yes _____

Yes No Head/brain injuries, seizure, stroke, concussion or loss of consciousness

Explain if yes _____

Yes No Current treatment for medical condition/infection

Explain if yes _____

Yes No Past medical problems

List if yes _____

Yes No Pain which interferes with daily activities - Explain if yes _____

Yes No Recent significant weight gain/loss? (how much) _____

Yes No Caffeine consumption - Type & daily quantity _____

Yes No Tobacco (smoke/chew) - Daily quantity _____

Yes No Do you eat regular meals? Describe meal if yes _____

Yes No Exercise - List type & how often _____

WOMEN

Yes No Currently pregnant – Due date _____

Yes No Regular periods - Explain if no _____

MEDICATION			
Brand	**Dose**	**Brand**	**Dose**
1		6	
2		7	
3		8	
4		9	
5		10	

Yes No Mental Health Assessment within past year (date) _____

MENTAL HEALTH			
Type	**Facility**	**Date**	**Reason**
In-patient			
Out-patient			
Medication management			
Other (i.e., day treatment, partial hospitalization)			

CHEMICAL DEPENDENCY (CD) TREATMENT			
Type	**Facility**	**Date**	**Reason**
In-patient			
Out-patient			

Comments: _____

_____

_____

_____

_____ Date: _____

Client/Guardian signature

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

Version [GVER]: GSS 3.0.1

Name: _____ **Date:** _____
First/Middle/Last

The following questions are about common psychological, behavioral and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
IDSscr					
When was the last time you had significant problems...					
• with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
• with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	4	3	2	1	0
• feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	4	3	2	1	0
• becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
• thinking about ending your life or committing suicide?	4	3	2	1	0
• seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDSscr					
When was the last time that you did the following things two or more times?					
• Lied or conned to get things you wanted or to avoid having to do something?	4	3	2	1	0
• Had a hard time paying attention at school, work, or home?	4	3	2	1	0
• Had a hard time listening to instructions at school, work, or home?	4	3	2	1	0
• Had a hard time waiting for your turn?	4	3	2	1	0
• Were a bully or threatened other people?	4	3	2	1	0
• Started physical fights with other people?	4	3	2	1	0
• Tried to win back your gambling losses by going back another day?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
SDSscr When was the last time that…					
• you used alcohol or other drugs weekly or more often?.....	4	3	2	1	0
• you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (feeling sick)?.....	4	3	2	1	0
• you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?.....	4	3	2	1	0
• your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
• you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?.....	4	3	2	1	0
CVSscr When was the last time that you…					
• had a disagreement in which you pushed, grabbed, or shoved someone?.....	4	3	2	1	0
• took something from a store without paying for it?.....	4	3	2	1	0
• sold, distributed or helped to make illegal drugs?.....	4	3	2	1	0
• drove a vehicle while under the influence of alcohol or illegal drugs?..	4	3	2	1	0
• purposely damaged or destroyed property that did not belong to you?..	4	3	2	1	0

Do you have other significant psychological, behavioral or personal problems that you want treatment for or help with? If yes, please describe: _____ Yes _____ No

_____

_____

_____ _____

Client Signature Date

Staff Use Only

Number of 2's, 3's, and 4's: IDSscr: _____ EDSscr: _____ SDSscr:_____ CVSscr: _____ TDSscr: _____

Referral: _____ MH _____ SA _____ ANG _____Other: _____

NAME: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle 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**
☐	☐	☐	☐

WHODAS 2.0
World Health Organization
Disability Assessment Schedule 2.0

Name:_____ Date:_____

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 check only one response.

		None (1)	Mild (2)	Moderate (3)	Severe (4)	Extreme or cannot do (5)
1	Standing for long periods such as 30 minutes?					
2	Taking care of your household responsibilities?					
3	Learning a new task, for example, learning how to get to a new place?					
4	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?					
5	How much have you been emotionally affected by your health problems?					
6	Concentrating on doing something for ten minutes?					
7	Walking a long distance such as a mile (or equivalent)?					
8	Washing your whole body?					
9	Getting dressed?					
10	Dealing with people you do not know?					
11	Maintaining a friendship?					
12	Your day-to-day work?					

1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ____
2	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 ____
3	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.