Intermountain® Healthcare

Mental Health Integration

Adult Baseline Evaluation Packet

Dear Patient,

Mental health is important for overall health. That's why we have an integrated mental health team at our clinic. To help us assess this critically important part of your health, please fill out the forms in this packet. Your answers will help us best support you and your family.

- **Initial Behavioral Health Intake Questionnaire** (6 pages): This form asks about your main problems and symptoms. It gives us an overall view of your mental health history. It also includes what's called an "overall impairment scale." This scale tells us how much you think your problems are affecting your life at home or at work.
- **Family Rating Scale** (1 page): This form asks questions about your family and your support system. It helps us understand your family's style of dealing with stress or difficult health problems.
- **Patient Health Questionnaire (PHQ-9)** (1 page): This form asks questions about your recent feelings and behaviors. Your answers help us check for signs and symptoms of depression.
- **Anxiety & Stress Disorder Symptom Rating Scale** (1 page): This form helps us check for problems related to stresses in your life.
- **Mood Disorder Questionnaire (MDQ)** (1 page): This form helps us check for signs of a possible mood problem called bipolar disorder.
- **ADHD Self-Report Scale Symptom Checklist** (1 page): This form asks you how often you have each of 18 different symptoms. Your answers help us check for possible adult attention deficit hyperactivity disorder (ADHD).

Please bring these completed forms to your next office visit. If you're unable to complete them beforehand, please come 20 minutes early so that you'll have time to complete them before your appointment begins.

If you have any questions or concerns, please call us here at the clinic at: _____

Thank you

Patient and Provider Publications MHI014CL (Adult Baseline Cover Letter) - 12/16 *Also available in Spanish.*

Initial Behavioral Health Intake Questionnaire

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

1. **What are the main concerns you are dealing with at this time?** _____
   Physical: _____
   Emotional: _____

2. **What are your current symptoms, and how long have you had them?** _____

3. **What is currently causing you stress (at home, school, or work; in relationships)?**

4. **Functional disability rating scale.** In the past 2 weeks, how much have your mental health symptoms **interfered** in the following areas of life? (Answer **all 3** questions.)

Area of life	My symptoms interfered:										
	Not at all		A little		Pretty much			Very much			Severe
Family life and home responsibilities	0	1	2	3	4	5	6	7	8	9	10
Work or school (includes any volunteer or regularly scheduled activities out of the home)	0	1	2	3	4	5	6	7	8	9	10
Social or leisure activities (includes activities with friends, hobbies, or attending church)	0	1	2	3	4	5	6	7	8	9	10

5. **Do you have problems sleeping? If no, skip to question #6. If yes, answer the following:**

   How long have you had sleep problems? _____

   On average, how many nights per week do you have sleep problems? ____

   On average, how many hours do you sleep each night? _____

   Which of the following best describes your sleep pattern (check all that apply):

   ☐ I have trouble falling asleep. ☐ I wake up frequently at night. ☐ I don't feel rested the next day.

   How bad would you say your sleep problem is?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Not present		A little bad			Pretty bad			Very bad		Couldn't be worse

Notes:

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

6. Abuse and traumatic events:

Check any events below that you have experienced in the past **OR** that are going on now.

- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Emotional neglect
- ☐ Physical neglect
- ☐ Traumatic events
- ☐ Drug abuse in the family

Now, answer the following questions about the items you checked above.

	Yes	No
Are any of the situations either occurring now or still affecting you?	☐	☐
Do you feel in any danger or at risk because of any of these issues?	☐	☐
Have you sought help from a professional to deal with any of these issues?	☐	☐

If so, who?_____

7. Alcohol or drug use. In the **past year**, how often have you used the following:

Yes	**No**	**Substance**	**If yes,** how often?			
			Once or twice	Monthly	Weekly	Daily or almost daily
☐	☐	Alcohol (more than 4 or 5 drinks in a day)				
☐	☐	Tobacco products (including e-cigarettes)				
☐	☐	Prescription medicines for non-medical reasons				
☐	☐	Prescription medicines in amounts greater than prescribed, for reasons other than prescribed, or that weren't prescribed for you				
☐	☐	Drugs (street drugs, marijuana, huffing, and other)				

(from Intermountain-NIDA Quick Screen)

Notes:

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

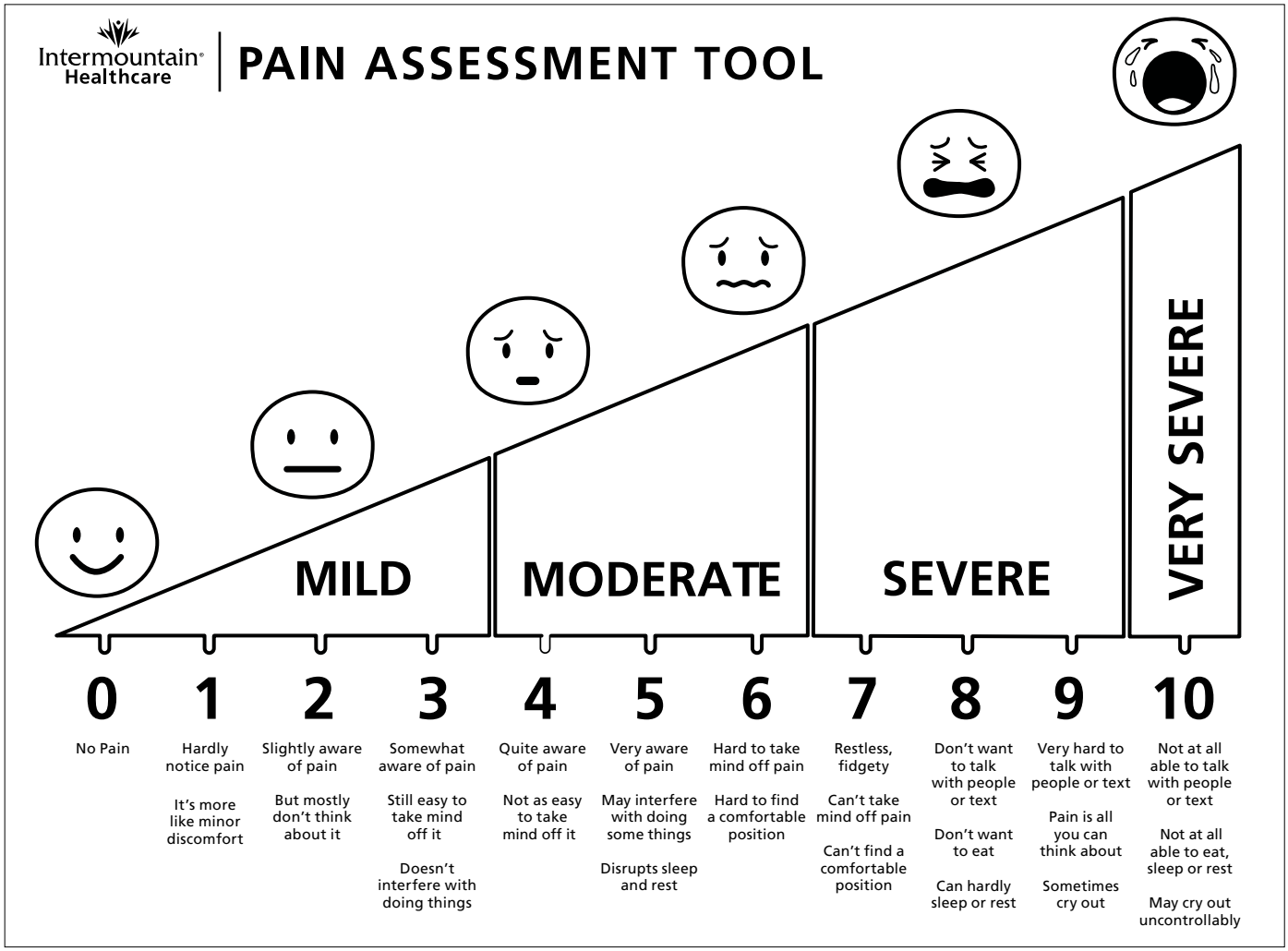
8. Eating behaviors.

Yes	No		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?

9. Chronic pain assessment.

Have you had pain every day for the last 6 months or more?
____Yes ____ NO

If yes, please rate your average daily level of pain on a scale of 0–10 (using the pain scale at the bottom of this page), with 0 being no pain, and 10 being most severe. Average pain level (0–10)_____



Mental Health *Integration*

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

10. Overall health. How would you rate your overall health?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Great		Okay			Not so good			Bad		Very bad

11. Current medicines you are taking. List **ALL** medicines prescribed by a physician **AND** any vitamins, supplements, herbal preparations, or other over-the-counter medicines you take:

_____

_____

_____

12. Are you allergic to any medicines? If so, please list the medicine and your reaction below:

_____

_____

13. Have you experienced any of the following conditions in the past 6 months?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Chest pain	☐	☐	Shortness of breath	☐	☐	Tension headache	☐	☐	Asthma
☐	☐	Fatigue	☐	☐	Back pain	☐	☐	Migraine headache	☐	☐	Diabetes
☐	☐	Dizziness	☐	☐	Stomachache	☐	☐	Irritable bowel syndrome	☐	☐	High blood pressure
☐	☐	Obesity	☐	☐	Head injury	☐	☐	Fibromyalgia			

14. Have you been treated for mental health or other medical problems in the past? Complete the table below (use other side if needed). Include any type of outpatient or inpatient treatment or therapy you received. **Be sure to list all medicines that you have tried.**

Type of illness or concern?	**When** did you seek help?	**(If applicable)** What medicines were you given for this illness or concern?	**How much** medicine did you take (number of "mg" from the pill bottle label), and **how often**?	Are you still taking this medicine **(Yes or No)**?	Are you still being treated for this problem? **(Yes or No) How?**
Mental health problems					
Other medical problems					

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Mental Health *Integration*

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

16. Social and family information.

Where were you born and raised? _____

Please list your brothers and sisters. Use the back for more space if needed.

Brother's or sister's name	Living?		Relationship?		
	Yes (If checked, current age?)	No	Good	Fair	Poor
	☐ Age?_____	☐	☐	☐	☐
	☐ Age?_____	☐	☐	☐	☐
	☐ Age?_____	☐	☐	☐	☐
	☐ Age?_____	☐	☐	☐	☐
	☐ Age?_____	☐	☐	☐	☐

Highest grade level or degree completed: _____

Current occupation: _____ **Is this job satisfying to you?** ☐ Yes ☐ No

Current income source(s): ☐ Self ☐ Spouse ☐ Disability ☐ Other: _____

Current legal problems: ☐ Yes ☐ No If yes, please explain: _____

Served in armed services: ☐ Yes ☐ No If yes, please explain: _____

Current marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner

Describe your marital history. _____

Whom do you live with (spouse, children, roommates, etc.)? _____

Please list your children. Use the back for more space if needed.

Child's name	Age	Living at home?		Relationship?		
		Yes	No	Good	Fair	Poor
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

Current religion (optional): _____

Your family's religion growing up (optional): _____

Is spirituality important in your life? ☐ Yes ☐ No

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

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Today's Date: _____ Patient's Name: _____ Date of Birth: _____

17. Lifestyle, strengths/weaknesses, and goals.

On average, how many days per week do you exercise or do physical activity? _____

On average, how many minutes of physical activity or exercise do you perform on each of those days? _____

At what intensity (how hard) do you usually exercise?
☐ Light (casual walk) ☐ Moderate (brisk walk) ☐ Vigorous (jog/run)

Do you have access to firearms? ☐ Yes ☐ No

List your strengths and weaknesses. (What are you good at? What are some things that are difficult for you?)

My strengths	My weaknesses

What goals do you hope to achieve with this treatment? _____

_____

_____

_____

_____

Notes:

Family Rating Scale

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Who do you most commonly talk to or go to for help when you do not feel well or you are distressed?

☐ I don't usually talk to anyone ☐ My support is exhausted or burnt out ☐ I talk to a friend, clergyman, church leader, spouse, or partner

There are many definitions of "family," such as people related to you by birth or marriage, the people you live with, or your group of friends. This form is about your family or current support system as you would define it. Each family has their own style for dealing with stress and other health problems. This rating scale may help you — and us — understand *your* family's style. On each row, please circle the number that best describes how you and your family (or current support system) act when you're under stress or dealing with a difficult health problem.

	Family style descriptions	Rating Scale										
		Not at all		A little		Pretty much			Very much			Accurately describes my family
1	We are often in crisis. We have many problems and unsolved concerns. The result of our family contact is confusion and chaos. It is hard for us to keep regular appointments.	0	1	2	3	4	5	6	7	8	9	10
2	We have people who can help us in times of stress. We value and ask for experts' (doctors'/nurses') help with our problems.	0	1	2	3	4	5	6	7	8	9	10
3	We are very independent and don't often need to count on others. We like to handle problems on our own. Asking for help is scary and often upsetting, so we may avoid getting the support we need.	0	1	2	3	4	5	6	7	8	9	10
4	Our family and friends are worn out because it is difficult to deal with all our needs. We are grateful for help but not sure it will work.	0	1	2	3	4	5	6	7	8	9	10
5	We think family relationships are important. Relationships are safe and helpful to us.	0	1	2	3	4	5	6	7	8	9	10
6	We have many friends, but not close friends. We are often alone with our problems.	0	1	2	3	4	5	6	7	8	9	10
7	We are helpful and open when dealing with problems. Our family contacts are direct and caring, even when we fight or disagree with each other.	0	1	2	3	4	5	6	7	8	9	10
8	Our family contacts can be rejecting, distant, and cold. The importance of early family relationships is ignored or forgotten.	0	1	2	3	4	5	6	7	8	9	10
9	We have painful memories of early family relationships. We are still angry with our parents.	0	1	2	3	4	5	6	7	8	9	10

For office use only:

Style I: _____ (3) + _____ (6) + _____ (8) = _____ /30

Style II: _____ (1) + _____ (4) + _____ (9) = _____ /30

Style III: _____ (2) + _____ (5) + _____ (7) = _____ /30

Patient and Provider Publications 801-442-2963 MHI018 - 11/13

MHI Pack 50402

Intermountain® Healthcare

Patient Health Questionnaire (PHQ-9) *(page 1 of 1)*

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

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
Total each column				

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?

A. ☐ *Not difficult at all* ☐ *Somewhat difficult* ☐ *Very difficult* ☐ *Extremely difficult*

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

☐ **YES** ☐ **NO**

Comments:

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Symptom score *(total # of answers in shaded areas)*:_____

Severity score *(total all points from all questions)*:_____

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PHQ 50408

Patient and Provider Publications 801-442-2963 DEP601 - 10/14

Anxiety & Stress Disorder Symptom Rating Scale *(page 1 of 1)*

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Completed by: _____ Relationship to patient: ☐ Self ☐ Parent ☐ Other: _____

The patient is 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/your child? Circle a number for each item.*

	General Anxiety Disorder (GAD-7)	How Often			
		Not at all	Several days	More than half the days	Nearly every day
1	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**

Circle the number on the rating scale that corresponds to how much the symptoms below apply to you/your child.

	Other Symptoms	Rating Scale										
		Not at all		A little		Pretty much			Very much		Couldn't be worse	
2	**Panic:** This can include increased heart rate, increased blood pressure, chest pain or pressure, irregular breathing, getting lightheaded	0	1	2	3	4	5	6	7	8	9	10
3	**Physical symptoms:** This can include stomachache, headache, tight muscles, shaking, muscle twitching, sweats	0	1	2	3	4	5	6	7	8	9	10
4	**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	4	5	6	7	8	9	10
5	**Post-traumatic stress:** This can include repeated, disturbing thoughts or dreams about a traumatic experience from the past, having physical reactions when reminded of the traumatic experience, avoiding situations that are reminders of the experience, feeling distant or emotionally numb, feeling jumpy or easily startled Check if post-traumatic symptoms have lasted **more than 4 weeks:** ☐	0	1	2	3	4	5	6	7	8	9	10
6	**Hallucinations:** This can include hearing voices or seeing things that others don't hear or see.	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle 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

For office use only: GAD-7 score (item 1): _____ / 21 Other symptoms (Q 2–5): _____ /40 Hallucinations (Q 6): _____ /10

Patient and Provider Publications 801-442-2963 MHI013 - 10/14

MHI Pack 50402

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Mood Disorder Questionnaire (MDQ) *(page 1 of 1)*

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

		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 much 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 into 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?	☐	☐
3	During the period of time indicated above, do you think any of these symptoms were brought on by prescription or other drugs?	☐	☐

4 How much of a problem did any of these cause you — like being unable to work; having family, money, or legal troubles; or getting into arguments or fights?

☐ no problem ☐ minor problem ☐ moderate problem ☐ serious problem

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Patient and Provider Publications 801-442-2963 MHI019-10/14

MHI Pack 50402

Intermountain Healthcare

ADHD Self-Report Scale Symptom Checklist *(page 1 of 1)*

Today's Date: _____ Name: _____ Date of Birth: _____

For each question below, place an X in the box that best describes how you have felt and acted over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	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 A
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?					
					Part B

Patient and Provider Publications 801-442-2963 ADD011 - 10/14

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