Date: _____ Patient's Name_____ Date of Birth _____

Pediatrician or Primary Care Doctor _____

1. What are your main concerns and/or symptoms that you are dealing with?
   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. What are your **strengths?** What **challenges** do you have?
   (What are you good at? What are somethings that are difficult for you?)

My strengths	**My challenges**

Comments:

Depression Screening (Patient Health Questionnaire, PHQ-A):

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, irritable, 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 school work, reading, 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

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**

In the past year, have you felt depressed or sad most days, even if you feel 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**

Access to Firearms: Do **you have access to firearms**? ○ Yes ○ No

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

Anxiety and Stress Disorder Symptoms (GAD 7):

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

Generalized Anxiety Disorder (GAD-7)	How Often			
	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

Eating Behaviors- (Ages 12 and older)

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 (CRAFFT Questionnaire Version 2.0) for Ages 12 and older

Please answer all questions honestly; your answers will be kept confidential.

During the PAST 12 MONTHS, on how many days did you:	Number of days
1. Drink more than a few sips of beer, wine or any drink containing **alcohol**? Put "0" if none.	
2. Use any **marijuana** (pot, weed, hash or in foods) or "**synthetic marijuana**" (like K2 or Spice)? Put "0" if none.	
3. Use **anything else to get high** (like other illegal drugs, prescription or over the counter medications, and other things that you sniff or "huff")? Put "0" if none.	

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0"in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in any of the boxes above, ANSWER QUESTIONS 4-9**

	No	Yes
4. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	○	○
5. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	○	○
6. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	○	○
7. Do you ever **FORGET** things you did while using alcohol or drugs?	○	○
8. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	○	○
9. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	○	○

Abuse and Traumatic Events.

Read below and answer first two questions:

Sometimes people have violent or very scary or upsetting things happen to them. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened to you **RECENTLY**? ◯ Yes ◯ No

If yes, what happened?

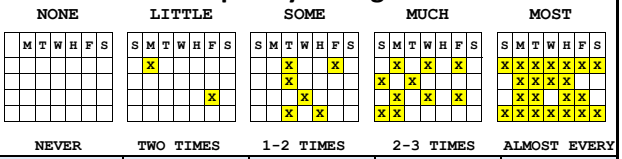
Has something like this happened to you **IN THE PAST**? ◯ Yes ◯ No

If yes, what happened?

If '**YES'** to either question above, please continue.

Select how often the problem happened to you in the **past month**, even if the bad thing happened a long time ago. Use the Frequency Rating Calendar on the right to help you decide how often the problem happened in the past month.

Frequency Rating Calendar



	HOW MUCH OF THE TIME DURING THE PAST MONTH…	None	Little	Some	Much	Most
1	I have bad dreams about what happened or other bad dreams.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
2	I have trouble going to sleep, wake up often, or have trouble getting back to sleep.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
3	I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
4	When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
5	When something reminds me of what happened, I get very upset, afraid, or sad.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
6	I have trouble concentrating or paying attention.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
7	I get upset easily or get into arguments or physical fights.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
8	I try to stay away from people, places, or things that remind me about what happened.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
9	I have trouble feeling happiness or love.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
10	I try not to think about or have feelings about what happened.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
11	I have thoughts like "I will never be able to trust other people."	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
12	I feel alone even when I am around other people.	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4