Intermountain® Healthcare

Mental Health Integration

Adult Follow-up Evaluation Packet

Dear Patient,

A little while ago, you filled out some forms to help us evaluate your mental health needs. Now we'd like to evaluate how well your treatment plan is working. **Please help us by repeating some of the forms related to your condition. The forms we'd like you to fill out are checked below.** If nothing is checked, please fill out ALL forms.

- ❒ **Follow-up Consultation** (2 pages)
- ❒ **Patient Health Questionnaire (PHQ-9)** (1 page)
- ❒ **Anxiety & Stress Disorder Symptom Rating Scale** (1 page)
- ❒ **Mood Symptom Rating Scale** (1 page)
- ❒ **ADHD Self-Report Scale Symptom Checklist** (1 page)

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

Thank you

MHI016 (Adult Follow-up Evaluation Packet) - 09/15

Follow-up Consultation *(page 1 of 2)*

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

Doctor's Name: _____ MRN (office use only): _____

1. Conditions being followed: *(check all that apply)*

☐ ADHD ☐ Depression ☐ Mood regulation
☐ Anxiety/PTSD ☐ Other: _____
☐ Chronic medical conditions: _____ ☐ Don't know / don't remember

Did your provider explain your diagnosis and review treatment options and preferences with you? ☐ Yes ☐ No ☐ Don't remember

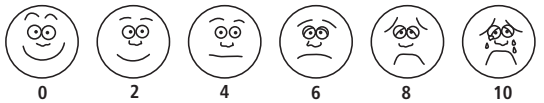
2. Chronic pain assessment follow-up

Yes	No	
☐	☐	Have you had pain every day for the last 6 months or more?

_____ Average pain level (0–10)

If yes, please rate your average daily level of pain on a scale from 0–10, with 0 being no pain, and 10 being the most severe. The faces scale at the right may be helpful.

Wong-Baker FACES Pain Rating Scale



0 No hurt | **2** Hurts little bit | **4** Hurts little more | **6** Hurts even more | **8** Hurts whole lot | **10** Hurts worst

From Hockenberry-Eaton M, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, Mosby, P. 1259. Used with permission. Copyright, Mosby.

3. Sleep assessment follow-up

Yes	No	
☐	☐	Do you have problems sleeping? If yes, answer the following:

On average, how many hours do you sleep when you're having problems? _____

How bad has your sleep problem been since your last visit?

☐ 0 not present ☐ 1 ☐ 2 a little bad ☐ 3 ☐ 4 pretty bad ☐ 5 ☐ 6 very bad ☐ 7 ☐ 8 ☐ 9 ☐ 10 couldn't be worse

4. Overall impairment. Check the box by the statement that best describes how much you think your **mental health symptoms** are interfering with your life at home, at work or outside the home, or in social situations.

☐ **1** **No impairment.** Symptoms are *not present* any more than expected and *do not interfere* with life.

☐ **2** **Slight impairment.** Symptoms are present *a little more frequently or intensely* than expected and only *rarely interfere* with life.

☐ **3** **Mild impairment.** Symptoms are present *somewhat more frequently or intensely* than expected and *sometimes interfere* with life.

☐ **4** **Moderate impairment.** Symptoms are present *a lot more frequently or intensely* than expected and *usually interfere* with life.

☐ **5** **Severe impairment.** Symptoms are present *a great deal more frequently or intensely* than expected and *most of the time interfere* with life.

☐ **6** **Very severe impairment.** Symptoms are present *so much more frequently or intensely than expected* that they *almost always interfere* with life.

☐ **7** **Maximal (profound) impairment.** Symptoms are *so frequent or intense* that they *completely interfere* with life. The symptoms may *create a crisis* that needs action right away to prevent serious danger or harm.

5. Missed days follow-up

_____ # days missed

Since the last visit, how many days of work, school, or other activities outside the home have you missed because of your current mental health problems?

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Follow-up Consultation *(page 2 of 2)*

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

6. Disability scale follow-up

In the past two weeks, how much have your **mental health symptoms** interfered in the following areas of life?

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

7. Self-management progress

Please check the aspects of self-management you have successfully focused on since your last visit:

☐ Taking medications ☐ Counseling ☐ Maintaining fulfilling relationships (using a support system)

☐ Improving nutrition ☐ Exercising ☐ Spirituality ☐ Hobbies and fun activities

I feel confident in my own ability to effectively take care of my own health issues.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

not at all confident somewhat confident confident very confident extremely confident

8. Medication follow-up

Are you taking any new medications since your last visit?

Name and dose of medication	When started?	Has well does it work?	What side effects?

Have you had any side effects from any of your medications, such as stomach or digestive problems, sexual side effects, headache, sleeping problems, tiredness, or anything else? List below.

Name and dose of medication	What side effects?

For use by healthcare provider:

BP: _____ / _____ HR: _____ EKG: _____

Labs: _____ Other: _____

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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:

For Office Use Only:

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

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

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PHQ 50408

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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 (2–6): _____ /50

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Mood Symptom Rating Scale *(page 1 of 1)*

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

Is the patient currently: ☐ on medication for mood regulation ☐ not on medication ☐ not sure ☐ in counseling

Circle the number on the rating scale that corresponds to how much the described symptoms apply to you.

	Symptoms	Rating Scale
1	**Elevated mood** May include the following symptoms: driven, high energy, never stops, silliness, unusual happiness	Not at all A little Pretty much Very much Couldn't be worse 0 1 2 3 4 5 6 7 8 9 10
2	**Irritable mood** May include the following symptoms: intense anger, temper tantrums, aggression, inability to deal with frustration, rage episodes	0 1 2 3 4 5 6 7 8 9 10
3	**Self-centered** May include the following symptoms: grandiose, bossy, entitled, unaware of others feelings, believes they are always right, believes nothing can hurt them, believes they are better than others	0 1 2 3 4 5 6 7 8 9 10
4	**Sleep problems** May include the following symptoms: trouble getting to sleep, wakes frequently, naps during the day, gets to sleep late and wakes early	0 1 2 3 4 5 6 7 8 9 10
5	**Talkative** May include the following symptoms: talks constantly, interrupts others, chatterbox	0 1 2 3 4 5 6 7 8 9 10
6	**Racing thoughts** May include the following symptoms: thinks faster than can speak, goes from topic to topic, mind is going 100 miles per hour	0 1 2 3 4 5 6 7 8 9 10
7	**Poor concentration** May include the following symptoms: can't focus, short attention span, poor listening, easily distracted	0 1 2 3 4 5 6 7 8 9 10
8	**Agitation** May include the following symptoms: restless, hyperactive, can't relax	0 1 2 3 4 5 6 7 8 9 10
9	**Increased involvement in high-risk activities** May include the following symptoms: fascination with sex, alcohol/drug use, excessive gambling, reckless driving	0 1 2 3 4 5 6 7 8 9 10
10	**Impulsivity** May include the following symptoms: suicidal gestures, self-harm, running away, poor judgment, sneaky, acting without thinking, not learning from consequences	0 1 2 3 4 5 6 7 8 9 10
11	**Impairment at home caused by the symptoms on this sheet:** symptoms impair overall functioning at home	0 1 2 3 4 5 6 7 8 9 10
12	**Impairment outside the home caused by the symptoms on this sheet:** symptoms impair overall functioning outside the home (school, work, church, with friends, etc.)	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 ☐ over 2 years

For office use only: Symptom score (1–10): _____ /100 Impairment score (11–12): _____ /20

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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

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