RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

Consent For Services

Please read the Client Service Agreement Guide, which can be found on our website at: https://rivervalleybhwc.com/patient-forms/
After reading the Client Service Agreement Guide, initial the required boxes.

- **Treatment** (***please initial***): _____
  - Consent For Treatment (check all that apply):
    - Therapy ☐
    - Medication Management ☐
    - Psychological Assessment ☐
      - Minor ☐
      - Adult ☐
  - Safe Harbor and The Divorce & Custody Litigation Agreement.
    - Filled out (separate form) (***please initial***) _____
    - Not applicable (Adult Client)
  - I understand treatment is confidential; however, there are limits to confidentiality under the mandatory laws of Minnesota.

- **Financial Policy** (***please initial***): _____
  - I understand and agree with the Financial Policy of RVBHWC (***initial***) _____
    - I am using my insurance (100% responsible for what they do not pay).
    - I am paying privately and/or not using my insurance (separate form).
    - Credit Card Information (**must have one on file in order for treatment at RVBHWC).**
    - **Copays and private pay are due at the time of service and credit cards will be run** unless other arrangements have been made with the billing department and approved before your visit.
    - If there is a balance before your next visit your card will be run on the 15th and 30th of each month (if these dates fall on a holiday or weekend, it will be run on the next business day).
  - I understand and agree to the late cancellation policy (***please initial***). _____
  - I give permission to the following person _____ to
    - Make or Cancel appointments ☐
    - Have access to my financial information ☐
  - Patient Portal and Newsletter (check all that apply):
    - Please sign me up for the patient portal ☐
    - Please sign me up for RVBHWC Newsletter ☐

- **Client's Rights and Responsibilities reviewed** (***please initial***). _____

Adult or Minor Consent to Treatment
Therapy, Assessment &/or Psychiatric Medication Management Services

I, _____, adult client OR parent and/or guardian of _____(minor client if applicable), hereby acknowledge that I have been given a copy of the River Valley Behavioral Health and Wellness Center Client Service Agreement. I have read and by signing below, I agree to all terms and conditions with the Service agreement along with the highlighted areas below.

_____ _____
Signature of adult client OR parent/legal guardian Date

_____ _____
Signature of minor client (REQUIRED IF APPLICABLE) Date

I have reviewed RVBHWC's Client Service Agreement Guide and Consent with my client:

_____ _____
Provider's Signature Date

RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER

Client Demographic Information

Client name: _____ Date of Birth: _____

Preferred Name (if any): _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ ☐Cell ☐Home ☐Business Messages - ☐ Yes ☐ No

Secondary Phone: _____ ☐Cell ☐Home ☐Business Messages - ☐ Yes ☐ No

Email Address: _____

Gender: ☐ Male ☐ Female ☐ non-Binary

Pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Other: _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic ☐ Declined to specify

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legally separated ☐ Domestic partner

Employment Status: ☐ Employed ☐Retired ☐Disabled ☐ Student ☐ Not employed

Text Appointment Reminders? ☐ YES ☐ NO *THESE REMINDERS ARE COURTESY & NOT GUARANTEED. Text messages go out 2 days prior to the appointment, do not text back to confirm/cancel. If you need to cancel the appointment, please call prior to 24 hours of the appointment. (This excludes Saturdays, Sundays & holidays)

EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____

Email: _____ Relationship: _____

LEGAL GUARDIAN

Is the Adult Client their own Legal Guardian? ☐ YES ☐ NO

If NO, please provide the guardian information below and provider River Valley Guardianship Paperwork.

Legal Guardian: _____ Phone: _____

Email: _____ Relationship: _____

RESPONSIBLE PARTIES

Responsible Party #1: _____ Date of Birth: _____

Responsible Party Address: _____ City: _____State: _____Zip: _____

Relation to Client: _____ Phone: _____

Responsible Party #2: _____ Date of Birth: _____

Responsible Party Address: _____ City: _____State: _____Zip: _____

Relation to Client: _____ Phone: _____

Pharmacy (Name): _____ Phone: _____

Address: _____ City: _____ State: _____

Phone: _____ Fax: _____

PRIMARY CARE COMMUNICATION

Would you like River Valley Behavioral Health and Wellness Center, LLC to communicate with your other health care providers? It is your right to either agree or disagree to this request. If you would not like information sent to your primary care physician's office, please indicate below. Release of Information Forms must be signed for each physician, psychiatrist or healthcare provider who will be contacted outside of River Valley.

☐ I agree to this request and would like for immediate contact between you and my primary care physician, psychiatrist, or nurse practitioner.

☐ I decline contact between you and my primary care physician at this time. Should something arise, I will complete a release of information form.

INSURANCE

Insurance Information/Private Pay: *ALL COPAYS, BALANCES AND PRIVATE PAY AMOUNTS ARE DUE IN FULL AT TIME OF SERVICE UNLESS AGREEMENT IS SET UP WITH BILLING DEPARTMENT

PRIMARY INSURANCE COMPANY Name: _____ Member ID#: _____ Group #: _____	SECONDARY INSURANCE COMPANY Name: _____ Member ID#: _____ Group #: _____
Copay: _____ Deductible: _____	Copay: _____ Deductible: _____

CREDIT CARD INFORMATION

It is a requirement to have a credit card on file with River Valley. If you want to use an HSA card you will need to have a credit card on file as a secondary payment form. Please review your service agreement for more information.

☐ I have given my credit/debit card information to River Valley BHWC Staff, and it has been saved in the secure and PCI compliant credit card processing service that River Valley BHWC operates with.

If you have not, please call 952-746-7664 to provide this information over the phone. It is directly entered into an encrypted credit card processing service which is very safe and secure as required by our bank. This is required to avoid your appointment(s) cancellation.

I hereby give consent to charge my credit card below for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me. All balances will be run the next day if balance is not paid at time of service.

Signature (Responsible Party): _____ Date: _____

RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

Informed Consent for Telehealth Sessions

Telehealth allows my provider to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment. I hereby consent to participate in psychotherapy and or medication management services via the internet (hereinafter referred to as telehealth) with the clinician listed below:

Client: _____ Address: _____

Email: _____ Phone Number:_____

Emergency Contact: _____
Name & Relationship - Phone Number

I understand I have the following rights under this agreement:

- I have the right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy or medication management. Any information disclosed by me during the course of my session is generally confidential.
- There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and vulnerable adult abuse, and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such a mental or emotional condition to be a danger to myself or others, my provider has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent.
- I understand that while psychotherapy and medication management have been found to be effective in treating a wide range of mental disorders and personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.
- River Valley utilizes secure and reliable HIPAA compliant platforms as their primary telehealth and virtual care communication. I understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our sessions or other communication by my provider to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. In the event of disconnection, the provider will call the client at the phone number listed above to discuss rectifying technical issues or rescheduling the session. Telehealth sessions are not permitted by phone only.
- I understand that telehealth treatment is different from in-person therapy and medication management and that if my provider believes I would be better served by another form of psychotherapeutic or medication management services, such as in-person treatment, I will be referred to a provider in my geographic area for such services.

- I understand that some parts of the examination involving physical tests for medication services cannot be conducted during a telehealth session, and my provider may direct me to have these tests conducted by a professional at my location.
- I accept that telehealth does not provide emergency services. During our first Telehealth session, my provider will discuss an emergency response plan, which will include contacting the listed emergency contact and/or 911 for the address listed. If I am experiencing an emergency situation, I understand I can call 911 or proceed to the nearest hospital emergency room. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.
- I understand I am responsible for 1) providing the necessary computer, telecommunications equipment, and internet access for my telehealth sessions; 2) maintaining the information security on my computer; and 3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.
- I understand that I cannot be driving at the time of my session. If I am to take my telehealth session within my vehicle, I must be parked.
- I understand that it is my responsibility as the client to call my insurance company and ask if the benefits under my plan cover telehealth and telemedicine sessions.
- I understand that I must be present in the state of MN for my telehealth appointment. If I am outside of the state of MN during a scheduled telehealth appointment, the appointment will be cancelled and I may be charged the $100 late cancel fee.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to telehealth communications by providing written notification to River Valley Behavioral Health & Wellness Center. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Client (or Guardian) Signature Date

RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER

Psychiatric Adult Intake Form

Client Name: _____ DOB: _____

Smoking Status/Rx/Allergy/Immunizations

1. **Smoking Status** (Individuals age 13 years and older)

❑Smoker-Daily, _____packs/day(or) _____Cigarettes/day, for _____ years or since ____/_____/_____
❑Smoker – Occasionally (not daily)
❑Former - _____packs/day (or)_____Cigarettes/day, form: Age _____ to Age ____
❑Never
❑Nicotine Gum: _____ Pieces per day
❑Nicotine Patch
❑ E-Cigarettes
❑Chewing Tobacco

2. **Current Prescription Medications**:

◯None

Name of Prescription:	*Dose* (mg, ml, etc.)	*Form* (tab, caps, etc.)	*Duration* (#times per day, wk, mo)	–or-	chronic	Unknown
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____
_____	_____	_____	_____x per _____		_____	_____

3. **Allergies:**

◯None

Drug/Medication	*Food*	*Other: (animals, pollen, latex, etc)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. **Please check the boxes of all immunizations since birth:**

◯None

Vaccination:	*Date (range)*	*Vaccination*	*Date (range)*
❑Chicken pox (Varicella)	_____	❑Pertussis	_____
❑Diphtheria	_____	❑Polio	_____
❑Hepatitis A	_____	❑Rubella	_____
❑Hepatitis B	_____	❑Tetanus	_____
❑HPV	_____	❑ None administered for health reasons	
❑Influenza	_____	❑ None administered for religious belief	
❑Measles	_____	❑Other_____	
❑Mumps	_____	_____	

What problem or issue are you here to address?

_____

_____

Medical History

Current Primary Care Physician: _____ Clinic: _____

Last physical exam_____ Current Height _____Weight _____

Supplements in addition to those listed previous: include over-the-counter medication, herbal, diet pills, homeopathic remedies

Started When? _____Is it beneficial?_____

Are there any side effects from medications you are currently experiencing?

_____

Describe current physical health: ☐Good ☐ Fair ☐ Poor _____

Any abnormal lab test results (what/when): _____

Please indicate if you have had any of the following medical illnesses or problems:_____

☐High blood pressure ☐ Lung Problems ☐ Cardiac Disease ☐ Fainting ☐ Eye Problems

☐Thyroid problems ☐ Glaucoma ☐ Prior EKG ☐ Neurological Problems ☐ Headaches

☐Low Blood Count/Anemia ☐Cardiac arrhythmias ☐ Accidents ☐ Heart murmurs ☐ Broken bones

☐ History of head injury ☐Loss of consciousness ☐ Seizures

Other:_____

_____

Surgical History ☐ Yes ☐ No_____

Has you ever experienced a physical trauma or injuries?

_____

If applicable, regular menstrual cycle? ☐ Yes ☐ No

_____

Using birth control? ☐ Yes ☐ No ☐Not Applicable If so method of birth control? _____

Mental Health Treatment History

If you are currently seeing a therapist:

Name of Therapist: _____ Location: _____

For how long: _____

Other Current Psychiatric Providers, if any: _____ Location: _____

Previous Psychiatric Diagnosis you are aware _____

Please list any past psychiatric or psychological evaluations and/or therapy or counseling provided by school, physicians, clinics, counselors, or psychologists (include phone # if possible). PLEASE BRING EVALUATIONS TO FIRST APPOINTMENT IF ABLE

_____

_____

Prior inpatient treatment/hospitalization or residential care for a psychiatric, emotional, or substance use disorder? ☐No ☐Yes
Please list dates and facility names:

_____

_____

Past psychiatry provider (who prescribed your medications): _____
Please list prior medication trials (if any):

_____

_____

Family History – (Biological)

	Father	Father's Family	Mother	Mother's Family
Attention Difficulties and/or Hyperactivity	☐	☐	☐	☐
Learning Difficulties	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐
Bipolar (Manic/Depressive) Disorder	☐	☐	☐	☐
Tourette's syndrome	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Substance use	☐	☐	☐	☐
Suicide	☐	☐	☐	☐
Legal Problems (Incarceration)	☐	☐	☐	☐

Biological family medical history (check all that apply)

☐ Thyroid Problems ☐ Diabetes ☐High Blood Pressure ☐Stroke ☐ Heart Trouble/Heart Attack
☐ Sudden Cardiac Death at Age _____ ☐ Cancer ☐ Elevated Cholesterol/Lipids ☐ Liver Problems
☐Arthritis ☐Glaucoma ☐ Lung Problems ☐ Stomach Problems
☐Blood clotting or bleeding problems ☐ Cardiac Defects/Arrhythmias ☐Seizures/Epilepsy
Other_____

Social History

Born in (city/state)_____ and raised in_____
Biological parents ☐ Married ☐ Never married ☐ Separated ☐ Divorced when you were _____years old.
Siblings/ages: _____
Out of home placements in childhood: ☐ Yes ☐ No _____
Highest level of educations: _____
Children: ☐ Yes ☐ No How many _____

List all persons currently living in household:			
Name	Age	gender	Relationship to client
		M/F	
		M/F	
		M/F	
		M/F	
		M/F	

Have you ever experienced trauma/abuse? ☐ Physical ☐ Emotional ☐ Sexual ☐ Other_____

Legal history ☐ Yes ☐ No Describe_____

Childhood Development History

Prenatal History - Please recall the following the best you can:

Did biological mother use any substances during pregnancy? ☐ Yes ☐ No

Were there any complications during the pregnancy? _____

Full-term? ☐Yes ☐No If not, how many weeks old at birth? _____

Were there any problems with delivery? ☐ Yes ☐ No _____

Additional Developmental History

Had trouble hearing as a child? ☐Yes ☐ No

Had visual problems as a child? ☐Yes ☐ No

History of IEP in school or special education? ☐ Yes ☐ No

Sudden recurrent motor movements (blinking, shoulder shrugging, or head jerking)? ☐ Yes ☐ No

Sudden recurrent vocalizations (chirping, sniffing, snorting, or coughing)? ☐ Yes ☐ No

Substance Use History

Do you currently drink alcohol, use marijuana, or use other recreational drugs? ☐ Yes ☐ No

Are you currently on Methadone or Suboxone? ☐ Yes ☐ No

Have you ever received counseling for substance abuse? ☐Yes ☐No_____

Substances used: ☐not applicable

Substance	Age Started	Last used	Current	Frequency	Formulation Pills/smoking/snorting/IV/etc
alcohol			Y / N		
marijuana or cannabinoid			Y / N		
ecstasy, cocaine, crack, amphetamines			Y/N		
heroin			Y / N		
hallucinogens (e.g., LSD, PCP)			Y / N		
prescriptions (pain)			Y / N		
sedatives / sleeping pills			Y / N		
methamphetamine			Y / N		
K2, bath salts,			Y / N		
inhalants (e.g., glue, gas)			Y / N		

Current Risk Assessment

Is there any history of domestic violence in the home? ☐ Yes ☐ No

If yes, has CPS (Child Protection Services) been involved? ☐ Yes ☐ No Or any legal action? ☐ Yes ☐ No

Are there any firearms in any homes you reside? ☐ Yes ☐No Are they locked? ☐ Yes ☐ No

Do you currently feel safe in your home? ☐ Yes ☐ No _____

Do you have other safety concerns at this time? ☐ Yes ☐ No

List safety concerns: _____

Review of Current Symptoms

*Please check any **current** symptom*

General/Constitutional-
- ❑ Good general health lately
- ❑ Weight loss or gain
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever or chills
- ❑ Weakness
- ❑ Trouble sleeping

Skin-
- ❑ Itching
- ❑ Rashes
- ❑ Dryness
- ❑ Color changes
- ❑ Hair/nail changes

Head & Neck-
- ❑ Headache
- ❑ Head injury
- ❑ Neck Pain
- ❑ Swollen glands
- ❑ Pain
- ❑ Stiffness

Eyes-
- ❑ Vision Loss/Changes
- ❑ Glasses/Contacts
- ❑ Blurry/double vision
- ❑ Irritation
- ❑ Drainage

Hematologic-
- ❑ Bruise easily
- ❑ Unexplained lumps

Cardiovascular-
- ❑ Chest pain
- ❑ Tightness
- ❑ Palpitati

Endocrine-
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Excessive sweating
- ❑ Excessive urination
- ❑ Excessive thirst

ENT-
- ❑ Difficulty swallowing
- ❑ Ringing in ears
- ❑ Nosebleeds
- ❑ Sore/scratchy throat
- ❑ Change in voice
- ❑ Stuffy nose
- ❑ Itchy eyes
- ❑ Sneezing

Respiratory-
- ❑ Cough
- ❑ Shortness of breath
- ❑ Congestion
- ❑ Wheezing

Gastrointestinal-
- ❑ Nausea
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Vomiting
- ❑ Blood in stool

Urinary-
- ❑ Frequency
- ❑ Urgency
- ❑ Burning or pain
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Difficulty urinating

Musculoskeletal-
- ❑ Muscle or joint pain
- ❑ Back pain
- ❑ Muscle aches
- ❑ Leg cramps
- ❑ Stiffness
- ❑ Joint swelling

Neurologic-
- ❑ Seizures
- ❑ Weakness
- ❑ Numbness
- ❑ Tingling
- ❑ Tremor
- ❑ Dizziness
- ❑ Fainting

Other symptoms:

_____

_____

_____

_____

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AUDIT

CLIENT NAME: _____ **DOB:** _____

1. How often do you have a drink containing alcohol?
(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

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Client Name: _____ **DOB:** _____

MDQ

	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. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❑	❑
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❑	❑

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ZAN-BPD

The ZAN-BPD by Mary C. Zanarini, EdD is a brief clinician administered interview to assess severity and change in BPD symptoms.

1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups? Yes____No____

2. Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? Yes____No____

3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)? Yes____No____

4. Have you been extremely moody? Yes____No____

5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? Yes____No____

6. Have you often been distrustful of other people? Yes____No____

7. Have you frequently felt unreal or as if things around you were unreal? Yes____No____

8. Have you chronically felt empty? Yes____No____

9. Have you often felt that you had no idea of who you are or that you have no identity? Yes____No____

10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? Yes____No____

Client Name: _____ DOB: _____

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Date: _____ Name: _____ DOB: _____

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

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

WHODAS 2.0

Client Name: _____ DOB: _____

Instructions: 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 **choose** only **one** response.

In the past 30 days, how much difficulty did you have in:					
Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme/cannot do
Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme/cannot do
Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme/cannot do
How much of a problem did you have joining in community activities (festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme/cannot do
How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme/cannot do
Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme/cannot do
Walking a long distance such as a kilometer (equivalent to 0.62 miles)	None	Mild	Moderate	Severe	Extreme/cannot do
Washing your whole body?	None	Mild	Moderate	Severe	Extreme/cannot do
Getting dressed?	None	Mild	Moderate	Severe	Extreme/cannot do
Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme/cannot do
Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme/cannot do
Your day-to-day work?	None	Mild	Moderate	Severe	Extreme/cannot do

Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** _____
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*** _____
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*** _____