Adult Intake Forms

How Did You Hear About Indigo Counseling Center?_____

Client's Legal Name_____Date____/____/_____
Preferred Name_____Gender_____
Pronouns (i.e. she/her, he/him, they/them)_____ Sexual Orientation_____
Cultural/Ethnic/Racial Identity_____
Religious/Spiritual Beliefs_____
Date of Birth____/____/_____Age_____Email Address_____
Phone (cell)_____(text)_____(other)_____
Okay to contact via phone?_____text?_____email?_____
Address_____City:_____State_____Zip_____
Emergency Contact Name:_____Phone:_____
Emergency Contact Address_____Email:_____

Primary Reason(s) for Seeking Services:
Abuse Issues_____Addictive Behaviors_____Alcohol/Drugs_____ Anger Management_____
Anxiety_____Coping_____Depression_____Eating Disorder_____Fears/Phobias_____
Gender Issues_____Grief_____Mental Confusion_____Relationship Struggles_____Sexuality/
Sexual Identity Concerns_____Sleeping Problems_____
Other Mental Health Concerns (Please specify):_____
_____

Marital Status:
Single_____Committed Relationship_____Married_____Divorced_____Separated_____
Divorce in Progress_____ Widowed_____ Unmarried, Living Together_____Polyamorous_____
Quality of Relationship: Great_____Good_____Fair_____Poor_____

Family Information:

Relationship	Name	Age	Living	Living with you
Mother				
Father				
Spouse				
Children				

Significant Others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living	Living with you

Parental Information

_____Parents Legally Married
_____Parents Have Ever Been Separated
_____Parents Ever Divorced

Mother Remarried: Number of Times:_____
Father Remarried: Number of Times:_____

Counseling/Prior Treatment History:

Information about CLIENT (past and present):

	Yes	No	When	Where	Your reaction to experience
Counseling					
Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Hospitalizations					
Self-Help Groups (i.e. AA, Al Anon)					

Information about FAMILY/SIGNIFICANT OTHERS (past and present):

	Yes	No	When	Where	Your reaction to experience
Counseling					
Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Hospitalizations					
Self-Help Groups (i.e. AA, Al Anon					

Development:

Childhood/Teen

Are there any special, unusual, or traumatic circumstances that affected your development?

_____Yes _____No

If yes, please describe:_____
Has there been a history of child abuse? _____Yes _____No
If yes, which type? _____Sexual _____Physical _____Emotional ____Verbal _____Neglect
Other childhood issues?_____

Young Adult/Adult

Have you experienced sexual assault as an adult? _____Yes_____No
Have you been or are you now in an abusive relationship?_____
physical?____sexual?_____verbal?_____psychological/emotional?_____

Trauma

Were there any other traumatic events in childhood or adulthood?_____
_____

Medical/Physical Health

_____Aids
_____Alcoholism
_____Abdominal Pain
_____Abortion
_____Allergies
_____Anemia
_____Appendicitis
_____Arthritis
_____Asthma
_____Bronchitis
_____Bed Wetting
_____Cancer
_____Chest Pain
_____Chronic Pain
_____Colds/Coughs
_____Constipation
_____Chicken Pox
_____Dental Problems
_____Diabetes
_____Diarrhea
_____Dizziness
_____Drug Abuse
_____Epilepsy
_____Ear Infections
_____Fainting
_____Fatigue
_____Frequent Urination
_____Headaches
_____Hearing Problems
_____Hepatitis
_____High Blood Pressure
_____Kidney Problems
_____Measles
_____Mononucleosis
_____Mumps
_____Menstrual Pain
_____Miscarriages
_____Neurological Disorders
_____Nausea
_____Nose Bleeds
_____Pneumonia
_____Rheumatic Fever
_____STD
_____Scarlet Fever
_____Sore Throat
_____Sleeping Disorders
_____Sinusitis
_____Smallpox
_____Sexual Problems
_____Tonsillitis
_____Tuberculosis
_____Toothache
_____Thyroid Problems
_____Vision Problems
_____Vomiting
_____Whooping Cough
_____Other (describe):
_____

Medications

Current Prescribed Medications	Dose	Date	Purpose	Side Effects

Current Over the Counter Meds	Dose	Date	Purpose	Side Effects

_____ _____ _____ _____ _____

Are you allergic to any medications or drugs? _____Yes _____No

Most Recent Doctor Examinations:	Date	Reason	Results
Last Physical Exam	_____	_____	_____
Last Doctor's Visit	_____	_____	_____
Last Vision Exam	_____	_____	_____
Last Hearing Exam	_____	_____	_____
Most Recent Surgery	_____	_____	_____
Other Surgery	_____	_____	_____
Upcoming Surgery	_____	_____	_____

Family History of Medical Problems:_____

Please check if there have been any changes in the following:

_____Sleep Patterns _____Eating Patterns _____Weight _____Energy Level

_____Physical Activity Level _____General Disposition _____Behavior ____Tension

Describe changes in areas in which you checked above:_____

Social Relationships:

Check how you generally get along with other people: (check all that apply)

_____Affectionate _____Aggressive _____Avoidant _____Fight/argue often _____Follower

_____Friendly _____Leader _____Outgoing _____Shy/withdrawn _____Submissive

Other (specify):_____

Chemical Use History:

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours Yes	Used in last 48 hours No	Used in last 30 days Yes	Used in last 30 days No
Alcohol	_____	_____	_____	_____	___	___	___	___
Barbiturates	_____	_____	_____	_____	___	___	___	___
Valium/Librium	_____	_____	_____	_____	___	___	___	___
Cocaine/Crack	_____	_____	_____	_____	___	___	___	___
Heroine/Opiates	_____	_____	_____	_____	___	___	___	___
Marijuana	_____	_____	_____	_____	___	___	___	___
PCP/LSD/Mescaline	_____	_____	_____	_____	___	___	___	___
Inhalants	_____	_____	_____	_____	___	___	___	___
Caffeine	_____	_____	_____	_____	___	___	___	___
Nicotine	_____	_____	_____	_____	___	___	___	___
Over the Counter	_____	_____	_____	_____	___	___	___	___
Prescription Drugs	_____	_____	_____	_____	___	___	___	___
Other Drugs	_____	_____	_____	_____	___	___	___	___

Substance of preference:

1._____ 2._____

3._____ 4._____

Substance Abuse Questions:

Describe when and where your typically use substances:_____

_____

Describe any changes in your use patterns:_____

_____

Describe how your use has affected your family or friends (include their perception of your use):_____

Reasons for Use:

_____Addicted _____Build Confidence _____Escape _____Self-Medication

_____Socialization _____Taste _____Other (specify):_____

How do you believe your substance use affects your life?_____

Who or what has helped you in stopping or limiting your use?_____

Does/Has someone in your family have/had a problem with drugs or alcohol?____Yes____No

If Yes, describe:_____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?___Yes___No

If Yes, describe:_____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_____

_____

Employment:

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left Job	How Often Miss Work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: _____FT _____PT _____Temp _____Laid-off _____Disabled _____Retired

_____Social Security _____Student _____Other (describe):_____

Education:

Years of Education_____Currently Enrolled in School?_____Yes _____No

_____High School Grad/GED

_____Vocational: Number of Years_____Graduated_____Yes_____No Major:_____

_____College: Number of Years_____Graduated_____Yes_____No Major:_____

_____Graduate: Number of Years_____Graduated_____Yes_____No Major:_____

Other training:_____

Legal:

Are you involved in any active cases (traffic, civil, criminal)?_____Yes_____No

If yes, please describe:_____

Are you presently on probation or parole? _____Yes _____No

If yes, please describe:_____

Any current or history of being a sexual perpetrator?_____Yes_____No
If yes, please describe:_____

Military

Military Experience? _____Yes _____No Combat Experience? _____Yes _____No
Where?_____Branch_____Date enlisted_____
Date Discharged_____Type of Discharge_____Rank at Discharge_____

Leisure/Recreational

Describe special area of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, diet/health, fishing, bowling, traveling, etc._

Activity	How Often Now?	How Often in the Past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check symptoms and behaviors that occur to you more often than you would like:

_____Aggression
_____Alcohol Dependence
_____Anger
_____Antisocial behavior
_____Anxiety
_____Avoiding People
_____Chest Pain
_____Cyber Addiction
_____Depression
_____Disorientation
_____Distractibility
_____Dizziness
_____Drug Dependence
_____Eating Disorder
_____Elevated Mood
_____Fatigue
_____Gambling
_____Hallucinations
_____Heart Palpitation
_____High Blood Pressure
_____Hopelessness
_____Impulsivity
_____Irritability
_____Loneliness
_____Memory Impairment
_____Mood Shifts
_____Panic Attacks
_____Phobias/fears
_____Recurring Thoughts
_____Sexual Addiction
_____Sexual Difficulties
_____Sick Often
_____Sleeping Problems
_____Speech Problems
_____Suicidal Thoughts
_____Thoughts Disorganized
_____Trembling
_____Withdrawing
_____Worrying
_____Other (specify)_____
_____

Discuss how the above symptoms impair your ability to function effectively:

_____
_____
_____
_____
_____
_____
_____

Any additional information that would help us in understanding your problems or concerns?

_____
_____
_____
_____
_____
_____
_____

What are your goals for
therapy?_____
_____
_____
_____
_____
_____
_____
_____

Are you suicidal at this time?_____Yes_____No
If Yes,
explain:_____
_____
_____
_____
_____

For Staff Use:

Therapist's Signature/Credentials_____Date_____/_____/_____
Supervisor's
Comments:_____
_____
_____
Supervisor's Signature/Credentials_____Date_____/_____/_____

Insurance Information: Please check with your insurance carrier regarding mental health coverage. Also, ask about your co-pay and deductible.

Primary Insurance:
Primary Insurance Carrier _____
Policy Holder_____Relationship to Client_____
ID#_____Group #_____
Co-Pay_____Deductible_____

Secondary Insurance:
Secondary Insurance Carrier _____
Policy Holder_____Relationship to Client_____
ID#_____Group #_____
Co-Pay_____Deductible_____

Insurance Billing: I authorize Indigo Counseling Center to release any medical information to my insurance company that may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Indigo Counseling Center. I understand that I am responsible for payment of services rendered by Indigo Counseling Center regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify Indigo Counseling Center immediately whenever my insurance coverage changes.
Signature: _____Date:_____

Credit Card on File: Indigo Counseling requires a credit card on file. I hereby give my consent to charge my credit card for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier deems payable by me. **Cancellation Policy:** Indigo Counseling requires 24 hour cancellation notice. I hereby give consent to charge my credit card on file for missed ($100.00) or late cancel ($85.00) appointments.

Card Type: Visa_____Master Card____American Express_____Discover_____
Card Holder Name_____
Card Number_____
Exp. Date_____ CVV Code_____Billing Zip Code_____
Card Holder Signature_____Date_____

Private Pay: All payments are due at beginning of each session. Private pay session amount is:
$_____ Signature_____

Fees for 2019

Intake Session: 90791, 50-55 minutes, $225.00
Individual Therapy: 90837, 53+ minutes, $175.00
Individual Therapy: 90834, 38-52 minutes $150.00
Couples/Family Therapy, 90847 53+ minutes $175.00
Group Therapy, 90853, 60+ minutes $55.00

Fees Not Billable to Insurance:
Late Cancel (less than 24-hour notice): $85.00
No Show: $100.00
Returned Check: $30.00
Phone Calls, Letters, Reports, Consultation: $43.75 per fifteen minutes/$175.00 per hour
Telephone Consultation: $43.75 per fifteen minutes/$175.00 per hour

Limits of Confidentiality:
Content of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:
--**Duty to Warn and Protect:** When a client discloses intentions to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

--**Abuse of Children and Vulnerable Adults:** If a client states or suggests he or she is abusing a child or vulnerable adult, the mental health professional is required to report this information to the appropriate authorities.

--**Court Order:** A court order, subpoena, or other legal process.

--**Prenatal Exposure to Controlled Substances:** Mental health care professionals are required to report prenatal exposure to controlled substances to the appropriate authorities.

--**Insurance Providers** (When applicable): Insurance providers and other third party payers are given information that they request regarding services to clients. Information that may be requested may be: types of services, dates/times of services, diagnosis, treatment plan, progress in therapy, case notes and summaries.

I have **read and understand** the **Limits of Confidentiality:**

Signature_____**Date**_____

CLIENT NOTICE OF PRIVACY PRACTICES: This notice describes how your health may be used and disclosed and how you are able to access this information. Please review it carefully. Protecting our client's privacy has always been important to this practice. A new federal and state law entitled the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Indigo Counseling Center, we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a physician specialist, with whom we may involve in your care plan. We may use or disclose your health information for payment for your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff members will enter your information into our computer. We may share your medical information with our business associates, such as a billing representative or service. We have a written contract with each business associate which requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about appointments. If you are not home, we may leave this information on your answering service or with the person who answers the telephone unless you have instructed us otherwise. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will advise you if we are able to fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Supply us, in writing, your request to make changes. If you request to include a statement in your file, please submit it to us in writing. We reserve the right to make the changes or not, however, we will accommodate your request by including your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes, in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. If you believe that your privacy has been compromised or if you are seeking more assistance regarding your personal health information, we ask that you first contact Indigo Counseling Center, owner, Joan Hause at 612-293-5124.

I have **read and understand** the **HIPAA/Privacy Practices**:

Signature_____Date_____

Court and Legal Proceedings:
Indigo Counseling Center does NOT provide disability determination, custody studies or handle court issue. Indigo Counseling Providers do not perform court evaluation, nor do they appear in court on behalf of children, or adults. Indigo Counseling Center providers are not trained for, nor do they maintain records with the intended purpose of court involvement.

If we are forced to further document or respond to information requests, meet with your representative, or testify in court, our fees are $400.00 per hour, plus all expenses, half-day minimum, paid in advance.

Consultation and Supervision: To provide you with the best possible service, Indigo Counseling Center providers engage in ongoing supervision and consultation with other mental health professionals. When discussing clients in other forums, confidentiality is protected.

After Hours Emergencies: Indigo Counseling Center clinicians are not available for after-hour emergencies. Messages are checked week days from 9:00 to 5:00. For after hour emergencies, if you need immediate assistance, call 911 or these crisis phone numbers:
Crisis Connection: 612-379-6363
National Suicide Prevention Lifeline: 1-800-273-8255
Riverwind Crisis Services: 763-755-3801
Dakota County Crisis: 952-891-7171
Ramsey County Crisis: 651-266-2700
Hennepin County Crisis: 612-596-1223

I understand and agree to abide by the policies stated above.

Signature_____**Date**_____

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered at all**	**Bothered some**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐	☐
b. Back pain	☐	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐	☐
f. Headaches	☐	☐	☐	☐
g. Chest pain	☐	☐	☐	☐
h. Dizziness	☐	☐	☐	☐
i. Fainting spells	☐	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐	☐
k. Shortness of breath	☐	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not bothered at all**	**Bothered several days**	**Bothered more than half the days**	**Bothered nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Maj Dep Syn if #2a or b and 5 or more of #2a-i are at least "More than half the days" (count #2i if present at all)
Other Dep Syn if #2a or b and 2, 3 or 4 of #2a-i are at least "More than half the days" (count #2i if present at all)

3. Questions about anxiety.	**No**	**Yes**
a. In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.		
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue – that	☐	☐

is, in situations where you don't expect to be nervous or uncomfortable?		
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
4. Think about your last bad anxiety attack.	**No**	**Yes**
a. Were you short of breath?	☐	☐
b. Did your heart race, pound, or skip?	☐	☐
c. Did you have chest pain or pressure?	☐	☐
d. Did you sweat?	☐	☐
e. Did you feel as if you were choking?	☐	☐
f. Did you have hot flashes or chills?	☐	☐
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h. Did you feel dizzy, unsteady, or faint?	☐	☐
i. Did you have tingling or numbness in parts of your body?	☐	☐
j. Did you tremble or shake?	☐	☐
k. Were you afraid you were dying?	☐	☐

5. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not bothered at all**	**Bothered several days**	**Bothered more than half the days**	**Bothered nearly every day**
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	☐	☐	☐	☐
If you checked "Not bothered at all", go to question #6.				
b. Feeling restless so that it is hard to sit still	☐	☐	☐	☐
c. Getting tired very easily	☐	☐	☐	☐
d. Muscle tension, aches, or soreness	☐	☐	☐	☐
e. Trouble falling asleep or staying asleep	☐	☐	☐	☐
f. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
g. Becoming easily annoyed or irritable	☐	☐	☐	☐

FOR OFFICE CODING:
Pan Syn if #3a-d are all "Yes" and 4 or more of #4a-k are "Yes"
Other Anx Syn if #5a and answers to 3 or more of #5b-g are "more than half the days"

6. Questions about eating	**No**	**Yes**
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked 'NO' to either #6a or #6b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	**No**	**Yes**

a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted - not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐
	No	**Yes**
8. If you checked 'YES' to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

FOR OFFICE CODING: Bul Ner if #6a, b and c and #8 are all "Yes"; Bin Eat Dis is the same but #8 either 'No' or left blank

	No	**Yes**
9. Do you ever drink alcohol (including beer or wine)?	☐	☐

If you checked "NO" go to question #11.

10. Have any of the following happened to you <u>more than once</u> <u>in the last 6 months</u>?	**No**	**Yes**
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over	☐	☐
d. You had a problem getting along with other people while you were drinking	☐	☐
e. You drove a car after having several drinks or after drinking too much	☐	☐

FOR OFFICE CODING:
Alc Abu if any of #10a-e are "Yes"

	Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
11. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

12. During the <u>last 4 weeks</u>, how much have you been bothered by any of the following problems?	**Not bothered at all**	**Bothered several days**	**Bothered more than half the days**	**Bothered nearly every day**
a. Worrying about your health	☐	☐	☐	☐
b. Your weight or how you look	☐	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐	☐
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	☐	☐	☐	☐
e. The stress of taking care of children, parents or other family	☐	☐	☐	☐

members				
f. Stress at work or outside of the home or at school	☐	☐	☐	☐
g. Financial problems or worries	☐	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐	☐

	No	Yes
13. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	☐	☐

14. What is the most stressful thing in your life right now? _____

_____

	No	Yes
15. Are you taking any medicine for anxiety, depression or stress?	☐	☐

16. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes your menstrual periods?

- ☐ Periods are unchanged
- ☐ No periods because pregnant or recently gave birth
- ☐ Periods have become irregular or changed in frequency, duration or amount
- ☐ No periods for at least a year
- ☐ Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive

	No	Yes
b. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability anger or mood?	☐	☐
IF YES: Do these problems go away by the end of your period?	☐	☐
c. Have you given birth within the last 6 months?	☐	☐
d. Have you had a miscarriage within the last 6 months?	☐	☐
e. Are you having difficulty getting pregnant?	☐	☐

Adapted from the PRIME-MD Patient Health Questionnaire, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues.

17. Which one of the following statements most accurately characterizes you?

- ☐ As far as I'm concerned, I do not have any problems that I need to change.
- ☐ I am aware of some problems and am considering beginning to work on them.
- ☐ I have worked on problems unsuccessfully but intend to continue trying.
- ☐ I am currently taking steps to overcome the problems that have been bothering me.
- ☐ I have already overcome some problems and want help now to avoid backsliding.

Adapted by G Ilagan (2009) from the Stages of Change/Transtheoretical Model (TIM), developed by Prochaska & DiClemente (1982).