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 History & Consultation form** (3 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

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Patient and Provider Publications 801-442-2963 MHI014CL (Adult Baseline Cover Letter) - 10/14 *Also available in Spanish.*

2014

Adult

Mental Health *Integration*

Initial History and Consultation (page 1 of 3)

Today's Date: __________ Patient's Name: ______________________________ Date of Birth: __________

Doctor's Name: ______________________________ MRN (office use only): __________

1. **What are the main problems or concerns you are dealing with?**

   Physical: ______________________________

   Emotional: ______________________________

2. **Have you been treated for mental health problems in the past?** ☐ Yes ☐ No (If yes, answer questions that follow. If no, skip to 3.)

   Please select the one that most reflects your situation: ☐ I was treated once, and it helped me.
   ☐ I was treated more than once, and sometimes it helped. ☐ I was treated multiple times, and nothing helped. ☐ Other: __________

   Are you being treated now? ☐ Yes ☐ No

   Who is/was treating you? Name: ______________________________ **When were you last seen?** ___/___/___ (mm/dd/yyyy)

   What else have you tried for your mental health problems? Did it work? ______________________________

3. **What medications have you tried for your mental health problems, if any?** List below. Use the back for more space if needed.

Name and dose of medication	When started?	If stopped, when?	How well did/does it work?	What side effects?

What other medications are you currently taking? List below. Include over-the-counter medications, vitamins, and herbal supplements. Use the back for more space if needed.

Name and dose of medication, vitamin, or herbal supplement	When started?	If stopped, when?	How well did/does it work?	What side effects?

4. **Have you been to the Emergency Department or had inpatient treatment (in the hospital) for a mental health problem in the last 2 years?** ☐ Yes ☐ No **If yes, how many times?** __________ **What for?** __________

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

   Have you been diagnosed with a chronic medical condition? ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic pain ☐ Obesity

Yes	No		Yes	No		Yes	No	
☐	☐	Chest pain	☐	☐	Shortness of breath	☐	☐	Tension headache
☐	☐	Fatigue	☐	☐	Back pain	☐	☐	Migraine headache
☐	☐	Dizziness	☐	☐	Stomachache	☐	☐	Irritable bowel syndrome

   ☐ Other: ______________________________

6. **Chronic pain assessment:**

   Yes ☐ No ☐ **Have you had pain every day for the last 6 months or more?**
   If yes, please rate your average daily level of pain on a scale of 0–10, with 0 being no pain, and 10 being most severe. The faces scale at right may help.

   ______ Average pain level (0–10)

Wong-Baker FACES Pain Rating Scale

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

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Initial History and Consultation *(page 2 of 3)*

Today's Date: ______________ Patient's Name: ______________________________ Date of Birth: ______________

7. Sleep assessment:

Yes No

☐ ☐ **Do you have problems sleeping?** 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 when you're having problems? ______________________________

Which of the following best characterizes your sleep pattern?

☐ I have trouble falling asleep. I usually go to bed at __________ AM/PM and fall asleep at __________ AM/PM.

☐ I wake up frequently at night. ☐ I wake up and can't fall back to sleep. ☐ I sleep all the time and want to take naps.

How bad would you say your sleep problem is?

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

8. Family history:

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*, list which relatives and what problems:

____

____

9. Abuse and traumatic events: Do you have a history of any of the following?

Yes	No		Yes	No	
☐	☐	Physical abuse	☐	☐	Physical neglect
☐	☐	Emotional abuse	☐	☐	Traumatic events
☐	☐	Sexual abuse	☐	☐	Drug abuse in the family
☐	☐	Emotional neglect			

☐ ☐ Are any of the above occurring now?

☐ ☐ Are any of the above still affecting you?

☐ ☐ Are you 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? ______________________________

10. 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 medications for non-medical reasons	☐	☐	☐	☐
☐	☐	Prescription medications in amounts greater than prescribed, for reasons other than prescribed, or than weren't prescribed to you	☐	☐	☐	☐
☐	☐	Drugs (street drugs, marijuana, huffing, and other)	☐	☐	☐	☐

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Initial History & Consultation (page 3 of 3)

Today's Date: ______________ Patient's Name: ______________________________ Date of Birth: ______________

11. Eating behaviors:

Yes No
- ☐ ☐ Are you concerned with your eating patterns?
- ☐ ☐ Do you ever eat in secret?
- ☐ ☐ Does your weight affect the way you feel about yourself?
- ☐ ☐ Have any members of your family suffered from an eating disorder?

12. Social stress: *In the past 6 months:*

Yes No
- ☐ ☐ Are you facing stressful situations at home, school, or work? (Work includes job, volunteer work, and training.)
  If *Yes*, briefly describe: ______________________________
- ☐ ☐ Are there other stressors not yet mentioned in this questionnaire that might be harming your physical or emotional health?
  If *Yes*, briefly describe: ______________________________

13. Work and friends:

Yes No
- ☐ ☐ ***In the past 6 months***, have your symptoms caused you to miss responsibilities outside of the home (work, school, friends)?
  If yes, please describe (for example, days of work)? ______________________________
- ☐ ☐ Are you content with your friends and social relationships?

14. 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.

15. Disability scale. If you have **experienced** any mental health problems, mark one box for each scale to identify the disability and impairment caused by your mental health symptoms.

Work*/School: The symptoms have disrupted your work/school work ***in the past week***:

Not at all	Mildly			Moderately			Markedly			Extremely
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

☐ I have not worked/studied at all during the past week for reasons unrelated to the disorder. *Work includes paid, unpaid volunteer work, or training.

Social Life: The symptoms have disrupted your social life/leisure activities ***in the past week***:

Not at all	Mildly			Moderately			Markedly			Extremely
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Family Life/Home Responsibilities: The symptoms have disrupted your family life/home responsibilities ***in the past week***:

Not at all	Mildly			Moderately			Markedly			Extremely
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

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

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
great		okay		not so good			bad		very bad

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Family Rating Scale *(page 1 of 1)*

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: ____ + ____ + ____ = ____ /30 (3, 6, 8)   Style II: ____ + ____ + ____ = ____ /30 (1, 4, 9)   Style III: ____ + ____ + ____ = ____ /30 (2, 5, 7)

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Mental Health *Integration*

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)*: ________

PHQ 50408

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Mental Health *Integration*

Child/Adolescent and Adult

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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Mental Health *Integration*

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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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______ /14

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Mental Health *Integration*

Adult

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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