

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
<p>Depression – Have you had a period of time during which you felt unhappy, depressed, irritable, and felt no interest in life consistently for at least two to four weeks?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>High Periods or Mania – Have you had moods that lasted one week or more in which you had so much energy you did not sleep for several nights, or felt you could accomplish many difficult tasks easily? Were you feeling so good that others commented on your elevated mood?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Chronic Feelings of Unhappiness – Have you felt mildly unhappy or unable to enjoy life for many years, for no apparent reason?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Suicide Attempts – Have you ever attempted suicide?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Self Harm – Besides attempting suicide, have you attempted to do physical harm to yourself in other ways, such as cutting or burning yourself?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Chronic Tension or Anxiety – Have you ever had problems with chronic anxiety, tension, nervousness, or constant worrying? Do you worry about minor concerns? (Not connected to anxiety attacks)</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Panic Attacks – Have you had brief anxiety attacks during which you felt like you were going to die, lose control, were very frightened, extremely anxious, or uncomfortable?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Panic Associated Fears – Have you ever been afraid of going out of the house alone, going to the grocery store, driving or using public transportation because of fear of having a panic attack?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Obsessive/Compulsive Symptoms – Have you had compulsions to repeat tasks such as checking things, washing hands, counting, or obsessions (ideas that make no sense but keep repeating in your mind?)</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Social Fears or Phobias – Have you been fearful in specific social situations, or felt uncomfortable doing things in front of other people? Do you worry excessively about being embarrassed or humiliated in social situations?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	
<p>Phobias – Have you had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with your life?</p>	
<p><input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
<p>Posttraumatic Symptoms – Have you ever experienced a very traumatic event that has continued to bother you or cause emotional problems later in life, such as nightmares or flashbacks of the event? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Hyperactivity/Inattention – Were you considered hyperactive and/or inattentive, or have you been treated with Ritalin or another stimulant, or been diagnosed with ADHD? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Psychotic Symptoms – Have you ever had hallucinations, heard voices, felt that you had special powers or were receiving special messages, felt inappropriately suspicious that people were trying to hurt you? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Chronic Physical Symptoms – Have you had a period of time during which you felt physically sick or worried about your health when no physical cause could be found? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Chronic Pain – Have you had problems with chronic pain such as headaches or stomachaches? If so please specify: _____ <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Sleep Problems – Have you experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Anorexia – Have you ever been anorexic or purposely lost weight to obtain a weight below normal? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Binge Eating or Bulimia – Have you had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Compulsive Behaviors – Have you had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Temper/Anger Problems – Have you had problems with your temper? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Dissociative Symptoms – Have you had periods of time during which you feel “out of touch”, removed from the world around you, or lost large amounts of time that you cannot account for? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	

Client Name: _____

(3) BEHAVIORAL HEALTH TREATMENT HISTORY

	Who provided the service?	When and how often?	Was it helpful? Please explain.
Counseling			
Medication Management			
Family Therapy			
Case Management			
CBRS/PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
IEP or 504 Plan			
Personal Care Services			
Other			

Have you been admitted to a residential treatment program or psychiatric hospital? No Yes – please complete:

Institution	Reason for admission	Dates of stay	Did it help?
_____	_____	_____	_____
_____	_____	_____	_____

(4) SUBSTANCE USE/ABUSE

Alcohol Use/Abuse – Do you drink alcohol? Yes, now Yes, in the past No

I drink occasionally: ___ x per month I drink most days: ___ x per week I drink daily: ___ drinks per day

I, or others I associate with, believe I have a drinking problem.

Drug Abuse – Have you ever abused “street” or prescription drugs? Yes, now Yes, in the past No

If yes, what drug(s) and what ages with each drug? _____

Smoking/Vaping/Other – Do you smoke, use other tobacco products, or vape? Yes, now Yes, in the past No

If yes how much per day/week and for how long? _____

Caffeine – Do you regularly drink coffee, tea or colas? No Yes – How much? _____

Clinician Comments:

Client Name: _____

(5) FAMILY PSYCHIATRIC HISTORY

Please include psychiatric problems in your biological relatives. Consider problems such as depression, bipolar disorder, anxiety disorders (OCD, panic disorder, PTSD), schizophrenia, ADHD, alcohol or drug abuse, anger or criminal problems, suicides, etc.

Relative	Yes	No	?	Type(s) of Problem(s)
Mother				
Mother's Relatives				
Father				
Father's Relatives				
Siblings				
Children				

(6) MEDICAL HISTORY & FUNCTIONING

How is your general health? Good Fair Poor

Medical Doctors/Specialists: _____

History of significant illness or medical treatment in the family: _____

Health Conditions - Check any health conditions that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Trouble eating | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |

Do you have

any contagious diseases?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What/When: _____
any disabilities or handicaps?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What/When: _____
any allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What/When: _____

Have you had any

Client Name: _____

accidents/injuries? No Yes What/When: _____

surgeries? No Yes What/When: _____

major illnesses? No Yes What/When: _____

hospitalizations? No Yes What/When: _____

loss of consciousness? No Yes What/When: _____

Menstrual and Reproductive History – Number of pregnancies: _____ Number of live births: _____

Do you have any history of:

premenstrual syndrome? No Yes What/When: _____

amenorrhea (absence of periods)? No Yes What/When: _____

irregular periods? No Yes What/When: _____

Medication - Please list all current prescribed or over-the-counter drugs/medications.

No medications

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Can you self-administer your medication? No Yes

Medication compliance: Regularly taken as prescribed Occasionally miss a dose

Miss doses regularly Refuse/forget to take meds most days

Have you been treated in the past with psychiatric medication? No Yes – please complete:

<u>Antidepressants</u>		<u>Mood Stabilizers</u>	<u>Tranquilizers</u>	<u>Sleeping Aids</u>	<u>Stimulants</u>	<u>Others</u>
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Risperdal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexedrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Trazodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium		Clonidine	Haldol
Celexa	Desipramine	Neurontin	Buspar		Concerta	Prolixin
Effexor	Anafranil				Provigil	Thorazine
Remeron					Vyvanse	Trilafon
					Strattera	Antabuse
						Naltrexone

Clinician Comments:

Client Name: _____

(7) FAMILY HISTORY & FUNCTIONING

Current Status – Please indicate your current relationship status:

- Single Married Re-Married Separated Divorced Widowed Living Together

Please indicate your sexual orientation: _____

gender: _____

Marital History:	Age	Year	Duration	# Children	Comments
1 st Marriage:	_____	_____	_____	_____	_____
2 nd Marriage:	_____	_____	_____	_____	_____
3 rd Marriage:	_____	_____	_____	_____	_____
4 th Marriage:	_____	_____	_____	_____	_____

Please check all that apply to your current marriage:

- Good, Satisfied Supportive Warm relationship Stable Bored
- Poor communication On verge of breakup Abusive (physical, verbal, sexual)

Conflicts over:

- Finances Sex Children Friends Alcohol/Drugs
- Legal issues Mental health Religion Many minor conflicts

Household members:	Name	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children not in the home:	Name	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please explain your family’s cultural and/or spiritual background: _____

What resources and supports do you and/or your family have? _____

What are your strengths in the family setting? _____

Clinician Comments:

Client Name: _____

Family of Origin - Place of birth: _____ Ages of parents when you were born: _____

Parents at the time of birth were: Married Separated Unmarried

Where did you live while you were growing up? Did the family move frequently? _____

Father: Living Deceased, year: _____ Education: _____ Occupation: _____

Mother: Living Deceased, year: _____ Education: _____ Occupation: _____

Did your parents divorce? If so, when? _____ Remarriages? _____

Were you adopted? No Yes – Age at time of adoption: _____ Circumstances: _____

FAMILY HISTORY

Please describe your relationship with your father: _____

Please describe your relationship with your mother: _____

Siblings: _____ Full Sisters _____ Full Brothers _____ ½ Sisters _____ ½ Brothers
_____ Step Sisters _____ Step Brothers _____ Deceased, age(s) at death: _____

Were you ever physically or sexually abused, assaulted or molested, or been a perpetrator? No Don't know Yes

Please specify when and by whom: _____

Please explain your family's cultural and/or spiritual background: _____

Clinician Comments:

(8) SOCIAL HISTORY & FUNCTIONING

How would you describe your friendships? No friends Only acquaintances Acquaintances & Friends

How would you describe your behavior/comfort level when you are in social situations? _____

Have you experienced any difficulties related to age, gender, sexual orientation, culture, race, or religion? No Yes – please explain: _____

What leisure/recreational activities are you involved in? _____

What are your talents and social strengths? _____

Clinician Comments:

Client Name: _____

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education – Highest degree of education: Grade School GED High School Degree Advanced Degree

Partner’s highest degree of education: Grade School GED High School Degree Advanced Degree

Vocational Training: _____

Please describe how you did in grade school:

academically: _____

behaviorally: _____

socially: _____

Please describe how you did in secondary school:

academically: _____

behaviorally: _____

socially: _____

Were you in a specialized classroom setting or did you receive special education? No Yes – please explain: _____

Do you have any educational goals at this time? _____

Employment – Are you currently employed? No Yes – job title/description: _____

How long have you been at this job? _____ Months/Years Are you satisfied with the job? Yes No – why? _____

Work History:

Job	Length of time	Reason for leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever

been reprimanded at work? No Yes – please explain: _____

been fired from a job? No Yes – please explain: _____

participated in a work program? No Yes – please explain: _____

What are your employment goals? _____

Military Service - No Yes – Specify: _____

Rank: _____ Branch: _____ Saw Combat? No Yes

Were you Honorably Discharged? Yes No – please explain: _____

Clinician comments:

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe your/the family's source(s) of income: _____

Are finances adequate to meet the family's needs? Yes No – please explain problems and supports/resources available: _____

Do you/your family receive

child support? No Yes – amount/frequency: _____

SSDI? No Yes – amount/frequency: _____

SSI? No Yes – amount/frequency: _____

food stamps? No Yes – amount/frequency: _____

cash assistance? No Yes – amount/frequency: _____

other income? No Yes – amount/frequency: _____

Do you have a history of financial problems? No Yes – please explain: _____

Clinician comments:

(11) BASIC LIVING SKILLS HISTORY & FUNCTIONING

Please indicate your habits with regard to the following basic living skill practices:

Bathing (using soap, washing hair) Daily A few times per week Once per week or less

Brushing teeth Daily A few times per week Once per week or less

Dress in clean/appropriate clothes Daily A few times per week Once per week or less

Go to bed/wake up at regular times Always Most of the time Rarely

Making/Following a shopping list Each time I shop Sometimes Rarely or never

Preparing balanced meals Twice per day Once per day Few times per week Rarely/Never

Housekeeping activities Daily A few times per week Once per week Less than 1x week

Laundry Weekly or more often Every couple of weeks Once per month or less

Do you regularly perform the following safety practices?

Lock doors/secure home Yes No

Turn off the stove, running water, etc Yes No

Are you receiving personal care services, Meals on wheels, or any other basic living skill providers? No Yes –

Specify: _____

Clinician comments:

THIS SECTION IS FOR CLINICIAN USE ONLY. PLEASE DO NOT COMPLETE THIS SECTION.

(15)– MENTAL STATUS EXAM

SUICIDALITY/HOMICIDALITY

Client denies any **current** suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Client reports **current** suicidal or homicidal feelings.

Specify: _____

Client denies **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Client has **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Specify: _____

Immediate Therapist intervention needed: _____ (None needed)

MENTAL STATUS

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other: _____

Attire: appropriate, seductive, untidy, loud, meticulous, other: _____

Gait: normal, erect, stooped, ataxic, rigid, shuffling, manneristic, other: _____

Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other: _____

Productivity of thought: spontaneous, verbose, pressured speech, unproductive, other: _____

Progression of thought: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented, other: _____

Language: normal, baby-talk, peculiar, expression, stilted, other: _____

Mood: indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, normal, composed, anxious, sad, tearful, depressed

Affect: appropriate, inappropriate, other: _____

Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization, hypochondriasis, other: _____

Orientation: normal, disoriented to time, place, person

Memory: normal, defective (remote, recent, immediate), other: _____

General knowledge: consistent with education, inconsistent, able to abstract, concrete, other: _____

Insight: absent, good, fair, minimal

Judgment: good, fair, poor

(16) SIGNATURES (The CDA must be signed and dated by all professionals who contribute to its development – PSR staff, etc)

Therapist's Signature Date

Other Date

Wellness Assessment

What is the purpose of the Wellness Assessment?

The Wellness Assessment is a set of questions to help your Care Advocate at your insurance company understand how you are doing in treatment. It helps the Care Advocate in working with your therapist so that you receive the services you need. The direction of your therapy is the result of the treatment decisions that you make together with your therapist.

How long will it take me to complete the Wellness Assessment?

Completing the form only takes a few moments of your time. Discuss with your therapist anything on the Wellness Assessment that you find important.

Are my answers confidential?

Yes. Your responses on the Wellness Assessment are considered Protected Health Information and are kept confidential. Your insurance company follows the guidelines of the national Health Insurance Portability and Accountability Act (HIPAA) as set by the United States Department of Health and Human Services.

Will my responses affect my benefits?

No. Your answers on this Wellness Assessment will not affect your insurance coverage or eligibility.

Will all the Wellness Assessments I complete be done at my therapist's office?

No. About four months after the date you start treatment, you will receive a Wellness Assessment in the mail directly from your insurance company. A business reply envelope will be included. Simply complete the Wellness Assessment and return it in the envelope provided.

Visit www.liveandworkwell.com. It contains useful information on a variety of topics to help you take charge of your health and well-being.

