UB|MD PRIMARY CARE

INITIAL/ANNUAL MENTAL HEALTH HISTORY FORM

Please complete this form and send it back one week prior to your first visit by fax 716.932.7465, by mail to Shirley Mazourek, LCSWR, UBMD Primary Care, 850 Hopkins Road, Williamsville, NY 14221, or by dropping it off at the office. Thank you.

Today's Date: _____/_____/________

Patient Name: ____ Date of Birth: _____/_____/_________

Preferred Pronouns: ____________________ Cell Phone #: ____

Address: ____

Is patient under 18? YES NO If YES, Parent/Guardian Name: ___________________________________

Parent/Guardian Phone Number: ____

Primary Insurance Name: ____

Policy Holder: ____ Date of Birth: _____/_____/_________

Member ID: ___________________________________ Group #: _________________________________

Primary Care Physician: ______________________________________ Phone #: ______________________

CURRENT PROBLEMS: Describe in your own words the problems that the patient is seeking help for.

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PRIOR PROBLEMS: List any previous periods in the patient's life when they had this problem or another problem related to stress, mental health, addictions, alcohol, or family difficulties**.**

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TREATMENT GOALS: What is the patient hoping to achieve from psychological treatment?

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CONFIDENTIAL DOCUMENT

If the patient has ever received mental health or addiction services before, please complete the table below:

Professional's Name/Agency	Start/Stop Dates	Describe problem, treatment and effectiveness

Are you interested in participating?	NO	YES
Individual psychotherapy/counseling		
Group sessions for decluttering/hoarding		
Group sessions for substance use recovery/maintenance		
Group sessions/other (please list topic):		

Please list any psychiatric medications the patient has tried and describe the response:

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Please list any current health problems and/or physical limitations:

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PATIENT HEALTH QUESTIONNAIRE

Patient Name: ______________________________________ Date of Birth: _____/_____/________

Please complete the following questionnaire. If this is being completed by a parent/guardian, please answer on behalf of the identified patient.

1. Over the <u>last 2 weeks</u>, 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
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	☐	☐	☐	☐

2. Over the <u>last 4 weeks</u>, 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
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	☐	☐	☐	☐
If you checked "NO," go to question 3.				
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 a book or watching TV	☐	☐	☐	☐

3. In the last 3 months, have you <u>often</u> 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. Near-Fasted—eaten minimally (<500 cal) in 24 hours?	☐	☐
e. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

4. AUDIT-C	+4 points	+3 points	+2 points	+1 point	+0 points
How often do you have a drink containing alcohol?	Two to Three Instances per Week	Two to Four Instances per Month	Four or Greater than 4 Instances per Week	Monthly or Less	Never
How many standard drinks containing alcohol do you have on a typical occasion of drinking?	10 or more	7 to 9	5 to 6	3 to 4	1 or 2
How often do you have six or more drinks on one occasion?	Daily	Weekly	Monthly	Monthly or Less	Never

4a. Please name which drugs other than alcohol you use that are not prescribed for you personally.

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5. If you checked off <u>any</u> problems on this questionnaire so far, 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?

☐ Not at all difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

6. In the last year...	NO	YES
a. Have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	☐	☐
b. Have you ever been afraid to go home?	☐	☐

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

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Adapted from PHQ & PHQ-Brief by Drs. Robert Spitzer, Janet Williams, Kurt Kroenke, and colleagues. Published by Pfizer, Inc.

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