

Name: _____

Date: _____

13 years old and up complete.

Last 4 SSN: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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
	0	1	2	3
1 Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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

☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Name: _____

Date: _____

Last 4 SSN: _____

13 years old and up complete.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Column totals _____ + _____ + _____ + _____

= Total score _____

If you checked any problems, how difficult have they 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: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

Score

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Sleep Questionnaire

Name: _____

Today's Date: ____-____-____

**15 Yrs & Older
Complete**

"Check" how often each of the following sleep symptoms have been a problem during this **past week**.

Symptoms	Never a Problem 1	Seldom a Problem 2	Sometimes a Problem 3	Often a Problem 4	Almost Always a Problem 5
Trouble falling asleep	☐	☐	☐	☐	☐
Waking up during sleep	☐	☐	☐	☐	☐
Waking up too early in the morning	☐	☐	☐	☐	☐
Cannot stop thinking while trying to fall asleep	☐	☐	☐	☐	☐
Dread going to bed	☐	☐	☐	☐	☐
Sleeping during day	☐	☐	☐	☐	☐
Gasping for air during sleep	☐	☐	☐	☐	☐
Morning fatigue	☐	☐	☐	☐	☐
Legs jerk during sleep	☐	☐	☐	☐	☐
Cramps, pain, or crawling sensation in legs while lying in bed	☐	☐	☐	☐	☐
Involuntarily falling asleep during day	☐	☐	☐	☐	☐
Muscles become paralyzed briefly during day	☐	☐	☐	☐	☐
Strange feeling at beginning of sleep	☐	☐	☐	☐	☐
Sleep does not seem refreshing	☐	☐	☐	☐	☐
Bad dreams	☐	☐	☐	☐	☐

SLEEP Problem Cause(s)

"X"	Sleep Problem Caused and/or Made Worse by:
☐	Physical pain
☐	Too restless/tense or tired
☐	Personal stress
☐	Frustration and anger
☐	Worries or fears about current injury, re-injury, stressful problems
☐	Wrong or side effects from medication
☐	Environment: Noisy, poor mattress, etc.
☐	Afraid to go to sleep
☐	Cannot stop thinking
☐	Sleep disturbance is a viscous pattern or habit now.

Sleep Problem Severity Scale

0 – 15, None
 16 – 30, Mild
 31 – 45, Moderate to Serious
 46 – 60, Severe
 61 – 75, Extreme

Current Score/Rating: _____

SLEEP Problem Onset: How long have you had your sleep problem(s): _____

SLEEP Problem Frequency: During the past week, how many nights did you have trouble sleeping? ____ out of 7 days.

SLEEP Length/Duration: Within a 24-hour period, how many hours of sleep did you get on average this past week? ____ hours.

SLEEP Onset/Latency: This past week on average, how long did it take you to fall asleep? _____

SLEEP Awakenings: This past week on average, how many times did you wake up during the night? _____

After awakening how long did it take you to fall back to sleep? _____

SLEEP Efficiency: In general, how refreshing or energizing was your sleep this past week? _____

SLEEP Problem Treatment

Medication Management: Have you used any medications to help you sleep? _____

If you have, what medications have you used? _____

Did you use any sleep medications? ____ If so, what did you use, and how often did you use them? _____

Self-Medication: Did you use alcohol, nonprescription, or other substances to help you sleep? _____

If so, how often and what do you use? _____

Other Treatment(s): Describe other treatments or strategies you used to help you sleep _____

How well did the treatment(s) or strategies work? _____

What has helped you sleep most during this past week? _____

Nueva Vida Behavioral Health Associates

Behavioral Rating Scale - (Page 1 of 2)

Client Name: _____

Age: _____

Medicaid #/Member ID#: _____

Today's Date: _____

Person Completing form: _____

All Ages Complete

Please check off the box that best describes the frequency/severity of the problem in the person you are describing:

1=Not at All 2 = A Little 3= Moderately or Somewhat 4=Quite a bit 5=Extremely

Depression/Anxiety					
☐	☐	☐	☐	☐	Low self-esteem; shyness or problems making friends; sensitivity to criticism or rejection; feeling or inadequacy
☐	☐	☐	☐	☐	Feeling down or blue, irritable, crying easily; feeling easily hurt; quick mood changes
☐	☐	☐	☐	☐	Feeling hopeless about the future, thoughts of hurting self, thoughts about death or dying
☐	☐	☐	☐	☐	Separation anxiety; clinging to and/or sleeping with parents; fearful of being away from parents; difficulty going to school
☐	☐	☐	☐	☐	Worrying about things too much; feeling tense, anxious, nervous, or shaking; phobias
☐	☐	☐	☐	☐	Nightmares; easily startled; avoidance; flashbacks related to past abuse or other traumas

Anger/Irritability/Behavioral Problems					
☐	☐	☐	☐	☐	Anger control problems; thoughts about hurting others; violence; fighting, temper tantrums; cruelty to animals; stealing; fire setting
☐	☐	☐	☐	☐	Stubborn; defiant, trouble with authority; gang involvement, cult involvement

Relationships					
☐	☐	☐	☐	☐	Problems with parenting, disciplining, and/or communicating with your child
☐	☐	☐	☐	☐	Marital problems; family conflict; sibling fighting; conflicts with co-workers
☐	☐	☐	☐	☐	Relationship problems, distrust, interpersonal isolation, frequent arguments
☐	☐	☐	☐	☐	Abusive relationships; victim of abuse; perpetrator of abuse

Addictions/Compulsions					
☐	☐	☐	☐	☐	Obsessive-compulsive behaviors (ie., cleaning, cooking, exercise, rituals, gambling counting); odd thoughts that you can't get out of your head, perfectionism; excessive need for control
☐	☐	☐	☐	☐	Alcohol or drug abuse; describe
☐	☐	☐	☐	☐	Fatigue; low energy; problems concentrating

Sleep/Eating/Developmental/Physical					
☐	☐	☐	☐	☐	Problems with eating/appetite (changing in appetite/weight, bingeing/purging)
☐	☐	☐	☐	☐	Aches and pains; lots of physical symptoms (without a known physical cause)
☐	☐	☐	☐	☐	Sleep disturbance (trouble falling asleep, restless sleep, waking to early and being unable to fall back asleep, sleeping too much)
☐	☐	☐	☐	☐	Sexual problems
☐	☐	☐	☐	☐	Developmental delays in speech/language, toilet training, motor skills, social/emotional functioning; cognitive/academic skills

Nueva Vida Behavioral Health Associates
Behavioral Rating Scale – (Page 2 of 2)

Client Name: _____

Date: _____

Medicaid #/Member ID#: _____

All Ages Complete

1=Not at All 2 = A Little 3= Moderately or Somewhat 4=Quite a bit 5=Extremely

Academic/Learning/Vocational

1	2	3	4	5	
☐	☐	☐	☐	☐	Failing grades in school; declining work performance
☐	☐	☐	☐	☐	Learning problems; problems with memory; slowed thinking

Thought Process

☐	☐	☐	☐	☐	Hearing voices or seeing visions; mental confusion; odd beliefs; paranoia
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Stress

1	2	3	4	5	
☐	☐	☐	☐	☐	Financial problems
☐	☐	☐	☐	☐	Legal problems; pending court case or lawsuit
☐	☐	☐	☐	☐	Stress Management problems; difficulties coping and/or relaxing
☐	☐	☐	☐	☐	Work related stress
☐	☐	☐	☐	☐	Family problems (check those that apply)
					☐ Children difficult to manage
					☐ Marital stress
					☐ Spouse abuse
					☐ Child abuse

Inattention/Hyperactivity

☐	☐	☐	☐	☐	Hyperactive; impulsive; restless
☐	☐	☐	☐	☐	Inattentive, disorganization, forgetful, easily distress

Other problems not listed previously:

Child/Adolescent Strengths

☐	creative	☐	curious	☐	open-minded	☐	loves to learn	☐	has a sense of perspective that he/she offer to others	☐	authentic	☐	brave	☐	can be persistent when she/she wants something	☐	approach life with excitement and energy kind	☐	value love and relationships with others	☐	aware of how others are feeling	☐	fair	☐	has good leadership skills	☐	works well with others	☐	can forgive others	☐	modest	☐	makes choices carefully and thoughtfully	☐	regulates his/her own feelings	☐	appreciates beautiful things	☐	thankful and grateful	☐	has hope	☐	has a good sense of humor
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Nueva Vida Behavioral Health Associates
SYMPTOMS DISTRESS CHECKLIST
(Adapted from SCL-90 and BST)

Client Name: _____
 Medicaid #/Member ID#: _____
 Person Completing form: _____

Age: _____
 Today's Date: _____
All Ages Complete

These statements are about how much you have been distressed or bothered by something during the last seven (7) days. Please check off the box that best describes how you felt for each of the statements below:

1=Not at All 2 = A Little 3= Moderately or Somewhat 4=Quite a bit 5=Extremely

During the past 7 days about how much were you distressed or bothered by:					
1	2	3	4	5	
☐	☐	☐	☐	☐	Feeling so restless you couldn't sit still
☐	☐	☐	☐	☐	Being suddenly scared for no reason
☐	☐	☐	☐	☐	Feelings of worthlessness
☐	☐	☐	☐	☐	Feeling blue
☐	☐	☐	☐	☐	Spells of terror or panic
☐	☐	☐	☐	☐	Heavy feeling in arms or legs
☐	☐	☐	☐	☐	Feeling lonely
☐	☐	☐	☐	☐	Feeling tense or keyed up
☐	☐	☐	☐	☐	Feeling lonely even when you are with people
☐	☐	☐	☐	☐	Feeling afraid to go out of your home alone
☐	☐	☐	☐	☐	Feeling no interest in things
☐	☐	☐	☐	☐	Feeling fearful
☐	☐	☐	☐	☐	Feeling weak in parts of your body
☐	☐	☐	☐	☐	Nervousness or shakiness inside
☐	☐	☐	☐	☐	Feeling afraid in open spaces or on the streets

 Clinician Signature

 Date

 Adult Client or Guardian Signature

 Date



Nueva Vida Behavioral Health Associates, Inc.

Please complete the following PCL-5 assessment if you have severe stress responses.

Name: _____

Date: _____

Last 4 SSN: _____

18 years old and up complete.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then check off one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all 0	A little Bit 1	Moderately 2	Quite a bit 3	Extremely 4
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	☐	☐	☐	☐	☐
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	☐	☐	☐	☐	☐
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	☐	☐	☐	☐	☐
15. Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16. Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17. Being "superalert" or watchful or on guard?	☐	☐	☐	☐	☐
18. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19. Having difficulty concentrating?	☐	☐	☐	☐	☐
20. Trouble falling or staying asleep?	☐	☐	☐	☐	☐

Score