MAZZITTI & SULLIVAN

Counseling by Pyramid Healthcare

CLIENT INFORMATION – *Please print clearly*

Client Name: _____
(Last Name) *(First Name)* *(Middle Initial)*

Street Address: _____

City/State/Zip: _____

Home Ph:_____ Work Ph: _____ Cell Ph: _____ Marital Status:_____ Race: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: Male/Female: _____

Client's Email Address: _____

How did you hear about our agency? _____

*Parent/Guardian's Email Address (if adolescent client): _____
*if Parent/Guardian would like to receive weekly progress reports

General Health Questionnaire

Name_____ Date_____

1. Describe your current state of health: _____

_____

2. Past medical history (list major illnesses, surgery, etc., and give approximate dates): _____

_____

_____

_____

3. Current Medications

Drug (Name & mgs.)	Dosage (times per day)	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Allergies to Medications: _____ None_____

_____ None_____

5. Date of most recent physical examination: _____

6. Family Physician's Name _____ Phone: _____

7. Other treating physicians (gynecologist, allergist, surgeon, etc.):

Name_____Speciality:_____

Name_____Speciality:_____

Name_____Speciality:_____

Name_____Speciality:_____

Name_____Speciality:_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Medical Problems Checklist:

Please mark any applicable sections

	Past	Present	N/A	Mother	Father	Grandparents
Medical Issues:						
Abnormal bleeding:						
Diabetes:						
Hypertension:						
Swelling:						
Abscesses/Ulcers:						
Cancer:						
Kidney Disease:						
Seizures:						
Headaches:						
Liver Disease:						
Thyroid Issues:						
Anemia:						
Loss of Memory:						
Heart Conditions:						
Asthma:						
Neurological Disorders:						
Blood Disorders:						
Sleep Issues:						
Additional Comments/Treatment Recommendations:						

Nutritional Screen:

	Yes	No
Have you experienced weight loss or gain of 10lbs or more in the last 6 months?		
Have you experienced difficulty with your appetite?		
Has your food intake decreased to less than 50% of "normal" intake in the last 3 months?		
Are you satisfied 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 an eating disorder?		
Do you currently suffer with or have you suffered in the past with an eating disorder?		
Additional Comments/Treatment Recommendations:		
If indicated in answers above, refer to dietary consultation if appropriate		

Pain Assessment:

Are you currently being treated for pain?
If yes, please complete the following information:
Provider Name:
Provider Phone Number:
Type of Pain:
Location of Pain:
Frequency of Pain:
Duration of Pain:
Intensity of Pain - on a scale of 1-10, 1 being the least and 10 being the greatest:
Course of Treatment:
Additional Comments:

Medical Hospitalizations:

Medical Hospitalization History:
Name of Hospital:
Year:
Length of Stay:
Reason for Hospitalization:
Name of Hospital:
Year:
Length of Stay:
Reason for Hospitalization:
Name of Hospital:
Year:
Length of Stay:
Reason for Hospitalization:
Additional Comments:

Employment History:

	Full Time	Part Time	Disabled	Laid Off	Self-Employed	Unemployed
Employment Status:						
If employed, name of current employer:						
Job History, including current:						
What skills, abilities and interests do you have in regards to employment?						
What affect has your substance abuse or mental health concerns had on your employment?						

Finances:

Source of financial support?					
	Very Poor	**Poor**	**Fair**	**Good**	**Excellent**
In general, how would you describe your financial situation?					
	Save	**Budget Towards Basic Needs**	**Other**		
What do you typically do with your money?					

Military:

	Yes	No
Do you have Military Experience?		
What branch of military?		
Type of discharge?		

Family Information:

Household Members: Please indicate below all members of your household:

Household Member Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Household Member Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Household Member Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Household Member Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Household Member Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Household Member Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				

SIGNIFICANT OTHERS: Please indicate below any significant others not listed as a household member:				
Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
Name:				
Relationship:				
Age:				
	Excellent	**Good**	**Fair**	**Poor**
Relationship Status:				
FAMILY CONCERNS: **Please indicate any family concerns below:**				
	YES	**NO**		
Alcohol Abuse:				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				
	YES	**NO**		
Substance Abuse:				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				
	YES	**NO**		
Mental Health Problems:				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				
	YES	**NO**		
Health Problems:				
	Parent	**Sibling**	**Child**	**Other**
IF yes, select all that apply:				
	Yes	**No**		
Disability:				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				

	Yes	No		
Legal Issues				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				
	Yes	**No**		
Financial Concerns:				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				
	Yes	**No**		
Deceased Family Member:				
	Parent	**Sibling**	**Child**	**Other**
If yes, select all that apply:				
Additional Comments:				

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This survey asks about how you are feeling and doing in different areas of life. Please check the box to the left of your answer that best describes yourself during the PAST WEEK. Please answer every question. If you are unsure about how to answer, please give the best answer you can.

During the PAST WEEK, how much difficulty did you have...

1. Managing your day-to-day life?

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ Quite a bit of difficulty
- ☐ Extreme difficulty

2. Coping with problems in your life?

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ Quite a bit of difficulty
- ☐ Extreme difficulty

3. Concentrating?

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Moderate difficulty
- ☐ Quite a bit of difficulty
- ☐ Extreme difficulty

During the PAST WEEK, how much of the time did you...

4. Get along with people in your family?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

5. Get along with people outside your family?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

6. Get along well in social situations?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

7. Feel close to another person?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

8. Feel like you had someone to turn to if you needed help?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

9. Feel confident in yourself?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

10. Feel sad or depressed?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

11. Think about ending your life?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

12. Feel nervous?

- ☐ None of the time
- ☐ A little of the time
- ☐ Half of the time
- ☐ Most of the time
- ☐ All of the time

During the PAST WEEK, how often did you...

13. Have thoughts racing through your head?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

14. Think you had special powers?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

15. Hear voices or see things?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

16. Think people were watching you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

17. Think people were against you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

18. Have mood swings?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

19. Feel short-tempered?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

20. Think about hurting yourself?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

During the PAST WEEK, how often...

21. Did you have an urge to drink alcohol or take street drugs?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

22. Did anyone talk to you about your drinking or drug use?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

23. Did you try to hide your drinking or drug use?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

24. Did you have problems from your drinking or drug use?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always