ARMY NATIONAL GUARD BEHAVIORAL HEALTH INTAKE - PSYCHOSOCIAL HISTORY & ASSESSMENT

Template! Template!

SECTION I - IDENTIFYING DATA

A. SPONSOR:

Name (Last, First, Middle Initial):		SSN (last 4 digits)/DoDID:	
Rank/Grade:	Date of Birth/Age:	Sex: ☐ Male ☐ Female ☐ Prefer not to answer	Today's Date:

Relationship Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Single, Intimately Involved
☐ Separated ☐ Partner/ed

Race and Ethnicity (*Check all that apply)*:
☐ American Indian or Alaska Native ☐ Hispanic or Latino ☐ Other:
☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White ☐ Middle Eastern or North African

Military Affiliation:
☐ Active Duty
☐ Family Member
☐ Retired
☐ T-32
☐ Active Guard
☐ National Guard (MDAY)
☐ Family Member of Retired Military
☐ Dual
☐ ADOS ☐ AGR
☐ Reserve

Branch of Service:
☐ Army National Guard ☐ Navy
☐ Air National Guard ☐ Marines
☐ Air Force ☐ Space Force
☐ Army ☐ Other:

Time In Service: _____ Years _____ Months

Job Description:

MOS/AOC:	Job Title:	
Unit:	Commander & 1SGs Name:	Unit Phone:
Home Address:		Home Phone:
		Work Phone:
Email Addresses:		Cell Phone:

May we leave a message? Home: ☐No ☐Yes Work: ☐No ☐Yes Cell: ☐No ☐Yes
Email: ☐No ☐Yes Other: _____

Emergency Contact Name/Relationship:	**Phone Number(s):**

B. CHILDREN:

Name (Last, First, Middle Initial)	Sex	Age / Date of Birth	Grade / School	Living with you?
	☐M ☐F	/	/	☐No ☐Yes
	☐M ☐F	/	/	☐No ☐Yes
	☐M ☐F	/	/	☐No ☐Yes
	☐M ☐F	/	/	☐No ☐Yes
	☐M ☐F	/	/	☐No ☐Yes
Are you or partner pregnant? ☐No ☐Yes	☐M ☐F	Months Pregnant:	Anticipated Birth Date:	

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

C. OTHERS LIVING IN HOME:

Name (Last, First, Middle Initial)	Sex	Age / Date of Birth	Relationship:
	☐M ☐F	/	Mother / Father / Other:
	☐M ☐F	/	Mother / Father / Other:
	☐M ☐F	/	Mother / Father / Other:
	☐M ☐F	/	Mother / Father / Other:

SECTION III - MOBILIZATION & DEPLOYMENT

Mob/ Deployment Location	Departure Date	Return Date	Combat Exposure	Combat Related Injuries
			☐ No ☐ Yes	☐ No ☐ Yes
			☐ No ☐ Yes	☐ No ☐ Yes
			☐ No ☐ Yes	☐ No ☐ Yes

The following screens should be completed by provider based on assessment/ intervention with patient.

Perceived level of threat during any deployment: High Medium Low
Explain if High or Medium:

Do you expect: ☐ MEB ☐ REFRAD ☐ ETS ☐ Return to Duty

Additional comments:

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

SECTION IV - PRESENTING PROBLEMS

A. STRESSORS *(Check all that apply)*

Marital/Relationships:
- ☐ Recent or pending divorce
- ☐ Separation
- ☐ Infidelity
- ☐ Abuse
- ☐ Frequent Conflict
- ☐ Alcohol/Drugs
- ☐ Sexual
- ☐ Death
- ☐ Birth
- ☐ Illness (EFMP)

Social:
- ☐ Loss of friend(s)
- ☐ Broken romance
- ☐ Loneliness
- ☐ Lack of Social Support
- ☐ Transportation
- ☐ Religious/Spiritual
- ☐ Neighbor/Housing
- ☐ Other (Describe)

Military:
- ☐ Deployment
- ☐ Recent Move
- ☐ Pending Move
- ☐ Job Related
- ☐ ETS/Retirement
- ☐ Chapter/ Separation
- ☐ Promotion Issues
- ☐ Weight/PT Problems

Legal:
- ☐ Letter of Reprimand
- ☐ Article 15
- ☐ Court Martial
- ☐ Arrested
- ☐ Probation/Parole
- ☐ Criminal
- ☐ Family
- ☐ Child Custody
- ☐ Protective Order
- ☐ DUI

Personal:
☐Financial ☐Mental Health ☐Illness ☐Injury
☐Physical Assault ☐Sexual Assault ☐Other: _____

Occupational:
☐Conflict with supervisor(s) ☐Discrimination ☐Other: _____
☐Excessive hours ☐Harassment
☐Fired/Relieved ☐Boring/Meaninglessness

SECTION V - BEHAVIORAL / MENTAL HEALTH

A. DEPRESSION

What is your current level of **emotional pain or distress**? Rating: _____

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Pain Free Mild Moderate Severe Totally Disabling

During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐No ☐Yes
(If "Yes," please explain)

During the past month, have you often been bothered by little interest or pleasure in doing things? ☐No ☐Yes
(If "Yes," please explain)

In the past have, you suffered any emotionally or physically traumatic event? ☐No ☐Yes
(If "Yes," please explain)

Have you experienced a recent loss (including separation / divorce)? ☐No ☐Yes
(If "Yes," please explain)

POSITIVE RESPONSES REQUIRE COMPLETION OF THE PHQ-9

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

SECTION V - BEHAVIORAL / MENTAL HEALTH (Continued)

For Provider Use Only
***All screens are to be completed by the provider**

B. SELF HARM

Are you having thoughts of **harming or killing yourself**? ☐No ☐Yes

Do you have a **plan to harm yourself** (shoot self, overdose, cut self with knife, hang self, etc.)? ☐No ☐Yes

Do you have access to a means to carry out a plan to hurt yourself (knives, rope, gun, drugs/medications, etc.)? ☐N/A ☐No ☐Yes

Have you ever tried to harm yourself? ☐No ☐Yes
(If "Yes," please explain – include history of suicide thoughts, gestures, attempts, etc.)

Are you hopeful about your future? ☐Yes ☐No

How often do you perceive you have failures in your life?
☐Never ☐Rarely ☐Occasionally ☐Frequently

Have you ever been diagnosed with a mental health condition/illness by a health care provider?
(If "Yes," please explain) ☐No ☐Yes

POSITIVE RESPONSES REQUIRE COMPLETION OF THE C-SSRS

C. MENTAL STATUS

During the past week, have you had thoughts "racing" through your head? ☐No ☐Yes

Do you believe you have special powers? ☐No ☐Yes

Do you hear voices or are you "seeing things"? ☐No ☐Yes

Do you believe that people are watching you [paranoia]? ☐No ☐Yes

POSITIVE RESPONSES TO MENTAL STATUS QUESTIONS REQUIRE FULL ASSESSMENT------

D. ANXIETY / PANIC

Do you have any problems with anxiety, "nerves" or panic attacks? ☐No ☐Yes

Have you ever experienced a sudden surge of overwhelming discomfort or extreme "anxiety" that came on without any warning or for no apparent reason? ☐No ☐Yes

Do you avoid certain people, places, conversations, or other non-combat situations because you are concerned that you may experience a sudden surge of overwhelming discomfort or "anxiety"? ☐No ☐Yes

POSITIVE RESPONSES REQUIRE COMPLETION OF THE GAD-7

E. POST TRAUMATIC STRESS

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you…

1. Have had **nightmares** about it or thought about it when you did not want to? ☐No ☐Yes
2. **Tried** hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐No ☐Yes
3. Were constantly on guard, watchful, or easily startled? ☐No ☐Yes
4. Felt numb or detached from others, activities, or your surroundings? ☐No ☐Yes

POSITIVE RESPONSES REQUIRE COMPLETION OF THE PCL-5

F. ANGER / AGGRESSION INCLUDING DOMESTIC VIOLENCE

Are you currently angry at anyone or about any situation? ☐No ☐Yes
(If "Yes," please explain)

Do you have thoughts or plans to harm or kill another person? ☐No ☐Yes
(If "Yes," please explain)

Have you recently broken objects or hurt yourself, others (emotionally, physically, sexually), or an animal due to your anger? ☐No ☐Yes

Are you currently involved in physical, emotional or sexual abuse of anyone (including family members)? ☐No ☐Yes

Do you currently have a restraining or protection order in place against you? ☐No ☐Yes

Have you ever been charged or convicted of an offense of assault, battery, or abuse? ☐No ☐Yes

Do you have weapons in your home (firearms, switchblades, knife collections, etc.)? ☐No ☐Yes

Have you recently had a relationship break-up, separation, or divorce due to you or your intimate partner's anger/aggressive behavior? ☐No ☐Yes
(If "Yes," are you in agreement with the break-up / separation / divorce?) ☐N/A ☐Yes ☐No)

G. SUBSTANCE USE

1. Have you ever felt you should cut down on your drinking? ☐No ☐Yes
2. Have people annoyed you by criticizing your drinking? ☐No ☐Yes
3. Have you ever felt bad or guilty about your drinking? ☐No ☐Yes
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? ☐No ☐Yes
Reference: Kitchens JM (1994) "Does this patient have an alcohol problem?"
5. Do you drink alcohol or use drugs to cope with stress? ☐No ☐Yes

Are you currently using any controlled or illegal substances (i.e., marijuana, cocaine, crack, stimulants, sedatives, tranquilizers, heroin, opiates, psychedelics)?
(If "Yes," please explain) ☐No ☐Yes

Are you currently misusing prescribed medications, herbal supplements/remedies, sports nutritional supplements? ☐No ☐Yes

Have you been involved in any alcohol or drug treatment? ☐No ☐Yes

Have you ever dropped out or failed any prior alcohol or drug treatment? ☐No ☐Yes

POSITIVE RESPONSES REQUIRES COMPLETION OF THE AUDIT-C

H. BEHAVIORAL / MENTAL HEALTH HISTORY

Have you ever received counseling or mental health services? ☐No ☐Yes
(If "Yes," please explain)

Diagnosis	Location	Hospitalized?	Date Treatment Began	Date Treatment Ended
		☐No ☐Yes		
		☐No ☐Yes		
		☐No ☐Yes		

Have you ever been diagnosed with: Adjustment Disorder, Depression, Bi-Polar, Anxiety, PTSD, Acute Stress Reaction or Personality Disorder? *(Circle all applicable diagnoses)* ☐No ☐Yes

For Provider Use Only

***All screens are to be completed by the provider**

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

SECTION VI - PSYCHOSOCIAL HISTORY

For Provider Use Only
***All screens are to be completed by the provider**

A. EARLY CHILDHOOD & FAMILY RELATIONSHIPS

Where were you born?

Are your parents still married to one another? ☐Yes ☐No

If they are divorced, how old were you when they divorced?

Who raised you? | Where were you raised?

How many siblings do you have?

What was it like in your childhood home? ☐Loving ☐Comfortable ☐Supportive ☐Chaotic ☐Abusive ☐Other (please describe):

Were you adopted? ☐No ☐Yes If yes, at what age?

Were you emotionally, physically or sexually abused, neglected or sexually assaulted as a child or an adult? ☐No ☐Yes

(If "Yes," please explain)

Please identify any mental health issues that seem to "run in the family" or have occurred in family members in the past:

☐Alcoholism/Drug Addiction ☐Anxiety ☐Attention Deficit Hyperactivity Disorder
☐Depression ☐Hyperactivity ☐Manic-Depression/Bi-Polar Disorder
☐Schizophrenia ☐Sexual Abuse ☐Suicide ☐Other:

Please explain any identified issues:

POSITIVE RESPONSES REQUIRES COMPLETION OF THE ACE

B. MARRIAGE & RELATIONSHIPS

Are you currently married? ☐No ☐Yes
(If "No," skip to "If not married" below)

How long have you been married?
___ Years ___ Months

Are you currently living with your spouse? ☐Yes ☐No

How many times have you been married? _____ Your Partner? _____

Date of marriage	Date of divorce or death of spouse	Reason the relationship ended

If not married, are you currently in a relationship? ☐No ☐Yes
If "Yes," how long have you been involved with that person? _____ Years _____ Months

Please rate your satisfaction with your marriage/relationship: Rating: _____

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10
Completely Satisfied Satisfied Dissatisfied

Are you experiencing any problems with your spouse or in your relationship? ☐No ☐Yes
(If "Yes," please explain)

Have past deployment(s) impacted your marriage, relationship, and family? *(If "Yes," please explain)* ☐No ☐Yes

Do you and your children feel safe from domestic abuse at home? ☐Yes ☐No

C. CHILDREN & HOME

Are you currently having any problems with your children? ☐**N/A** ☐No ☐Yes
(If "Yes," please explain)

☐Abuse / Neglect ☐Behavior ☐Illness / Disability / EFMP
☐Child Care ☐School Problems ☐Special Issues
☐Parenting / Nurturing ☐Mental Health
☐Other: _____

Have you, your family or a person you are currently in a relationship with ever been to counseling or had involvement with any agency such as Child Protective Services or Family Advocacy due to physical, sexual, or emotional abuse or neglect? *(If "Yes," who participated in the counseling; please explain)* ☐No ☐Yes

Are you involved in the care of any family member for illness or otherwise? ☐No ☐Yes
(If "Yes," please explain)

D. EDUCATION

Highest level of education completed: ☐ Elementary ☐ Junior High ☐ High School
☐ Technical School ☐ Some college ☐ 2-Year college degree
☐ 4-Year college degree ☐ Graduate school ☐ Other:

If you did not graduate from high school, did you get your GED? ☐**N/A** ☐Yes ☐No

Did you repeat any grades? ☐No ☐Yes
(If "Yes," please explain)

Were you ever in special education classes or did you have a learning disability? ☐No ☐Yes
(If "Yes," please explain)

Did you have any disciplinary problems in school? ☐No ☐Yes

Were you ever suspended or expelled? ☐No ☐Yes
(If "Yes" to either question, please explain)

E. FINANCIAL

Do you currently have any financial problems? ☐No ☐Yes
(If "Yes," please explain)

Are you currently having any of the following problems? *(Select all that apply)*
☐Garnished wages ☐Filed bankruptcy ☐Bounced checks
☐No money for food ☐Late on payments or loans
☐Item repossession ☐Disciplined for debts or bad checks
☐Having "no pay due" ☐Pawning items to make ends meet
☐Other:

Do you need a referral to an agency for financial assistance/counseling? ☐No ☐Yes

For Provider Use Only

***All screens are to be completed by the provider**

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

F. ENVIRONMENT / SUPPORT SYSTEMS

Do you have good social support systems (friends, family, neighbors, co-workers, organizations, etc.)? List your support systems: ☐Yes ☐No

Are you having trouble in your relationships with family or friends? ☐No ☐Yes

Do those surrounding you have sufficient knowledge about your condition? ☐Yes ☐No

Do you have adequate housing or a place to live? ☐Yes ☐No

Who do you rely on for help with problems? (e.g. family, friends, extended family)
Names:

Services you are currently receiving:

☐Alcohol and Drug ☐Army Community Services ☐Chaplains ☐Child Care/CYS
☐Child and Adolescent Counseling ☐Child Protective Services ☐Community Health Nurse
☐Community Mental Health ☐Court Mandated Counseling ☐English as a Second Language
☐Family Readiness Group ☐Family Member Employment Assistance Program
☐Legal Services ☐Marriage and Family Counseling ☐New Parent Support Program
☐Respite Care ☐School Counselor ☐Social Work Service
☐Special Needs Assistance Program (SNAP) ☐Tri-Care (Counseling/Psychiatric Care)
☐Use of Shelter ☐Victim Advocate ☐Others:

G. EMPLOYMENT

Are there any problems with your civilian or military job? ☐No ☐Yes
(If "Yes," please explain)

Do you need a referral for civilian employment or vocational rehabilitation? ☐No ☐Yes

If Reservist or National Guard, what is your civilian occupation?

Are you returning to your job? ☐Yes ☐No
(If "No," please explain)

What are your plans:
☐Stay in and re-enlist ☐Stay in until my ETS
☐Get out ASAP with a good discharge ☐Get out ASAP with any discharge
☐I don't know right now ☐Other: _____

Partner's Occupation:
Length of Employment: _____ Years _____ Months
If unemployed, how long since last employment: _____ Years _____ Months

H. LEGAL

Do you presently have any legal problems? ☐No ☐Yes
(If "Yes," please explain)

Have you ever had any administrative or legal action taken against you?
☐No ☐Yes *(If "Yes," please select all that apply)*
☐Letter of Reprimand ☐Article 15 ☐Court Martial ☐Chapter ☐Arrest ☐DUI
☐Other: _____ Reason for action:

For Provider Use Only
***All screens are to be completed by the provider**

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

I. LEISURE AND RECREATION

Please list activities which you enjoy or have enjoyed in the past, including hobbies, volunteer work, sports, etc.

J. SPIRITUAL AND CULTURAL

What is your religious or spiritual affiliation?

Are you an active participant with your religious/spiritual affiliation? ☐Yes ☐No

What is your cultural affiliation/heritage (i.e., American Indian, Asian, Irish, Hispanic, etc.)?

Do you have any religious or spiritual practices that the provider needs to be aware of during treatment? *(If "Yes," please explain)* ☐No ☐Yes

SECTION VII - HEALTH HISTORY

A. PHYSICAL HEALTH

How would you describe your physical health? ☐Excellent ☐Good ☐Fair ☐Poor

Current medical treatment: ☐None ☐Inpatient
☐Outpatient w/out Follow-up ☐Outpatient with Follow-up

MEDICAL HISTORY: List any medical conditions you have or have had:

Medical Diagnosis	Diagnosis Date	Treatment Completion Date	Provider

Were any of these illnesses/injuries combat or deployment related? ☐No ☐Yes
(If "Yes," where and when?)

What physical limitations do you have as a result of your illness/injury(s)?

B. MEDICATIONS

List ***ALL*** medications, over-the-counter or herbal supplements/remedies you are currently using, the dosage and the prescribing provider, if applicable: ☐**N/A**

Medication	Dosage	Prescribing Provider

Are you currently taking your prescribed medications as prescribed? ☐N/A ☐Yes ☐No
(In "No," please explain):_____

Are you satisfied with how your medications are working? ☐Yes ☐No
(If "No," please explain): _____

For Provider Use Only

***All screens are to be completed by the provider**

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

C. TRAUMATIC BRAIN INJURY (TBI) & CONCUSSION

Did any injury received while you were deployed result in being dazed, confused or "seeing stars", not remembering the injury, losing consciousness (knocked out), having symptoms of concussion (headaches, dizziness, memory problems, balance problems, ringing in ears, irritability, sleep problems, etc.)? ☐No ☐Yes

Did you have any **concussions or open or closed head injuries** during deployment? ☐No ☐Yes

Have you had a **previous history of a TBI or concussion**? ☐No ☐Yes

D. PAIN

Are you experiencing physical pain today? (*If "Yes," please explain)* ☐No ☐Yes

Please rate the severity of your pain: Rating Injury/Illness #1:_____ Rating Injury/Illness #2:_____

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

Pain Free Mild Moderate Severe Totally Disabling

If you have physical pain, are you being treated for that pain? ☐N/A ☐Yes ☐No

(If "Yes," where or by whom?)

E. SLEEP

Are you experiencing difficulty sleeping? ☐No ☐Yes

(If "Yes," please explain) ☐Falling Asleep ☐Staying Asleep ☐Waking During Sleep

Are you taking medications (over-the-counter or prescribed) to help you sleep? ☐No ☐Yes

F. NUTRITION

Have you ever had problems with your weight or eating habits? ☐No ☐Yes

(If "Yes," please explain – include weight gain and loss and body image issues)

Have you ever had problems with binge eating or compulsive overeating, or purging (making yourself vomit or using laxatives to excess)? ☐No ☐Yes

(If "Yes," please explain)

SECTION VIII - ADDITIONAL INFORMATION

Please use this space to document any information you feel is relevant:

For Provider Use Only

***All screens are to be completed by the provider**

If "**NO**," refer for pain management, if needed

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

ASSESSMENT TOOLS

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

To be completed by Patient

ALCOHOL USE

Date: _____

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT-C)

1. How often did you have a drink containing alcohol **in the past year**?

_____ Never

_____ Monthly or less

_____ 2 - 4 times a month

_____ 2 - 3 times per week

_____ 4 or more times per week

2. How many drinks containing alcohol did you have on a typical day when you were drinking **in the past year**?

_____ 0

_____ 1 - 2

_____ 3 - 4

_____ 5 - 6

_____ 7 - 9

_____ 10 or more

3. How often did you have 6 or more drinks on one occasion **in the past year**?

_____ Never

_____ Less than monthly

_____ Monthly

_____ Weekly

_____ Daily or almost daily

OFFICE
USE
ONLY:

REFERENCE: Bush K, Kivlahan DR, McDonell MB, et al (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Arch Intern Med. 158:1789-95.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

For **Provider Use Only**

AUDIT-C CHECKLIST SCORING

Instrument: AUDIT-C Questionnaire

Description:
The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument that reliably identifies persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

The AUDIT-C has 3 questions and is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices valued from 0 points to 4 points. In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive. Generally the higher the score, the more likely it is that a person's drinking is affecting his or her safety.

The AUDIT-C is a modified version of the 10-item Alcohol Use Disorders Identification Test developed by the World Health Organization and published in 1998. The AUDIT-C is available for use in the public domain.

Reference: Bradley KA, Bush KR, Epler AJ, et al (2003). Two brief alcohol-screening tests From the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female Veterans Affairs patient population. Arch Intern Med. 163:821-9.

Source: https://cde.nida.nih.gov/instrument/f229c68a-67ce-9a58-e040-bb89ad432be4

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

For Provider Use Only

ACE QUESTIONNAIRE SCORING

Adverse Childhood Experience (ACE) Questionnaire for Adults

Administering, Scoring, and Interpreting the ACE

The questionnaire begins with the following statement: While you were growing up, during your first 18 years of: Did you …. The answer choices are Yes or No. Each affirmative answer (Yes) is assigned 1 point. ACE score is determined by adding up all the points.

An ACE Score of 0 suggest that the person reported no exposure to childhood trauma. An ACE Score of 10 suggests that the person reported exposure to childhood trauma. The higher the ACE Score, the greater the likelihood that a person will develop one or more of the following health problems: ischemic heart disease, cancer, chronic bronchitis or emphysema, hepatitis or jaundice skeletal fractures, diabetes, smoking, sexually transmitted diseases , depression, etc.

Reference: Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., Steele, H. (2014). Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships. Child Abuse & Neglect, 38(2), 224-233.

Source: https://med.fsu.edu/childStress/measures#:~:text=Administering%2C%20Scoring%2C%20and%20Interpreting%20the%20ACE&text=The%20answer%20choices%20are%20Yes,no%20exposure%20to%20childhood%20trauma.

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 circle one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month**.

Your worst event:_____

	In the past MONTH, how much were you bothered by	Not at all	A little Bit	Moderately	Quite a bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2	Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8	Trouble remembering important parts of the stressful experience?	0	1	2	3	4
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)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13	Feeling distant or cut off from other people?	0	1	2	3	4
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being "superalert" or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

REFERENCE: Blevins CA, Weathers FW, Davis MT, Witte TK, Domino JL. The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and Initial Psychometric Evaluation. J Trauma Stress. 2015 Dec;28(6):489-98. doi: 10.1002/jts.22059. Epub 2015 Nov 25. PMID: 26606250.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

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PTSD CHECKLIST SCORING

How is the PCL-5 scored and interpreted?

Respondents are asked to rate how bothered they have been by each of 20 items in the past month on a 5- point Likert scale ranging from 0-4. Items are summed to provide a **total severity** score (range = 0-80).

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

The PCL-5 can determine a **provisional** diagnosis in two ways:

- Summing all 20 items (range 0-80) and using a cut-point score of 31-33 appears to be reasonable based upon current psychometric work. However, when choosing a cutoff score, it is essential to consider the goals of the assessment and the population being assessed. The lower the cutoff score, the more lenient the criteria for inclusion, increasing the possible number of false-positives. The higher the cutoff score, the more stringent the inclusion criteria and the more potential for false-negatives.
- Treating each item rated as 2 = "Moderately" or higher as a symptom endorsed, then following the DSM-5 diagnostic rule which requires at least: 1 Criterion B item (questions 1-5), 1 Criterion C item (questions 6-7), 2 Criterion D items (questions 8-14), 2 Criterion E items (questions 15-20). In general, use of a cutoff score tends to produce more reliable results than the *DSM-5* diagnostic rule.

If a patient meets a provisional diagnosis using either of the methods above, he or she needs further assessment (e.g., CAPS-5) to confirm a diagnosis of PTSD.

There are currently no empirically derived severity ranges for the PCL-5.

How might the PCL-5 help my patients?

Treatment Planning

When given at an intake or assessment session, the PCL-5 may be used to help determine the appropriate next steps or treatment options. For example:

- A total score of 31-33 or higher suggests the patient may benefit from PTSD treatment. The patient can either be referred to a PTSD specialty clinic or be offered an evidence-based treatment for PTSD such as Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), or Eye Movement Desensitization and Reprocessing (EMDR).
- Scores lower than 31-33 may indicate the patient either has subthreshold symptoms of PTSD or does not meet criteria for PTSD, and this information should be incorporated into treatment planning.

http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

Columbia Protocol

Always ask questions 1	**Past**	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask	**Life-Time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		**High Risk**

988 SUICIDE & CRISIS LIFELINE

Reference: Columbia Lighthouse Project (2016) Columbia Protocol. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Download Columbia Protocol app

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

For Provider Use Only

Columbia Protocol Scoring

Columbia Suicide Severity Rating Scale

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help:

Call or text 988, call 911 or go to the emergency room.

STAY WITH THEM until they can be evaluated.

Reference: Columbia Lighthouse Project (2016) Columbia Protocol. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

Generalized Anxiety Disorder 7-Item (GAD-7) Scale

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

	Not difficult	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? *(Place a "✓" in the applicable box)*				

Reference: Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092-7.

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PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7)SCALE

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

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Reference: Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092-7.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

Patient Health Questionnaire (PHQ-9)

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 or staying asleep, or 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 are a failure or have let yourself of 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	0	1	2	3

	Not difficult	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
10. 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? *(Place a "✓" in the applicable box)*				

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.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

To be completed by Patient

DEPRESSION SCALE - PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

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
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 or staying asleep, or 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 are 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
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. 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 _____

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PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

DEPRESSION SCALE - PHQ-9
SCORING

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

Insomnia Severity Index

For each question, please circle the number that describes your answer.

Please rate the **CURRENT** *(i.e. last 2 weeks)* severity of your insomnia problems

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty Sleeping	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

	Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
4. How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?	0	1	2	3	4

	Not at all	A little	Somewhat	Much	Very Much
5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?	0	1	2	3	4
6. How WORRIED / DISTRESSED are you about your current sleep problem?	0	1	2	3	4
7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, etc.) CURRENTLY?	0	1	2	3	4

Office Use Only

Source: Bastien, C. H., Vallières, A., & Morin, C. M. (2001). Validation of the insomnia severity index as an outcome measure for insomnia research. Sleep Medicine, 2 , 297–307.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**LAST 4 OF SPONSOR SSN/DoDID**:

Insomnia Severity Index Scoring

Guidelines for Scoring/Interpretation:

0 - 7	No clinically significant insomnia
8 - 14	Subthreshold insomnia
15 - 21	Clinical insomnia (moderate severity)
22 - 28	Clinical insomnia (severe)

Source: Bastien, C. H., Vallières, A., & Morin, C. M. (2001). Validation of the insomnia severity index as an outcome measure for insomnia research. Sleep Medicine, 2 , 297–307.

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