General Adult Pre-Evaluation Form

320 Rolling Ridge Dr., Suite 100
State College, PA 16801
814.867.0670 | (fax) 814.867.7616
www.forabrighterfuture.com

SUNPOINTE HEALTH

For a Brighter Future

Today's Date: _____

PRE-EVALUATION FORM

This form may take some time but it will better help your provider understand the frequency and severity of your symptoms at your first appointment. Don't forget the screening questionnaires at the end of the form (PHQ-9, Generalized Anxiety Disorder GAD-7, and Drug and Alcohol screenings).

NAME: _____ **MARITAL STATUS:** Single Married Divorced

DOB: _____ **AGE:** _____ **GENDER:** _____ Partnered Separated

REASON FOR APPOINTMENT

☐ I self-referred for an appointment
☐ I was referred by _____

PRIMARY CONCERN—List the reasons or concerns that brought you to the clinical today: (mood, anxiety, attention issues, etc.)

1. _____
2. _____
3. _____

What led to your decision to seek help now? Do you have other comments for your provider?

_____

_____

SAFETY CONCERNS—Please explain any YES Answers:

Do you have thoughts of hurting yourself or others?	**YES**	**NO**
Do you engage in any self-harm such as cutting or burning?	**YES**	**NO**
Do you have problems with hallucinations (hearing or seeing things)?	**YES**	**NO**
Do you feel paranoid (like others are out to get you)?	**YES**	**NO**
Do you experience thoughts others may think are unusual bizarre?	**YES**	**NO**

If Yes,describe:_____

_____

Family structure/Social supports—Please tell us about the important people in your life.

Name	DOB	Relation to you (spouse, child…)	Living where? Relationship?

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Past Psychiatric Medication ***(continue on an additional sheet of paper if more space is needed)***

Medication	Dosage	Duration	Diagnosis	List any Side effects or Benefits of the Med and Reason for Stopping

Indicate if at **any time in your life you:**

	None		Saw a physician for a mental health problem
	Saw a school counselor		Were given medication for a mental health problem
	Saw a chaplain/spiritual leader for counseling		Had a substance abuse evaluation or treatment
	Saw a psychologist, social worker, or other counselor		Had Residential or Group Home Placement
	Marital Counseling		Attempted suicide
	Hospitalization for Emotional Problems		Other (list please)

Please list dates, Places, and reasons for any treatment/evaluation below--include mental health hospitalizations and rehab stays.

_____

_____

_____

MEDICAL HISTORY

Medical condition	**SELF**	Mother	Father	Sibling (list brother or sister)	Mother's side	Father's side
Anxiety						
Bipolar disorder						
Heart Disease						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Obesity						
Heart Defect						
Sudden death/arrthymia						
Suicide attempts						
ADHD						
Alcoholism						
Drug Abuse/Addiction						
Learning disability						
Legal Problems						
Schiozphrenia						
Stroke						
OCD						
PTSD						
Eating disorder						
Other: list below						

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Please list major surgeries_____

_____

Females Only:

Date of Last Menstrual Period _____ Are your cycles regular? **Yes / No** Are you Pregnant? **Yes / No**

What Form of birth control do you currently use? _____

Do you have bothersome mood symptoms prior to your period? _____

Allergies

Are you allergic to any medications, foods, or other substance (e.g., latex)? YES NO

Substance:	Allergic Response:
Substance:	Allergic Response:
Substance:	Allergic Response:

Current Medications *List any medications you are currently taking (including over-the-counters, aspirin, laxatives, birth control pills, and alternative or herbal medicines) (continue on an additional sheet of paper if more space is needed)*

Medication	Dosage	When and how long?	For what condition?

Review of Symptoms

Are you currently having or have you had problems with: *(Check any physical symptoms that apply)*

General well-being
__ Fever
__ Weight loss (>10#)
__ Weight gain (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Eye symptoms
__ Visual Changes

Ears, Nose, Mouth & Throat
__ Hearing loss
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Dizziness
__ Nasal congestion
__ Nosebleeds
__ Sinus problems
__ Difficulty swallowing
__ Sore throats

Respiratory
__ Chronic cough
__ Shortness of breath
__ Snoring
__ Wheezing

Cardiovascular
__ Chest pain
__ Irregular heartbeat
__ Heart murmur
__ Exercise Intolerance
__ Low blood pressure
__ Arm and leg swelling

Gastrointestinal
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Constipation
__ Diarrhea

Hematologic/ Lymphatic
__ Anemia
__ Easy bleeding / bruising
__ Swollen glands

Genitourinary/Breast
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Irregular menstrual cycles
__ Unusual breast enlargement/tenderness
__ Leakage from nipple

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Memory problems
__ Concentration problems

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Neurologic continued
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Excessive sweating

Immunologic
__ Frequent colds / infections

Skin
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles

Musculoskeletal
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain

SOCIAL & DEVELOPMENTAL HISTORY

Relationships:

1. If you are currently in a relationship, how long have you been in this relationship? _____
2. Total number of marriages: _____What year(s) were you married? _____
3. How satisfied are you with current family life? **Very unsatisfied** **Unsatisfied** **Satisfied** **Very satisfied**
4. Are you experiencing any family problems or problems at home?

   _____
5. Who do you talk to about your problems/turn to for support? _____
6. How satisfied are you with this support? **Very unsatisfied** **Unsatisfied** **Satisfied** **Very satisfied**

Childhood:

1. How many siblings do you have?_____ What number in the birth order are you? _____(e.g. I am the 2nd of 4 children)
2. My Childhood was: **Normal** **Abusive** **Dysfunctional** **Rough** **Other:**_____
3. Where did you grow up? _____
4. Who raised you?_____
5. Describe your current relationship(s) with your parents & siblings:_____

_____

Home Environment:

Do you have guns in your home? **Yes / No** Do you have access to weapons otherwise? **Yes / No**

Education

What is the highest education you have completed? **GED** **High School** **Some College** **Bachelor's** **Graduate Degree**
When did you complete each? _____ _____ _____ _____ _____
Please list any learning problems or disciplinary concerns_____

_____

Occupation

1. What is your work status? *Circle most applicable*
   Employed **Not Employed by Choice** **Unemployed** **Short Term Disability** **Long Term Disability**
   If employed, what is your current job? _____
   How long have you been there? _____
   How satisfied are you with your current job? **Very unsatisfied** **Unsatisfied** **Satisfied** **Very satisfied**
2. Has your current problem/concern affected your work? **Yes / No**
   Have you received any disciplinary action at work? **Yes / No**
   If yes, please explain:_____
3. Work History
   How many jobs have you held in the last 5 years ? _____ How many jobs have you EVER been fired from?_____

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Past jobs, duration and reasons for leaving, etc.: _____

_____

_____

4. Have you ever served in the military? **Yes / No**

If So, what Branch? **US Army US Navy US Marine Corps US Air Force US Coast Guard National Guard**

Dates of Service: _____

Job/Role: _____ Highest rank: _____

Type of Discharge: **Regular/Honorable Dishonorable Medical Psychiatric General Other**

Religion and Spirituality

Do you consider yourself religious or spiritual? **Yes / No**

If yes, please describe. _____

Legal/Financial

Are you currently experiencing any legal difficulties? **Yes / No**

If yes, please explain: _____

Are you currently experiencing any financial difficulties? **Yes / No**

If yes, please explain: _____

Trauma History

Indicate if you experienced any of the following at **any time in your life:**

	None		Experienced domestic violence		Natural disaster
	Verbal abuse		Witnessed domestic violence		Unhappy childhood
	Physical abuse		Rape		Death of parent
	Emotional abuse		Miscarriage		Death of a child
	Sexual abuse/assault		Abortion		Death of someone close
	Witnessed physical abuse		Crime victim		Filed for bankruptcy
	Witnessed emotional abuse		War		Teased by peers
	Witnessed sexual abuse		Poverty		Other:

If yes, please describe. _____

_____

Are you currently experiencing any physical, sexual, or emotional abuse? **Yes / No**

If yes, please describe _____

Personal Habits

Caffeine/Tobacco

Do you use caffeinated products (e.g., coffee, tea, soda, tablets, energy drinks)? **Yes / No**

If yes, what kind? _____

How much (e.g., servings per day)? _____

Do you use tobacco products? **Yes / No**

If yes, what kind? _____

How much (e.g., # per day)? _____

For how many years? _____

Hobbies/Leisure Activities

List a few activities that you enjoy or that help you to relax: _____

_____

ADDITIONAL INFORMATION OR CONCERNS:

_____

_____

Thank you for taking the time to complete this pre-evaluation form.

PATIENT HEALTH QUESTIONNAIRE
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle the number 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 hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	____ +	____ +	____ +	____
				= 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 _____

Please use this space to give details about any of the questions above. List the question number and your explanation:

_____

_____

_____

GAD-7

	Over the **last 2 weeks**, how often have you		**Several**	**More than**	**Nearly every**
	been bothered by the following problems?	**Not at all**	**Days**	**half the**	**day**
	Circle the number for your answer			**days**	
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 is 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
	For office coding: 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 ____

Please use the following space to give details about any of the questions above. List the question number and your explanation

AUDIT-C QUESTIONNAIRE – PAGE 1

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2–4 times a month
- 2–3 times a week
- 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

3. How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

AUDIT-C QUESTIONNAIRE – PAGE 2

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the past year
- Yes, during the past year

Please use the lines below to further explain any of the answers given above. Please reference the question number when giving your explanation.

_____

_____

_____

_____

_____

_____

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs **excluding alcohol and tobacco** during the past 12 months. Carefully read each statement and decide if your answer is "NO or "YES". Place an "X" in the appropriate column.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants, (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin. Remember that the questions do not include alcohol or tobacco.

Please answer every questions. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months	**NO**	**YES**
1. Have you used drugs other than those required for medical reasons?	___	___
2. Do you abuse more than one drug at a time?	___	___
3. Are you always able to stop using drugs when you want to?	___	___
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
5. Do you ever feel bad or guilty about your drug use?	___	___
6. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
7. Have you neglected your family because of your use of drugs?	___	___
8. Have you engaged in illegal activities in order to obtain drugs?	___	___
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	___	___
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___

Please use the lines below to further explain any of your answers given above. Please reference the question number with your explanation.

_____
_____
_____
_____
_____
_____