MH Adult Assessment

MHC: **Pat Name:** **DOB:**

Complete Date: **Start Date:** **Current Date:**

Main concern(s)/complaint(s) as expressed by the client/patient (symptoms and functional impact):

History of present difficulties:

Screening for:

☐ Depression **Patient Health Questionnaire for Depression (PHQ-9)**

	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
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	☐	☐	☐	☐

9a. Has there been any time in the last 4 weeks when you have had serious thoughts about killing yourself?

☐ Yes ☐ No

9b. Have you ever deliberately hurt yourself or made a suicide attempt?

☐ Yes ☐ No

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

PHQ9-TOTAL:

☐ Mania

How often DURING YOUR LIFE TIME have you been periods of time FOR AT LEAST A WEEK when...	(0) Never	(1) Rarely	(2) Some-times	(3) Often	(4) Very often	Mania total
1. You talked almost constantly?	☐	☐	☐	☐	☐	
2. You were extremely active and productive?	☐	☐	☐	☐	☐	
3. You felt so high or irritable you might lose control?	☐	☐	☐	☐	☐	
4. You had too much energy to be able to concentrate?	☐	☐	☐	☐	☐	

☐ Anxiety

Panic Disorder [PD]:

Yes No

☐ ☐ *Have you ever had a spell or attack where all of a sudden you felt frightened, anxious, or uneasy?*

☐ ☐ *Ever had a spell or attack when for no reason your heart began to race, you felt faint or nauseous or could not catch your breath?*

Generalized Anxiety Disorder [GAD] (If answer is yes, can follow these questions with GAD -7):

Yes No

☐ ☐ *Have you been bothered by nerves or feeling anxious or on edge for at least 6 months?*

☐ ☐ *Do you worry excessively and have trouble stopping or controlling the worry?*

☐ ☐ *Would people describe you as "a worrier"?*

Social Anxiety Disorder [SAD]:

Yes No

☐ ☐ *Have you had a problem being anxious or unconfortable around people?*

☐ ☐ *Does fear of embarrassment cause you to avoid doing things or speaking to people?*

☐ ☐ *Is being embarrassed or looking stupid among your worst fears?*

Obsessive Compulsive Disorder [OCD]:

Yes No

☐ ☐ *Do you experience unwanted recurrent and intrusive thoughts that cause anxiety but you cannot control? (e.g., thoughts about contamination, doubts about your actions, aggressive thoughts, etc.)*

☐ ☐ *Do you perform repetitive behaviours (or mental acts) in order to decrease the anxiety generated by the obsessions? (e.g., checking, washing, counting, or repeating)*

GAD-7 Screening Questions

	During the last 2 weeks, how often have you been bothered by the following problems?	not at all	several days	more than 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 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

Total Score: _______ = Add columns: _____ + _____ + _______

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
☐	☐	☐	☐

Post-traumatic Disorder [PTSD]:

Yes No

☐ ☐ *Have you had recurrent dreams or nightmares of trauma, or avoidance of trauma reminders?*

☐ Trauma

☐ *Physical (accidents, injury, abuse, violence)*

☐ *Sexual*

☐ *Witness*

☐ *Safety Risk Assessment (Suicide, homicide, abuse = self/children)*

☐ Substance use

In the last three months:

Yes No

☐ ☐ *Have you had 5 or more drinks on any one occasion?*

☐ ☐ *Have you used a drug (including marijuana)?*

☐ ☐ *Have you used more prescription medication than directed by your doctor?*

☐ ☐ *Over the past twelve months …"I was often intoxicated or suffering after effects of drinking during my work, childcare, or school responsibilities, or I put myself and other persons at risk (e.g. by impaired driving)."*

☐ Other Mental Health Concerns:

Mental Health History

Family Mental Health History

Relevant Medical Conditions