GroupWorks Wellness and Recovery Services

Name of Client: ______________ ______ ________________________ Date of Birth:______________________ Age:______
First Name M. I. Last Name

Former/maiden name: ______________________ SSN#______________________ Name Preference: ____________

Birth Gender: ☐ Male ☐ Female Gender Identity: ______________________ Pronoun Preference: ________________

Mailing Address: ______________________________________ ____________________________ ______ _____
address where you receive your mail city state zip code

Physical Address:______________________________________ ____________________________ ______ _____
address where you live city state zip code

County of Residence:__________________________________Home #___________________ Cell#___________________

Do you have difficulty with reading or writing? ☐ Yes ☐ No Name of person completing form:________________________

Employer:____ Occupation:____________________________________

Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married

Education: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ GED ☐ College/Vocational 1 2 3 4 5 6 Degree ____________

Race: ☐ White ☐ Black/African American ☐ Native American/Alaskan
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino

Client Lives: ☐ Alone ☐ With immediate family ☐ With extended family ☐ With non-related

Client lives in: ☐ Private Residence (home/apartment) ☐ Shelter/Homeless ☐ Other Residential Setting
☐ Correctional Facility ☐ Other institution setting ☐ Other ________________

Are you a Veteran? ☐ No ☐ Yes Date of discharge______________________

Is the reason you are wishing to be seen at GroupWorks military related? ☐ Yes ☐ No

Have you had a diagnostic assessment completed within the past year at another mental health agency? ☐ Yes ☐ No

If yes, please tell us the name of the agency ____

Who referred you to GroupWorks? ____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No If yes, please tell us

Who ____________________________ Office ____

People living in the same household:

____
Name Age Relationship M/F Employer Phone

____
Name Age Relationship M/F Employer Phone

____
Name Age Relationship M/F Employer Phone

____
Name Age Relationship M/F Employer Phone

____
Name Age Relationship M/F Employer Phone

In case of emergency, who may we contact

_____________________________ _______________________ ___________________________
Name relationship to you phone number

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WHODAS 2.0

Name: ____________________________ Chart#: _________ Date: _________________

This questionnaire asks about difficulties due to health conditions. Health conditions include disease or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please X only one response.

In the past 30 days, how much difficulty did you have in:	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or cannot do**
S1. Standing for long periods like 30 minutes	☐	☐	☐	☐	☐
S2. Taking care of your household responsibilities	☐	☐	☐	☐	☐
S3. Learning a new task like how to get a new place	☐	☐	☐	☐	☐
S4. Joining in community activities	☐	☐	☐	☐	☐
S5. Being emotionally affected by your health problems	☐	☐	☐	☐	☐
S6. Concentrating on doing something for 10 minutes	☐	☐	☐	☐	☐
S7. Walking a long distance – like half a mile	☐	☐	☐	☐	☐
S8. Washing your whole body	☐	☐	☐	☐	☐
S9. Getting dressed	☐	☐	☐	☐	☐
S10. Dealing with people you do not know	☐	☐	☐	☐	☐
S11. Maintaining a friendship	☐	☐	☐	☐	☐
S12. Your day-to-day work	☐	☐	☐	☐	☐
TOTAL number of Xs in each column	_____	_____	_____	_____	_____

H1. In the past 30 days, how many days were these difficulties present #of DAYS ___________

H2. In the past 30 days, how many days were you totally unable to carry out your usual activities or work because of any health condition? #of DAYS ___________

H3. In the past 30 days, not counting the days that you were totally unable, how many days did you cut back or reduce your usual activities or work because of any health condition? #of DAYS ___________

Clinical Notes: ____

____

Reviewed by: ___________________________________ Date: _______________________

Client name:_______________________________________ DOB:________________ Today's Date:________________

PHQ - 9 Depression Assessment

Over the past 2 weeks, how often have you been bothered by any of the following problems?
Circle the number under the correct answer heading for each question.

	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 family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	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. Thought that you would be better off dead or hurting yourself in some way	0	1	2	3
Total Score of each column	______	______	______	______

If you checked 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 ☐

PHQ-9 Score	Depression Severity
1 to 4	None
5 to 9	Mild
10 to 14	Moderate
15 to 19	Moderately Severe
20 to 27	Severe

Total of all columns ________________

Clinical Notes: ____

____

Reviewed by: ________________________________ Date: ______________________

Client name:________________________________ DOB:______________ Today's Date:______________

Substance Use Screening Tool

Name: ______________________________ Chart#: __________ Date: __________________

Alcohol: Age at first time used ____________ Age at first used to intoxication___________
Last used ____________ Last used to intoxication ____________
What? How often? How much?____
____

Marijuana: Age at first time used ____________ Age at first used to intoxication___________
Last used ____________ Last used to intoxication ____________
How often? How much?____
____

Other drugs: Please list ____
Age at first time used ____________ Age at first used to intoxication___________
Last used ____________ Last used to intoxication ____________
What? How often? How much?____
____

Have you ever abused over the counter medications, a prescription medication in your name or a prescription medication in someone else's name? ☐ YES ☐ NO

CageAid

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ YES ☐ NO
2. Have people annoyed you by criticizing your drinking or drug use? ☐ YES ☐ NO
3. Have you ever felt bad or guilty about your drinking or drug use? ☐ YES ☐ NO
4. Have you ever had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves or get rid of a hangover? ☐ YES ☐ NO

Do you drink caffeinated beverages? ☐ YES ☐ NO

What? __________________ How often? ______________ How much? ______________

Clinical Notes: ____
____
____
____

Reviewed by: ____________________________________ Date: __________________________

Nicotine dependence screen

Name: ____________________________ Chart#: _________ Date: _________________

For the purpose of this screen, nicotine includes cigarettes, chewing tobacco, e-cigarettes, cigars, pipes, vapes, etc.

Do you use nicotine? ☐ **No** ☐ **Yes** If you answered YES, please complete this screen

1. How soon after you wake up do you use nicotine? (Circle score)
   - Within 5 minutes 3
   - 6–30 minutes 2
   - 31–60 minutes 1
   - After 60 minutes 0
2. Do you find it difficult to refrain from using nicotine in the places where it is forbidden (e.g., in church, at the library, in cinema)?
   - Yes 1
   - No 0
3. Which use of nicotine would you hate most to give up?
   - The first one in the morning 1
   - Any other 0
4. How many times do you use nicotine in a day?
   - 10 or less 0
   - 11–20 1
   - 21–30 2
   - 31 or more 3
5. Do you use nicotine more frequently during the first hours after waking than during the rest of the day?
   - Yes 1
   - No 0
6. Do you use nicotine when you are so ill that you are in bed most of the day?
   - Yes 1
   - No 0

Total Score: _____________

Scores: 1-2 = very low dependence 3-4 = low dependence 5 = moderate dependence
6-7 = high dependence 8+ = very high dependence

This is a modified version of The Fagerstrom Test for Nicotine Dependence.

Clinical Notes: ____

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Reviewed by: ___________________________________ Date: ________________________

Client name:____ DOB:______________ Today's Date:_______________

General Anxiety Disorder 7-item (GAD-7) Scale

Name: ____________________________ Chart#: _________ Date: _________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?
Circle the number under the correct answer heading for each question.

	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'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
Total Score of each column	______	______	______	______
			Total of all columns	______

If you checked 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 ☐

Scoring Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.

Clinical Notes: ____

____

Reviewed by: ________________________________ Date: _____________________

Order for protection and restraining order policy (Please read and sign):
In order to ensure the safety of our clients and clinicians, it is mandatory that we be informed and provided copies of any current or future Orders for Protection and/or Restraining Orders concerning our clients. We are further bound to comply with existing OFP's and Restraining Orders. I understand and will comply with the GroupWorks policy concerning disclosure of restraining orders.

____ ________________________
Signature of client (or client's guardian) **Date**

Is there currently an Order for Protection (OFP) or Harassment Order in place from any state regarding a member of your household?

☐ Yes ☐ No If yes, name of family member ______________________________

Name of other party involved ______________________________

Expiration Date of Order ______________________________

CHECKLIST OF CONCERNS

Describe what changes in your life you are seeking by coming to GroupWorks:

____

Please mark all of the items below that apply to you. Circle the one that is most important.

☐ Marital/family problems
☐ Social/interpersonal (not family) problems
☐ Coping with daily roles
☐ Medical/physical symptoms
☐ Depression
☐ Attempt, threat, danger of suicide
☐ Alcohol/drugs
☐ Court evaluation referral
☐ Program entrance evaluation
☐ Eating disorder
☐ Anxiety
☐ Abuse/assault victim
☐ Sexual abuse/rape victim
☐ Child behavior problems
☐ Major mental illness
☐ Psychiatric medication
☐ Other ______________________________
☐ Perpetrator of sexual abuse
☐ Anger management
☐ Gambling
☐ Stress
☐ Codependency issues
☐ ADD/ADHD

Please continue checking all items that apply to you:

☐ Aggression, violence
☐ Career concerns, goals and choices
☐ Childhood issues (your own childhood)
☐ Children, child management, child care, parenting
☐ Concentration
☐ Compulsions (actions that are repeated)
☐ Custody of children
☐ Decision making, indecision, putting off decisions
☐ Delusions (false ideas)
☐ Dependence
☐ Emptiness
☐ Failure
☐ Fatigue, tiredness, low energy
☐ Fears, phobias
☐ Financial or money worries
☐ Work problems, workaholic, can't keep a job
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Relationship problems
☐ Self-centeredness
☐ Self-neglect, poor self-care
☐ Shyness, over sensitivity to criticism
☐ Smoking and tobacco use
☐ Thought disorganization and/or confusion
☐ Weight and diet issues
☐ Recreation/hobbies
☐ Headaches, other kinds of pain
☐ Inferior feelings
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Legal matters, charges, suits
☐ Loneliness
☐ Memory problems
☐ Menstrual problems, PMS, menopause
☐ Mood swings
☐ Motivation, laziness
☐ Nervousness, tension
☐ Obsessions (thoughts that are repeated)
☐ Overly sensitive to rejection
☐ Panic or anxiety attacks
☐ Perfectionism
☐ Pessimism
☐ Procrastination, work inhibitions
☐ School problems
☐ Self-esteem
☐ Sexual issues (dysfunction, conflicts, desire differences)
☐ Sleep problem (too much, too little, insomnia, nightmares)
☐ Suspiciousness
☐ Threats, violence
☐ Withdrawal, isolating
☐ Other concerns or issues______________________________

GroupWorks, LLC

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In order to provide high quality care, please complete the following. This information will become part of the Diagnostic Assessment.

Are you allergic to any drugs? ☐ Yes ☐ No

If Yes, please list ______________________________

Do you have any other allergies? ☐ Yes ☐ No

For example, foods, air borne, etc. If Yes, please list ______________________________

Are you pregnant? ☐ Yes ☐ No

Who is your medical doctor? ______________________________

Name of Clinic and location ______________________________

When was your last physical examination? ____________ Results: ____________

Have you experienced a recent weight loss or weight gain? ☐ Yes ☐ No

Do you have any problems that might interfere with your receiving service at GroupWorks? ☐ Yes ☐ No

If Yes, please list______________________________

Have you received services for alcohol and/or drug problems in the past? ☐ Yes ☐ No

If Yes, where?______________________________

Have you ever been treated for any of the following?

- ☐ Birth or developmental problems in childhood
- ☐ ADHD
- ☐ Alcohol issue
- ☐ Anemia
- ☐ Anxiety
- ☐ Cancer
- ☐ Chronic pain
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Depression
- ☐ Head injury (epilepsy, seizures, convulsions, confusion)
- ☐ Headaches, migraines
- ☐ Constipation ☐ Diarrhea
- ☐ Urinary incontinence
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Low energy
- ☐ Skin problems
- ☐ Past surgeries
- ☐ Gastric bypass
- ☐ Chronic illness
- ☐ Hepatitis
- ☐ Heart disease
- ☐ High blood pressure (hypertension)
- ☐ Chest pain, palpitations
- ☐ Kidney disease
- ☐ Lung disease, pneumonia
- ☐ PTSD
- ☐ Serious injury or accident
- ☐ Sexual performance problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Sexually transmitted disease
- ☐ Problems with appetite
- ☐ Gastrointestinal problems
- ☐ Ongoing pain or discomfort
- ☐ Other ______________________________

If any of the above boxes are checked, please comment on length and duration of problem ______________________________

____

____

____

Client name:______________________________ DOB:____________ Today's Date:____________

GroupWorks, LLC

Medical Information Supplement
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Have you had any past suicide thoughts or attempts? ☐ Yes ☐ No

If so, please list ______________________________

When ______________________________

Have you had any visits to the Emergency Room in the last year? ☐ Yes ☐ No

If Yes ,what symptoms were you experiencing when you went to the ER? ______________________________

____

Have you had any hospitalizations related to mental health? ☐ Yes ☐ No

If Yes, when ______________________________

Where ______________________________

What symptoms were you experiencing when you were hospitalized? ______________________________

____

Are you currently or have you been treated for any mental health conditions? ☐ Yes ☐ No

If Yes, when ______________________________

Where ______________________________

Are you currently taking any medications? ☐ Yes ☐ No If Yes, please list below

Medication Name	Dosage	How often	Prescribed by

Past Medications ______________________________

____

Do you take vitamins, herbal medications, diet supplements or over-the counter medications? ☐ Yes ☐ No

If yes, what type, how much and for how long? ______________________________

Have you taken more of a prescription medication than recommended by your doctor? ☐ Yes ☐ No

If yes, what type, how much and for how long? ______________________________

Do you have a Health Care Directive? ☐ Yes ☐ No

If yes, where do you keep it? ______________________________

If no, would you like information on one? ☐ Yes ☐ No If yes, was information given to client? ☐ Yes ☐ No

Client name:______________________________ DOB:________________ Today's Date:________________