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, select 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	

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UNIFIED COMMUNITY SERVICES
INTAKE HISTORY

NAME ____ DATE _________________

Please answer the following questions. Your answers will help us develop a comprehensive understanding of your concerns. If you need more space, please use the back of the page.

I. Briefly describe the problem that brought you here today:

____

____

____

II. Are you currently feeling suicidal? __________

If yes, how frequently in the last 48 hours have you thought about dying? _______________________ If yes, do you have a plan? ____

III. Please describe any past mental health treatment you've had. Include where you received treatment, date, and type of treatment:

____

____

____

Have you ever been hospitalized for emotional problems? _____ If yes, please describe:

____

____

Please list medications you have previously taken for mental health problems. Indicate any side effects, whether or not the medication was helpful, and how long you took the medication:

____

____

____

IV. Please describe any significant life events that may be influencing your current problem (for example, past abuse, family problems, loss of family member, divorce, etc.):

____

____

Please list the people living in your home, including each person's age and relationship to you:

____

____

NAME ____ DATE _________________

V. Please describe your current or past legal problems:

____
____
____

VI. Please describe any problems you had or are having in school:

____
____

If currently attending school, what grade are you in? ____________________

If you are not in school, what was the highest grade you completed? ___________________

VII. Please tell us about your blood relatives who have had mental health and/or substance abuse problems. Include suicides and significant legal problems. Describe the nature of the problem:

____
____
____
____

VIII. Name of your primary medical doctor: ____

Name(s) of other doctors you see: ____

Date of last complete physical: ____

Current health concerns: ____

Are you currently pregnant? ____

Allergies: ____

List all prescription, over-the-counter, and herbal medications you are currently taking. Include dosage and side effects:

____
____

Has a doctor recommended or prescribed medicine that you are not taking? ____ If yes, please explain:

____

Current height and weight: ____

Please select any physical health problems that you or your blood relatives have encountered:

Diabetes Heart disease High blood pressure Cancer Stroke

Seizures Thyroid Disorder Migraines TB Asthma Ulcers

NAME ______________________________ DATE ______________

How much and what type of caffeinated beverages do you drink each day?

___

Describe the frequency, amount and how long you used the following substances:

Marijuana: ______________________________

Street drugs (e.g. Cocaine, speed, acid, angel dust):

____

Alcohol: ______________________________

Tobacco: ______________________________

Other: ______________________________

Are you currently having problems related to these substances?:

___

Have you ever been treated for problems with alcohol or drugs?

___

Have you ever been hospitalized for problems with alcohol or drugs?

___

Have you ever been placed in detox? ______________________________

IX. Below is a list of concerns that people report. Please select any that are problematic for you:

Sleeping	Eating	Alcohol	Concentration
Memory decline	Shame	Guilt	Decision making
Anxiety	Depression	Fear	Worries
Feeling down	Over spending	Irritability	Anger outbursts
Hitting others	Suicidal thoughts	Verbal abuse	Poor frustration tolerance
Hallucinations	Being hit/hurt	Mood swings	Sexual difficulties
Nightmares	Panic attacks	Hopelessness	Sadness
Mind racing	Unwanted thoughts	Breaking things	Hurting yourself
Communication	Flashbacks	Hoarding/collecting	Being picked on

X. Please share any other information that will help us understand your problems:

___

___

Signature of Person Who Completed This Form ______________________________ 7/2023

NAME: ____ DATE:________________

Please add any additional information on this page:

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UNIFIED COMMUNITY SERVICES

Today's Date ____________________

CLIENT INFORMATION

Legal Name: ____
(First, Middle, Last)

Maiden Name: ____________________ Previous Married Names, Alias, etc. ____________________

Address: ____
Street City State Zip Code

County of Residence: __________ DOB: __________ Legal Gender: __________ Gender at Birth: __________

Gender Identity: ____________________ Social Security Number: ____________________

Cell Phone: ____________________ I request text appointment reminders Yes * No

Home Phone: ____________________ Email Address: ____________________

Race: (Select all that apply): White Black/African American Asian

Pacific Islander/Native Hawaiian Other Race

American Indian/Alaskan Native

Ethnicity (Select one): Hispanic or Latino Not Hispanic or Latino

Veteran: Yes No

Marital Status (Select one): Married Single Widowed Divorced Separated Legally Separated

Disability (Select one): Not disabled Physically Disabled Mentally Disabled

FAMILY INFORMATION/EMERGENCY CONTACT

Spouse, Parent(s), Legal Guardian or Next of Kin

____
Name Relationship Phone Number

____
Street City State Zip Code

REFERRAL INFORMATION

Who referred you to Unified Community Services? ____________________
(Spouse, Friend, Physician, Court, Teacher, Employer, Etc)

MEDICAL INFORMATION

Family Physician: ____
Physician Name Clinic Name City State

Pharmacy: ____
Pharmacy Name City State Phone Number

Power of Attorney for Health Care: ____________________
Name

____
Address Phone Number

Activated? (Select one): No Yes Date (if yes): ____________________

INSURANCE INFORMATION

Company Name: ____

Policy Holder: ______________________________ DOB: __________

Policyholder's Employer: ______________________________

Subscriber ID No: ______________________________ Group Number: __________

Medical Assistance # ____________________ Medicare # ____________________

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_______________ Patient Name:________________________________ Date of Birth: ______________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please select your answers.

PHQ-9	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 the score for each column				

Total Score (add your column scores): ______________

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? (Select one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please select your answers.

GAD-7	Not at all sure	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
Add the score for each column				

Total Score (add your column scores): ______________

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? (Select one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Interpreting PHQ-9 Scores

Diagnosis	Total Score	For Score	Action
Minimal depression	0-4	≤ 4	The score suggests the patient may not need depression treatment
Mild depression	5-9	5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderate depression	10-14		
Moderately severe depression	15-19	> 14	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.
Severe depression	20-27		

* The PHQ-9 is described in more detail at the Pfizer website: http://www.phqscreeners.com/

Interpreting Scores	
5-9	mild anxiety
10-14	moderate anxiety [1]
15-21	severe anxiety

[1] When screening for individual or any anxiety disorder, a recommended cut point for further evaluation is a score of 10 or greater.

1. Client Name: ___________________________
Maiden/Former Name: ___________________
Date of Birth: ______________________________
Address: ____________________________

____
Phone Number: ___________________________

Unified Community Services
Serving Grant and Iowa Counties

200 W. Alona Lane
Lancaster, WI 53813
Phone: (608) 723-6357
Fax: (608) 723-4417

1122 Professional Drive
Dodgeville, WI 53533
Phone: (608) 935-2776
Fax: (608) 935-3174

2. I hereby Authorize:
Unified Community Services (UCS)
☐To exchange information with ☐To disclose information to ☐To receive information from

____ ____
Name of Organization and/or Person Phone Number

____ ____
Street Address City State Zip

3. **Please check only one:**
- ☐ No records needed at this time. File in client's record for future use.
- ☐ Mail Records
- ☐ Will Pick Up Records (check only one box): ☐ UCS Lancaster ☐ UCS Dodgeville
- ☐ Fax Records to fax number: ________________
- ☐ Other: ____

4. **Format for Records (check only one):** ☐ Paper ☐ CD/DVD (requires PDF viewer)
☐ Other:____

5. State and Federal Laws require a specific authorization prior to disclosing certain information, and the type(s) of information to be disclosed.

- 2 year history unless specified: __/__/__ to __/__/__
  - ☐ Mental Health
    - ☐ Assessment ☐ Treatment Plan ☐ Discharge Summary ☐ Progress Notes ☐ Medications ☐ Crisis
    - ☐ Other: ____
  - ☐ Substance Abuse
    - ☐ Assessment ☐ Treatment Plan ☐ Discharge Summary ☐ Progress Notes ☐ Medications ☐ Crisis
    - ☐ Other: ____
  - ☐ Developmental Disability
    - ☐ ASQ ☐ Individual Service Plan ☐ Functional Screen ☐ Therapist evaluations & notes
    - ☐ Prescription and Plan of Care ☐ Other:____
  - ☐ Medical
    - ☐ Medications ☐ Lab Reports* ☐ Discharge Summary ☐ Assessment ☐ Progress Notes*
    - ☐ Other: ____
    - * Releasing drug testing results may have negative legal, employment, child custody, & other consequences

6. Purpose or need for disclosure: ☐ Request of client ☐ Insurance application/claim
☐ Further medical care/continuity of care/coordination of services ☐ Legal Investigation
☐ Disability Determination ☐ Other ____

7. Expiration Date: This authorization is valid for 15 months from date of signature or until ______________ (specific date up to 2 years) and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date.

Client Name: ___________________________ Date of Birth: _________________________

Your Rights With Respect To this Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my Protected Health Information (PHI) including but not limited to: Mental Health – Sec 51.30, Wis. Stats; & DHS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse – Sec. 51.30 Wis. Stats, DHS 92, Wis. Admin. Code; and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

Prohibitions on Redisclosure: This information has been disclosed to you from records protected by Wisconsin Administrative Code DHS 92.03 and/or Federal confidentiality rules (42 CFR part 2).

- DHS 92.03 requires that no personally identifiable information in treatment records may be re-released by a recipient of the treatment record unless re-release is specifically authorized by informed consent of the subject individual, DHS 92.03 or as otherwise required by law.
- The Federal rules prohibit you from making any further re-disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164.

Right to Receive a Copy of this Authorization: I have a right to receive a copy of this form after I sign it.

Right to Refuse to Sign This Authorization: I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written* statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosures of my PHI made prior to receipt of my withdrawal statement. *Consent for substance abuse treatment may be revoked verbally.

Re-disclosure: If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential.

Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies.

In accordance with the conditions listed on the first page of this form and above, I authorize the use and disclosure of my protected health information. This form must be legible and the first page must be completed in full (numbers 1– 7) in order to be valid.

Signature of Client: ____ **Date:**______________________

Signature of Parent/Guardian: ______________________________________ **Date:**_____ ________________

Mental Health: For a minor who receives **mental health** treatment, parent/guardian must sign if under 14; for a minor 14 and over either the minor or the parent may sign.

Substance Abuse: For a minor who receives **substance abuse** treatment, minor and parent/guardian must sign, except if a minor 12 and older receives substance abuse treatment without parental consent, the minor alone may sign.

Developmental Disability: A **developmentally disabled** minor 14 and over shall be notified of the right to file a written objection to access to treatment records by parent/guardian.

Guardian must sign for any adult with a legal guardian.

Legal Authority: If not signed by client, identify relationship to client. If other than a parent of minor, obtain court order or other documentation establishing the person's authority

☐Parent of Minor ☐Legal Guardian ☐Spouse of Deceased ☐Personal Representative/Domestic Partner of Deceased

☐Health Care Agent ________________________________ ☐Other: ____