DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

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…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2.	Worried about your health or about getting sick?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	5.	Had less fun doing things than you used to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	6.	Felt sad or depressed for several hours?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8.	Felt angry or lost your temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10.	Slept less than usual but still had a lot of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII.	11.	Felt nervous, anxious, or scared?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	12.	Not been able to stop worrying?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, select the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2.	Said he/she was worried about his/her health or about getting sick?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	5.	Had less fun doing things than he/she used to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	6.	Seemed sad or depressed for several hours?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8.	Seemed angry or lost his/her temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10.	Slept less than usual for him/her, but still had lots of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	12.	Not been able to stop worrying?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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 <u>past</u> 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 <u>previously</u> 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:

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**

UHS Rev 4/2020

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 Moderate depression	5-9 10-14	5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression Severe depression	15-19 20-27	> 14	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* 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: Labs done in last 12 months

■ Substance Abuse
□ Assessment □ Treatment Plan □ Discharge Summary ■ Progress Notes ■ Medications □ Crisis
■ Other: Labs done in last 12 months

□ 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: Labs done in last 12 months
* 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: _____