

Intake & Screening Packet



110 Campus Drive, Bradford, PA
Phone: (814) 362-6535
www.guidancecenter.net

PLEASE FILL OUT THE CLIENT INFORMATION BELOW AND RETURN THIS FIRST PAGE TO THE FRONT DESK IMMEDIATELY AFTER COMPLETING IT. THEN FINISH THE REST OF THIS PACKET WHILE YOU WAIT.

You can type directly into this form on a computer, then print it. It can also be printed blank and filled out by hand.

Client Information

Today's Date: _____

Full Name: _____ **Date of Birth:** _____

What type of insurance do you have? _____

What services are you seeking? (Check all that apply)

☐ Counseling ☐ Medications ☐ Other: _____

What Can I Expect?

- Your appointment may last up to two hours (per individual or intake).
- You will leave our office with an initial treatment plan, recommendations and referrals for follow-up care.
- If bringing a child: children should be accompanied by a parent or guardian. Please bring legal custody documentation (if applicable) and the name and social security number of the person responsible for payment.
- Please have your government-issued photo ID, insurance card, and co-payment (if applicable). If you do not have insurance, please bring proof of household income, including pay stubs and benefit statements, and a list of current medications.

Included in This Packet

1. Columbia Suicide Risk Assessment (Columbia Protocol screener)
2. Crisis Planning — Safety Plan
3. Substance Use Screening — AUDIT-C & Fagerström Test for Nicotine Dependence
4. Generalized Anxiety Disorder Screener (GAD-7)
5. Life Events Checklist for DSM-5 (LEC-5 Standard)
6. Patient Health Questionnaire-9 (PHQ-9) — Adults
7. Patient Health Questionnaire, Modified — Children
8. WellRx Questionnaire (social needs & safety screening)

Suicide Risk Assessment

Columbia Suicide Severity Rating Scale (Screener)



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Name: _____ Date of Birth: _____ Date: _____

ALL CLIENTS

Screening

Ask Questions 1 and 2.

1. Within the past month, have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No
2. Within the past month, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to Question 2, ask Questions 3, 4, 5, and 6. If NO, go directly to Question 6.

3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No
4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? ☐ Yes ☐ No
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No

If YES, how long ago did you do any of these?

- ☐ Over a year ago
- ☐ Between three months and a year ago
- ☐ Within the last three months

Additional Information / Follow Up

Crisis Planning

Safety Plan



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Triggers

When these things happen, I am more likely to feel unsafe or upset:

- | | |
|---|--|
| ☐ Not being listened to / not having control | ☐ Being isolated / feeling lonely |
| ☐ Loud noises | ☐ Relapse |
| ☐ Problems at work or school | ☐ Being stared at or touched |
| ☐ Feeling unwell | ☐ Hearing voices |
| ☐ Difficulties with family, friends, co-workers, etc. | ☐ Darkness |
| ☐ Loss of a loved one | ☐ People yelling / arguments |
| ☐ Financial problems / stressors | ☐ Other: _____ |
| ☐ Particular person: _____ | |
| ☐ Time of day and/or year / anniversary of loss: _____ | |

Inside Warning Signs

These are things I may notice just before I feel unsafe or upset:

- | | |
|--|---|
| ☐ Thoughts of hurting myself / others | ☐ Wanting to destroy things |
| ☐ Hallucinating | ☐ Feeling unwell |
| ☐ Negative thoughts | ☐ Cravings to use drugs and/or alcohol |
| ☐ Feeling disoriented | ☐ Change in appetite |
| ☐ Feeling anxious, nervous, or paranoid | ☐ Other: _____ |

Outside Warning Signs

These are things other people may notice just before I feel unsafe or upset:

- | | |
|---|---|
| ☐ Change in appearance | ☐ Using drugs and/or alcohol |
| ☐ Eating more / less | ☐ Change in physical behavior |
| ☐ Refusing to take my medication | ☐ Change in emotional behavior |
| ☐ Sleeping more / less | ☐ Change in aggressive behaviors |
| ☐ Paranoia | ☐ Other: _____ |

Risk Assessment

Check the items that increase my risk for crisis:

- | | |
|--|--|
| ☐ Access to firearms or sharp objects | ☐ Legal involvement |
| ☐ I feel I am in an unhealthy relationship | ☐ Prior or current suicidal ideation |
| ☐ Access to drugs or illegal substances | ☐ Family history of suicide |
| ☐ Med change or not taking prescribed medication | ☐ Major Depressive Disorder diagnosis |
| ☐ No identified natural supports / family discord | ☐ Financial difficulties |
| ☐ Being isolated for a long period of time | ☐ Sleep difficulties |
| ☐ Recent loss of person, home, job, or belonging | ☐ Other: _____ |

Crisis Planning

Safety Plan (continued)



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ALL CLIENTS

Things That Help Me Feel Better and Stay More in Control

Things that help me calm down, stay safe, or that I might like to try in the future:

- | | |
|--|---|
| ☐ Talking with friends, family, & peers | ☐ Exercising |
| ☐ Relaxing | ☐ Talking to my therapist or support staff |
| ☐ Taking my medication | ☐ Doing my favorite hobby |
| ☐ Deep breathing | ☐ Other: _____ |

Resiliency Factors

Strengths that help protect me:

- | | |
|--|---|
| ☐ Sense of meaning and purpose in life | ☐ Sense of hope or optimism |
| ☐ Religious or spiritual practice | ☐ Doing well at school or work |
| ☐ Identified natural supports / supportive family | ☐ Good health care practices |
| ☐ Positive help-seeking behaviors | ☐ Engagement in activities |
| ☐ Stable housing | ☐ Other: _____ |
| ☐ Stable income | |

Crisis Contacts

People and places I can contact during a crisis:

1. Call 911 for immediate physical danger.
2. Go to the Emergency Room at the nearest hospital for assistance and evaluation.

Hospital Name: _____

Hospital Address: _____

3. Call the 24-hour Crisis Hotline at **1-814-362-4623** or **1-800-459-6568**
4. Contact my Program Staff at **814-362-6535**
5. Emergency Contact:

NAME

PHONE NUMBER

NAME

PHONE NUMBER

Questions?

Call today at 814-362-6535

Substance Use Screen

AUDIT-C & Fagerström Test for Nicotine Dependence



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Ages 11 and older ONLY

AUDIT-C Questionnaire — Alcohol Use

AUDIT-C is available for use in the public domain.

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+ times a week

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

- ☐ 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

Fagerström Test for Nicotine Dependence

If you do not smoke, skip this section.

1. How soon after waking do you smoke your first cigarette?	☐ Within 5 min (3)	☐ 6-30 min (2)	☐ 31-60 min (1)	☐ After 60 min (0)
2. Do you find it difficult to refrain from smoking in places where it is forbidden?	☐ Yes (1)		☐ No (0)	
3. Which cigarette would you hate most to give up?	☐ The first in the morning (1)		☐ Any other (0)	
4. How many cigarettes a day do you smoke?	☐ 10 or less (0)	☐ 11-20 (1)	☐ 21-30 (2)	☐ 31 or more (3)
5. Do you smoke more frequently in the morning?	☐ Yes (1)		☐ No (0)	
6. Do you smoke even if you are sick in bed most of the day?	☐ Yes (1)		☐ No (0)	

Fagerström Total Score:

1-2 low · 3-4 low-moderate · 5-7 moderate · 8+ high dependence

Office use

Anxiety Screen

Generalized Anxiety Disorder Screener (GAD-7)



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Ages 11 and older ONLY

Over the Last 2 Weeks

How often have you been bothered by the following problems? Check one box per row.

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritated	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

Total Score:

Office use

8. 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

When did the symptoms begin? _____

Trauma Exposure

Life Events Checklist for DSM-5 (LEC-5 Standard)



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ALL CLIENTS

For each event, check one or more boxes to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job; (e) you're not sure if it fits; or (f) it doesn't apply to you. Consider your entire life (growing up as well as adulthood).

	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (car, boat, train, plane)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreation	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, forced sexual act)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (military or civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

Depression Screen

Patient Health Questionnaire-9 (PHQ-9)



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ADULTS 18+ ONLY

Over the Last 2 Weeks

How often have you been bothered by any of the following problems? Check one box per row.

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

Note: A positive response to Question 9 requires immediate clinical follow-up (see Suicide Risk Assessment).

Total Score:

Office use

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

Depression Screen

Patient Health Questionnaire, Modified (PHQ-A)



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CHILDREN AGES 11-17 ONLY

Over the Past 2 Weeks

How often have you been bothered by each of the following symptoms? Check one box per row.

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the past year have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room, or call 911.

Severity Score:

Office use

WellRx Questionnaire

Social Needs & Safety Screening



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ALL CLIENTS

WellRx Questions

Please check Yes or No for each question.

- | | | |
|--|------------------------------|-----------------------------|
| 1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food? | ☐ Yes | ☐ No |
| 2. Are you homeless or worried that you might be in the future? | ☐ Yes | ☐ No |
| 3. Do you have trouble paying for your utilities (gas, electricity, phone)? | ☐ Yes | ☐ No |
| 4. Do you have trouble finding or paying for a ride? | ☐ Yes | ☐ No |
| 5. Do you need daycare, or better daycare, for your kids? | ☐ Yes | ☐ No |
| 6. Are you unemployed or without regular income? | ☐ Yes | ☐ No |
| 7. Do you need help finding a better job? | ☐ Yes | ☐ No |
| 8. Do you need help getting more education? | ☐ Yes | ☐ No |
| 9. Are you concerned about someone in your home using drugs or alcohol? | ☐ Yes | ☐ No |
| 10. Do you feel unsafe in your daily life? | ☐ Yes | ☐ No |
| 11. Is anyone in your home threatening or abusing you? | ☐ Yes | ☐ No |

The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.