Intake & Screening Packet

THE GUIDANCE CENTER

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

Date:

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

Client Information

Full Name: **Date of Birth:**

What type of insurance do you have?

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

- ☐ **Counseling**
- ☐ **Medications**
- ☐ **Drug & Alcohol Services**
- ☐ **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 & co payment (if applicable) - If you do not have insurance, please bring proof of household income, including pay stubs and benefit statements, and list of current medications

Included in This Packet

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

Suicide Risk Assessment

Columbia Suicide Severity Rating Scale (Screener)

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Full Name:

Date of Birth:

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? **Y** **N**

2. Within the past month, have you actually had any thoughts of killing yourself? **Y** **N**

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? **Y** **N**

4. Have you had these thoughts and had some intention of acting on them? **Y** **N**

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? **Y** **N**

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? **Y** **N**

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

The Guidance Center

Triggers:

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

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

Inside Warning Signs:

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

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

Outside Warning Signs:

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

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

Risk Assessment:

The following checked items increase my risk for crisis

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

Crisis Planning

Safety Plan

The Guidance Center

Things that help me feel better and stay more in control:

These are things that help me calm down, stay safe, or things I might like to try in the future

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

Resiliency Factors:

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

Crisis Contacts:

These are the names and numbers of individuals I can contact during a crisis

1. Call **911** for immediate physical danger
2. Present 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 for assistance
4. Contact my **Program Staff at 814-362-6535** for support
5. Emergency Contact Info: _____
   NAME NUMBER

Questions?

Call today at 814-362-6535

Substance Use Screen

AUDIT-C & Fagerstrom Test for Nicotine Dependence

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

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 or more times a week

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

- 0-2
- 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

Fagerstrom Test for Nicotine Dependence

	Within 5 min (3)	5-30 min (2)	31-60 min (1)
How soon after waking do you smoke your first cigarette?			

	Yes (1)	No (0)
Do you find it difficult to refrain from smoking in places where it is forbidden?		

	The first in the morning (1)	Any other (0)
Which cigarette would you hate to give up?		

	10 or less (0)	11-20 (1)	21-30 (2)	31 or more (3)
How many cigarettes a day do you smoke?				

	Yes (1)	No (0)
Do you smoke more frequently in the morning?		

	Yes (1)	No (0)
Do you smoke even if you are sick in bed most of the day?		

Total Score: _____ (1-2 low · 3-4 low-mod · 5-7 moderate · 8+ high dependence)

Anxiety Screen

Generalized Anxiety Disorder Screener (GAD-7)

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Phone: (814) 362-6535
www.guidancecenter.net

Ages 11 and older ONLY

Over the Last 2 Weeks

How often have you been bothered by the following problems?

	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:

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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For each event, check one or more boxes to indicate: it happened to you personally; you witnessed it happen to someone else; you learned about it happening to a close family member or close friend; you were exposed to it as part of your job; you're not sure if it fits; or 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) — ADULTS ONLY

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

ADULTS 18+ ONLY

Over the Last 2 Weeks

How often have you been bothered by any of the following problems?

	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:

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
CHILDREN ONLY

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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 during the past two weeks?

	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? **Y** ○ **N** ○

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? **Y** ○ **N** ○

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? **Y** ○ **N** ○

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.

Office Use Only — Severity Score:

WellRx Questionnaire

Social Needs & Safety Screening

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WellRx Questions

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?	Y	N
2. Are you homeless or worried that you might be in the future?	Y	N
3. Do you have trouble paying for your utilities (gas, electricity, phone)?	Y	N
4. Do you have trouble finding or paying for a ride?	Y	N
5. Do you need daycare, or better daycare, for your kids?	Y	N
6. Are you unemployed or without regular income?	Y	N
7. Do you need help finding a better job?	Y	N
8. Do you need help getting more education?	Y	N
9. Are you concerned about someone in your home using drugs or alcohol?	Y	N
10. Do you feel unsafe in your daily life?	Y	N
11. Is anyone in your home threatening or abusing you?	Y	N

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.