Patient Health Questionnaire (PHQ-9)

Name _____ Phone # Date

Over the *last two weeks*, how often have you been bothered by any of the following problems? (use ✓ to indicate your answer)	**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 Columns			
(Healthcare professionals: For interpretation of TOTAL, please refer to accompanying scoring card.)	**TOTAL**			

10. 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 _____

Thank you for answering these questions. Your answers help us ensure the best care for your visit. Suicidal thoughts and substance use and mental health problems are common. If you currently feel unsafe due to your mental health, please call or text one of the following numbers now, or go to the emergency room for evaluation: Suicide & Crisis Lifeline 988 and Crisis Text Line (text "START" to 741741) for free, confidential support 24/7. These numbers may be important for you to keep for future use for yourself or someone else you care about.

16808 (10/2022)

CAGE Screening Tool

For Adults

CAGE-AID

☐ Yes ☐ No 1. Have you ever felt you ought to **cut** down on your drinking or drug use?

☐ Yes ☐ No 2. Have you ever had people **annoy** 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, or to get the day started?

For Adolescents 12-18

Kiddie-CAGE

☐ Yes ☐ No 1. Have you used more than one **chemical** at the same time in order to get high?

☐ Yes ☐ No 2. Do you **avoid** family activities so you can use?

☐ Yes ☐ No 3. Do you have a **group** of friends who also use?

☐ Yes ☐ No 4. Do you use to improve your emotions such as when you feel sad or depressed?

Generalized Anxiety Disorder Questionnaire (GAD-7)

Name _____ Date _____

Over the *last two weeks*, how often have you been bothered by any of the following problems?	**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 is 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 Columns		+	+
	TOTAL			

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

Score: 5-9 = mild anxiety; 10-14 = moderate anxiety; 15-21 = severe anxiety

HealthPartners®

Melrose Center Intake Questionnaire

QUESCSN

Whenever possible, please have the individual scheduled for an assessment complete this form. The following information will assist our clinical staff with getting to know you and completing the initial assessment appointment. **It is very important to completely fill out this form prior to your appointment.**

1. In your own words, tell us the reason for your visit.

_____

_____

2. How long have you been experiencing these concerns? (check one)

☐ 0 to 2 Weeks ☐ 2 to 4 Weeks ☐ 1 to 3 Months ☐ 3 to 6 Months
☐ 6 to 12 Months ☐ 1 to 2 Years ☐ 2 to 5 Years ☐ Over 5 Years

3. Do you have a legal guardian?

☐ No ☐ Yes, please list name _____ phone number _____

4. Please list any important relationships you have. (examples include parents, spouse, children, friends, etc.)

_____

_____

_____

5. How supportive are these relationships? (check one)

☐ Very supportive ☐ Somewhat supportive ☐ A little supportive ☐ Not supportive at all

6. Have you ever experienced any of the following symptoms or behaviors related to eating? (check all that apply)

	Past	Current	Never		Past	Current	Never
Overeating, emotional eating or binge eating				Purging (self-induced vomiting)			
Excessively picky eater				Laxative use			
Choking or vomiting phobia				Hiding food			
Compulsive or excessive exercise				Restrictive food, under-weight			
Diet pills, supplements, or weight loss programs							

7. In the last 3 months, have you experienced any of the following related to mood concerns? (check all that apply)

☐ Depressed mood or unhappy
☐ Appetite or weight changes
☐ Fatigue
☐ Feeling of worthlessness or guilt
☐ Problems concentrating or problems making decisions
☐ Too much energy
☐ None
☐ Other, please describe _____
☐ Little interest or pleasure in most activities
☐ Trouble falling asleep, sleeping too much or waking up during the night
☐ Have gone days without sleeping
☐ Thoughts of death
☐ Self-harm
☐ Impulsive behaviors

8. In the last 3 months, have you experienced any of the following related to anxiety concerns? (check all that apply)

- ☐ Worry about a number of things
- ☐ Anxiety or fear of social situations
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Feeling restless
- ☐ Rituals to lower anxiety
- ☐ Avoid people or places that bring up memories
- ☐ None
- ☐ Other, please describe _____
- ☐ Feel anxious a majority of the time or difficult to control the worry
- ☐ Fear others are judging you or worry you will embarrass yourself
- ☐ Obsessive thinking
- ☐ Nightmares
- ☐ Intrusive memories or flashbacks

9. In the last 3 months, have you experienced any of the following related to medical concerns? (check all that apply)

- ☐ Lightheadedness or dizziness
- ☐ Chest pain or irregular heartbeat
- ☐ Muscle cramps
- ☐ Chronic pain
- ☐ Stomach problems
- ☐ Vomiting blood
- ☐ Seizures
- ☐ None
- ☐ Other, please describe _____
- ☐ Fainting
- ☐ Sensitivity to cold
- ☐ Change to skin color
- ☐ Shortness of breath
- ☐ Diarrhea or constipation
- ☐ Trouble swallowing, heartburn, or reflux
- ☐ Headache

10. In the last 3 months, have you experienced any of the following general life concerns? (check all that apply)

- ☐ Financial problems
- ☐ Housing problems
- ☐ Hygiene issues
- ☐ Education concerns
- ☐ Legal issues
- ☐ Other, please describe _____
- ☐ Relationship or marital concerns
- ☐ Problems completing daily tasks
- ☐ Work concerns
- ☐ Childhood development concerns
- ☐ None

11. Have you received any of the following Behavioral Health services now or in the past? (check all that apply)

- ☐ Individual therapy
- ☐ Eating disorder treatment
- ☐ Psychological or neuropsychological testing
- ☐ Intensive in-home services: ARMHS, CTSS family worker, or ILS (Independent Living Skills)
- ☐ Emergency room or crisis assessment services
- ☐ Inpatient hospitalization
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Transcranial Magnetic Stimulation (TMS)
- ☐ Substance use treatment
- ☐ Other, please describe _____
- ☐ Family or couples therapy
- ☐ Psychiatry or medication management
- ☐ Case management or case manager
- ☐ Phone, text, or online crisis services
- ☐ Residential treatment or IRTS
- ☐ Current or past commitment
- ☐ Partial hospitalization program, day treatment, intensive outpatient program or DBT
- ☐ None

12. Have you ever contemplated suicide? ☐ No ☐ Yes
If yes, when was the last time you thought about suicide?
☐ Within the last week ☐ Within the last month ☐ Within the last year ☐ More than a year ago

13. Have you ever engaged in any kind of self-harm? ☐ No ☐ Yes
If yes, when was the last time you thought about self-harm?
☐ Within the last week ☐ Within the last month ☐ Within the last year ☐ More than a year ago

14. What medication have you taken in the past for mental health reasons? (examples include antidepressants, mood stabilizers, sedatives, antipsychotics, or medications for anxiety, ADHD or sleep)

_____

_____

15. How many alcoholic drinks do you have on average in a week? (check one)
☐ None ☐ 0 to 2 ☐ 3 to 5 ☐ Over 5

16. Are there any other substances you currently use or have used in the past? (check all that apply)
☐ Amphetamines ☐ Benzodiazepines ☐ Caffeine
☐ Cocaine or crack ☐ Hallucinogens ☐ Heroin
☐ Inhalants ☐ Khat ☐ Marijuana
☐ Opiates ☐ PCP ☐ Prescription drugs
☐ Sedatives or downers ☐ Stimulants or uppers ☐ Tobacco
☐ Vaping ☐ None
☐ Other, please describe _____

17. Have you ever needed help or tried to quit before? ☐ No ☐ Yes

18. Have you had any of the following problems as a result of alcohol or drug use? (check all that apply)
☐ Family problems (examples include arguments, verbal or physical abuse, separation, or divorce)
☐ Job or School problems (examples include absenteeism or tardiness, use of substance on job or school, loss of job or suspension from school)
☐ Legal problems (examples include drunk in public, assault and battery, DUI)
☐ Mental Health problems (examples include mood swings, depression, anxiety, temper)
☐ None

19. Have you had any of the following involvement with the legal system? (check one)
☐ Child Protective Services (CPS) ☐ Court ordered treatment
☐ Legal charges ☐ Parole
☐ Probation ☐ None
☐ Other, please describe _____

20. If female:
How old were you when you had your first period? _____

21. If female:
Do your periods occur monthly?
☐ Yes ☐ No, how often do they occur _____

22. If female:
Are you on hormonal contraception? (examples include IUD, implant, other) ☐ No ☐ Yes

23. Tell us a little bit about your weight?
Highest weight _____ Age at highest weight _____
Lowest weight _____ Age at lowest weight _____

24. During the day, what percentage do you spend thinking about food, weight and/or body image? (check one)
☐ Very little ☐ Less than half the day ☐ More than half the day ☐ All day

25. What is the approximate date of your last physical exam? _____

26. Have you ever had a head injury or seizure? ☐ No ☐ Yes

27. Do you need any special accommodations when coming into the clinic? (examples include motor, sensory, etc.)
☐ No ☐ Yes, please describe _____

28. Tell us a little bit about your childhood.
Where were you born?_____ Where were you raised?_____
Who raised you?_____ Were you adopted? ☐ No ☐ Yes

29. What is your religious affiliation or spiritual beliefs?
_____
_____
_____

30. What would you like us to know about you in terms of your race, ethnicity, gender identity, sexual orientation, national origin, language, etc.?
_____
_____
_____

31. What is your highest level of education? (check one)
☐ High School Diploma or GED
☐ 2 years of college completed
☐ Technical or Certificate
☐ Professional (examples include MD, PhD, DDS, JS)
☐ Some college
☐ 4 years of college completed
☐ Graduate (examples include MBA, Masters)
☐ Other, please describe _____

32. Have you ever been in the military?
☐ No ☐ Yes, which branch _____

33. What is your living situation?
☐ Rent
☐ Live with a friend, relative or guardian
☐ Homeless
☐ Live in a group home
☐ Own
☐ Live in temporary housing
☐ Live in residential care
☐ Live in nursing home
☐ Other, please describe _____

34. Tell us more about your living situation.
Is it stable? ☐ No ☐ Yes
Any financial concerns? ☐ No ☐ Yes
Are basic needs met? ☐ No ☐ Yes
Do you have children? ☐ No ☐ Yes

35. List the names and ages of the members of your household.
_____
_____
_____

Informed Consent and Notice of Rights for Psychological Services

(Check one box)

☐ Bring this copy to your appointment ☐ Keep this copy for your records

The care team at the Melrose Center is made up of a multidisciplinary group of professionals dedicated to helping women and men reclaim their lives from eating disorders. Psychotherapy services for the program are provided by licensed psychologists, licensed clinical social workers and licensed marriage and family therapists.

The following information covers many questions that may arise about psychotherapy and includes a listing of client's rights and psychologist's obligations. Any questions not covered should be brought to the attention of your psychologist.

The Bill of Rights for clients obtaining psychological services is posted in the waiting room. This provision is not a legal bill of rights, but a statement of what you can reasonably expect from a therapist.

Clients seeking psychological services have the right to know the following information.

1. Information about the availability of the therapist. Clients are invited to ask when the therapist is available and where to call during off-hours in case of emergency.

2. Information about the structure of the therapeutic relationship. Clients are invited to ask the following.
    - The manner in which the therapist conducts sessions around intake, treatment and termination. Clients may take an active part in their therapeutic process by asking questions about issues relevant to therapy, specifying therapeutic goals and renegotiating goals, when necessary.
    - The perspective(s) the therapist typically uses to structure therapy and treatment methods. Clients may refuse any intervention or treatment strategy. It is essential, however, that therapist and client work together on a mutually agreed-upon treatment plan.
    - The purpose of and risks involved in psychological treatment. Clients have a right to know, for example, that during the process of therapy, emotional pain and distress can arise that may be uncomfortable.
    - The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
    - The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consulting another therapist.

3. Information about fees and billing arrangements. Clients are invited to inquire about the amount of the fee, the time frame for payment, the method of payment, the access to billing statements and billing for missed appointments and late cancellations.
4. Information about the therapist's status including the therapist's training, credentials and years of experience.
5. Information about informed consent and exceptions to confidentiality. Clients are invited to inquire about the following.
    - The therapist's duty to maintain confidentiality by not releasing information to others unless authorized to do so by the client. Information about your psychotherapy treatment sessions will be discussed with members of your multidisciplinary care team at the Melrose Center to ensure integrated care. Information about your psychotherapy treatment sessions may be disclosed with an outside consultant to ensure quality care.
    - The circumstances under which confidentiality is limited. The therapist's duty is to:
        - warn another in case of potential suicide, homicide or the threat of imminent, serious harm to another individual
        - report knowledge of a child being neglected, physically or sexually abused
        - report knowledge of a vulnerable adult being mistreated
        - report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine and amphetamine or their derivatives
        - report the misconduct of other health care professionals
        - provide to a spouse or the parents of a deceased client access to their child's or spouse's records
        - release records if subpoenaed by the courts
        - provide to parents of minor children (under age 18) access to their children's records. There are situations in which minors can give consent for their own treatment without parental consent. Under these circumstances, the minor alone may authorize release of records. The minor also assumes financial responsibility for health care services when she or he consents to treatment.
        - to release records if subpoenaed by the courts
6. Information about counseling records. Clients are invited to inquire about the following.
    - Record maintenance, including the security and length of time they are kept. Files are stored in a secure, locked location and are kept a minimum of 10 years. For adolescents, records are kept 10 years after the client reaches age 18.
    - Client's right to access personal records.
    - Release policies and procedures.
7. Information about referral questions. Clients are invited to inquire about the client's right to request a referral and the right to require the current therapist to send a written report about services rendered to the qualified referred therapist or organization, upon the client's written authorization.

My signature indicates that I have read this document and have had the opportunity to have my questions answered. I consent to receive psychotherapy services.

Client signature: _____ Date: _____ Time: _____

Parent signature: _____ Date: _____ Time: _____
(if client is a minor)

Support Questionnaire

This is an optional form to help Melrose Center gather additional information about the individual coming in for an Initial Assessment. This form can be filled out by a parent, spouse, friend or other concerned person.

1) Name of person receiving assessment for an eating disorder at Melrose Center?

_____

2) Who is filling out this form and what is your relationship to the person getting an assessment?

_____

3) Please check any of the areas that concern you about this individual:

- ☐ Fights over food or during family meals
- ☐ Restricting, not eating, cutting food into small bits, hiding food
- ☐ Compulsive or excessive exercise; injuries due to this
- ☐ Hiding during meals, fears around eating with others
- ☐ Excessive eating / Binge Eating
- ☐ Purging (vomiting or laxative use)
- ☐ Supplements of any kind: diet pills, protein powders, hormone injections
- ☐ Physical appearance
- ☐ Depression, anxiety, isolation, irritability or other mood changes
- ☐ Compulsive behaviors
- ☐ Self-injurious behavior or suicidal thoughts
- ☐ Difficulty sleeping
- ☐ Alcohol or drug use
- ☐ Lack of resources for basic needs
- ☐ Legal issues
- ☐ Other _____

4) Describe any changes or events in the person's environment (new school, move, job loss, death in family, changes with friends, any changes in their relationships)?

_____

_____

5) Has the individual had significant changes in their academic, social or work performance in the past 6 months?

☐ No ☐ Yes, if yes, please describe: _____

_____

_____

6) Is anyone in the individual's household on a special diet including weight loss programs?

☐ No ☐ Yes, if yes, type of diet and reason for the special diet: _____

7) Has anyone in the family received eating disorder treatment?

☐ No ☐ Yes If yes, who? _____

8) Does anyone in the family have a history of an eating disorder?

☐ No ☐ Yes If yes, when and where? _____

9) Additional comments or concerns? Anything else you want us to know in order to help with our assessment?

Signature of person filling out the form	Printed name	Date

Outside Providers Contact Information

The Melrose Treatment team would like to communicate and best coordinate care with any outside providers you may be working with currently. Please list the names and contact information below of any outside providers you or your loved one have currently established care.

Do you attend the University of Minnesota?

☐ Yes ☐ No

Primary Medical Doctor

Name	
Clinic name	Phone number

Therapist

Name	
Clinic name	Phone number

Psychiatrist

Name	
Clinic name	Phone number

Other (for example: social worker, other medical provider, school counselor, legal, etc.)

Name	
Role	Phone number

Other (for example: social worker, other medical provider, school counselor, legal, etc.)

Name	
Role	Phone number

Melrose Center
3525 Monterey Drive
St. Louis Park, MN 55416

Melrose Center- Maple Grove
Suite 110
9600 Upland Lane N.
Maple Grove, MN 55369

Melrose Center – St. Paul
Suite 2165
2550 University Ave. W.
St. Paul, MN 55114