



# Shoreview Mental Health Center LLC

hope ... wellness ... peace

P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com  
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

## Adolescent Questionnaire

Ages 12-18

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_\_

Home Work Cell Parent

Address: \_\_\_\_\_ Primary phone: \_\_\_\_\_  
Secondary phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

What is the reason for your visit?

How serious is this issue for you (rate 1-10: 1 - not at all, 10 - most serious): \_\_\_\_\_

### Background Information:

Parents' Names:	Age	Job / Retired	Physical / Emotional / Psychological Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Siblings' Names:	Age	Job	Physical / Emotional / Psychological Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Children's Names:	Age	Physical / Emotional / Psychological Problems	
_____	_____	_____	
_____	_____	_____	

Current Living Situation:  House  Apartment  Other: \_\_\_\_\_

Others Living With You:  Mother  Father  Grandparent(s)  Significant Other: \_\_\_\_\_  
 Sibling(s)  Children  Other(s): \_\_\_\_\_

**Check any problems that trouble you in your family:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Parent is physically sick             | <input type="checkbox"/> Parents disapprove of friends           | <input type="checkbox"/> Don't want to live at home               |
| <input type="checkbox"/> Parent has emotional problems         | <input type="checkbox"/> Parents disapprove of activities/music  | <input type="checkbox"/> Family fighting                          |
| <input type="checkbox"/> Parent has trouble with alcohol/drugs | <input type="checkbox"/> Feeling ignored by Parent(s)            | <input type="checkbox"/> Don't have enough privacy                |
| <input type="checkbox"/> Parents fighting                      | <input type="checkbox"/> Pet dying                               | <input type="checkbox"/> Too many household chores                |
| <input type="checkbox"/> Parents divorcing                     | <input type="checkbox"/> Sibling is physically sick              | <input type="checkbox"/> Don't feel close to family               |
| <input type="checkbox"/> Problems with Step-Parent             | <input type="checkbox"/> Sibling has emotional problems          | <input type="checkbox"/> Parents disapprove of clothes/appearance |
| <input type="checkbox"/> Parents never home                    | <input type="checkbox"/> Sibling has problems with alcohol/drugs | <input type="checkbox"/> Parents favor siblings                   |
| <input type="checkbox"/> Can't talk to Parents                 | <input type="checkbox"/> Being physically abused at home         | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Parents too strict                    | <input type="checkbox"/> Being sexually abused at home           |   |
| <input type="checkbox"/> Parents expect too much               |  |   |

**Issues that concern you:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Suicidal thoughts        | <input type="checkbox"/> Alcohol use                                       | <input type="checkbox"/> Easily irritated              |
| <input type="checkbox"/> Anxious/worried          | <input type="checkbox"/> Frequently lying                                  | <input type="checkbox"/> Problems focusing             |
| <input type="checkbox"/> Bored                    | <input type="checkbox"/> Shy/uneasy with others                            | <input type="checkbox"/> Hearing voices/hallucinations |
| <input type="checkbox"/> Confused                 | <input type="checkbox"/> Unwanted behavior/habits                          | <input type="checkbox"/> Impulsive                     |
| <input type="checkbox"/> Cutting/burning self     | <input type="checkbox"/> Sleep problems:                                   | <input type="checkbox"/> Memory/concentration problems |
| <input type="checkbox"/> Difficulty being alone   | <input type="checkbox"/> At times it takes me over 1 ½ hour to fall asleep | <input type="checkbox"/> Motivation reduced/absent     |
| <input type="checkbox"/> Easily distracted        | <input type="checkbox"/> I wake up a lot at night                          | <input type="checkbox"/> Excessive organization        |
| <input type="checkbox"/> Fatigued                 | <input type="checkbox"/> Eating habits:                                    | <input type="checkbox"/> Parent problems               |
| <input type="checkbox"/> Guilt feelings/shame     | <input type="checkbox"/> Restricting                                       | <input type="checkbox"/> Sexual identity concerns      |
| <input type="checkbox"/> Hyperactivity            | <input type="checkbox"/> Overeating  | <input type="checkbox"/> Sexually active               |
| <input type="checkbox"/> Lonely                   | <input type="checkbox"/> Purging/vomiting                                  | <input type="checkbox"/> Unusual thoughts              |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Binging   | <input type="checkbox"/> Very concerned about germs    |
| <input type="checkbox"/> Obsessive thoughts       | <input type="checkbox"/> Laxative use for dieting                          | <input type="checkbox"/> Aggressiveness                |
| <input type="checkbox"/> Panic attacks            | <input type="checkbox"/> Suicide attempts                                  | <input type="checkbox"/> Drug use                      |
| <input type="checkbox"/> Low self esteem          | <input type="checkbox"/> Attitude issues                                   | <input type="checkbox"/> Perfectionist                 |
| <input type="checkbox"/> Sexual problems          | <input type="checkbox"/> Sibling problems                                  | <input type="checkbox"/> Unassertive                   |
| <input type="checkbox"/> Tearful                  | <input type="checkbox"/> Count excessively                                 | <input type="checkbox"/> Withdrawn                     |
| <input type="checkbox"/> Repeatedly washing hands | <input type="checkbox"/> Depressed   | <input type="checkbox"/> Weight changes                |
| <input type="checkbox"/> Anger problems           | <input type="checkbox"/> Disorganized                                      | <input type="checkbox"/> Increase                      |
|   |  | <input type="checkbox"/> Decrease                      |

**I worry about:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Being popular  | <input type="checkbox"/> Being bullied    | <input type="checkbox"/> My parents    |
| <input type="checkbox"/> My sibling(s)  | <input type="checkbox"/> My friends       | <input type="checkbox"/> School issues |
| <input type="checkbox"/> Money problems | <input type="checkbox"/> Everything       | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Being left out | <input type="checkbox"/> Being sick a lot |  |

**I feel bad about:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> People putting me down                           | <input type="checkbox"/> I like to argue/compete with others       | <input type="checkbox"/> My grades                      |
| <input type="checkbox"/> My family  | <input type="checkbox"/> Being excluded                            | <input type="checkbox"/> The way I treat people         |
| <input type="checkbox"/> My appearance                                    | <input type="checkbox"/> Not saying "no"                           | <input type="checkbox"/> I get in fights a lot          |
| <input type="checkbox"/> I get angry a lot                                | <input type="checkbox"/> Others' opinions of me are very important | <input type="checkbox"/> I try to get my own way a lot  |
| <input type="checkbox"/> I have trouble living up to others' expectations | <input type="checkbox"/> Not having enough friends                 | <input type="checkbox"/> I think I'm right all the time |
| <input type="checkbox"/> I try to please everyone                         |  | <input type="checkbox"/> Myself                         |
|   |  | <input type="checkbox"/> Other: _____                   |

**Medical History:**

Medical concerns in the last year: \_\_\_\_\_

Chronic illness: \_\_\_\_\_

Surgeries: \_\_\_\_\_ Disabilities: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Additional prescribing provider(s)? \_\_\_\_\_

Current medications and reasons prescribed: \_\_\_\_\_

**Counseling: (current and/or previous)**

Dates	Clinic / Therapist	Reason	Helpful? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Psychiatric Hospitalizations:**

Dates	Hospital / MD	Reason	Helpful? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Abuse Issues:**

Please indicate areas of abuse that **you have experienced**:

Not applicable

	Past	Current
Physical	<input type="checkbox"/>	<input type="checkbox"/>
Sexual	<input type="checkbox"/>	<input type="checkbox"/>
Verbal	<input type="checkbox"/>	<input type="checkbox"/>
Emotional	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate areas of abuse **by you**:

Not applicable

	Past	Current
Physical	<input type="checkbox"/>	<input type="checkbox"/>
Sexual	<input type="checkbox"/>	<input type="checkbox"/>
Verbal	<input type="checkbox"/>	<input type="checkbox"/>
Emotional	<input type="checkbox"/>	<input type="checkbox"/>

**Alcohol/Substance Use:** Please indicate any substances that you have used (current and/or previous)

	Type	Age at first use	How much and how often?	Last used
Nicotine:	_____	_____	_____	_____
Caffeine:	_____	_____	_____	_____
Alcohol:	_____	_____	_____	_____
Illegal/Street Drugs:	_____	_____	_____	_____
Misused Prescription Drugs:	_____	_____	_____	_____
Misused Over-the-Counter Drugs:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

	Y	N	Not applicable
Have there been any undesirable results of your chemical abuse? (Low job/school performance, physical or relationship problems, DWI, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been concerned about your own chemical abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have others expressed concern about your chemical abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do others who are close to you abuse alcohol or drugs? If yes, who: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever attended a self-help or support group? (Such as AA, NA, AlAnon, ACA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently attending a self-help or support group? If yes, name of group: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





**CURRENT WELL-BEING**

1. At the present time, how upset or distressed have you been feeling?  
 ① Not at all distressed      ④ Very distressed  
 ② Slightly distressed      ⑤ Extremely distressed  
 ③ Pretty distressed
2. At the present time, how energetic and healthy have you been feeling?  
 ① Not at all energetic and healthy  
 ② Slightly energetic and healthy  
 ③ Pretty energetic and healthy  
 ④ Very energetic and healthy  
 ⑤ Extremely energetic and healthy
3. At the present time, how well do you feel that you are getting along emotionally and psychologically?  
 ① Quite poorly; I can barely  
 ② Fairly poorly; life is pretty tough for me at times  
 ③ So-so; I manage to keep going with some effort  
 ④ Fairly well; I have my ups and downs  
 ⑤ Quite well; I have no important complaints  
 ⑥ Very well; much the way I would like to
4. At the present time, how satisfied have you been feeling with your life?  
 ① Not at all satisfied      ④ Very satisfied  
 ② Slightly satisfied      ⑤ Extremely satisfied  
 ③ Pretty satisfied

**CURRENT LIFE FUNCTIONING**

Please rate how much difficulty you are having in the following areas of your life:	No Difficulty	Some Difficulty	A Lot of Difficulty	Extreme Difficulty
1. Ability to perform routine tasks				
2. Ability to maintain my personal appearance				
3. Ability to concentrate and complete tasks				
4. Participation in physical activities				
5. Ability to function as an independent person				
6. Ability to manage my finances				
7. Being the kind of person I would like to be				
8. Maintaining good health habits				
9. Interactions with people at work				
10. Performance at work or school				
11. Developing or managing my career				
12. Creative activities				
13. Attending work/school or getting there on time				
14. Interactions with my spouse/romantic partner				
15. Interactions with my parents				
16. Interactions with my brothers or sisters				
17. Ability to form or sustain intimate relationships				
18. Enjoyment of sexual activities				
19. Carrying out family responsibilities				
20. Interactions with friends				
21. Participation in social activities				
22. Planning and enjoying leisure time activities				
23. Ability to control myself and stay out of trouble				
24. Ability to be comfortable with people				



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**Patient Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient Health Questionnaire (PHQ-9)

**Over the last 2 weeks 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				

<b>ADD COLUMNS FOR TOTAL SCORE</b>	_____	+	_____	+	_____	+	_____
<b>TOTAL SCORE:</b> _____							

**NOTE:** 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

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. PHQ-9 Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD® and PRIME MD TODAY® are trademarks of Pfizer Inc.



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**Patient Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## GAD-7 QUESTIONNAIRE

How often during the past 2 weeks have you felt bothered by:

1. Feeling nervous, anxious, or on edge?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
  2. Not being able to stop or control worrying?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
  3. Worrying too much about different things?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
  4. Trouble relaxing?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
  5. Being so restless that it is hard to sit still?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
  6. Becoming easily annoyed or irritable?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
  7. Feeling afraid as if something awful might happen?  
0 = not at all  
1 = several days  
2 = more than half the days  
3 = nearly everyday
- 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



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Name \_\_\_\_\_ Date \_\_\_\_\_

## The Burns Anxiety Inventory

Instructions: The following is a list of symptoms that people sometimes have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you *during the past week*:

**0** = Not at All    **1** = Somewhat    **2** = Moderately    **3** = A Lot

<b>Anxious Feelings</b>		0	1	2	3
1.	Anxiety, nervousness, worry, or fear.				
2.	Feeling that things around you are strange, unreal or foggy.				
3.	Feeling detached from all or part of your body.				
4.	Sudden unexpected panic spells.				
5.	Apprehension or a sense of impending doom.				
6.	Feeling tense, stressed, "uptight," or on edge.				
Subtotal from Section I					
<b>Anxious Thoughts</b>		0	1	2	3
7.	Difficulty concentrating.				
8.	Racing thoughts or having your mind jump from one thing to the next.				
9.	Frightening fantasies or daydreams.				
10.	Feeling that you're on the verge of losing control.				
11.	Fears of cracking up or going crazy.				
12.	Fears of fainting or passing out.				
13.	Fears of physical illnesses or heart attacks or dying.				
14.	Concerns about looking foolish or inadequate in front of others				
15.	Fears of being alone, isolated, or abandoned.				
16.	Fears of criticism or disapproval.				
17.	Fears that something terrible is about to happen.				
Subtotal from Section II					
<b>Physical Symptoms</b>		0	1	2	3
18.	Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19.	Pain, pressure, or tightness in the chest.				
20.	Tingling or numbness in the toes or fingers.				
21.	Butterflies or discomfort in the stomach.				
22.	Constipation or diarrhea.				
23.	Restlessness or jumpiness.				
24.	Tight, tense muscles.				
25.	Sweating not brought on by heat.				
26.	A lump in the throat.				
27.	Trembling or shaking.				
28.	Rubbery or "jelly" legs.				
29.	Feeling dizzy, light-headed, or off balance.				
30.	Choking or smothering sensations or difficulty breathing.				
31.	Headaches or pains in the neck or back.				
32.	Hot flashes or cold chills.				
33.	Feeling tired, weak, or easily exhausted.				
Subtotal from Section III					
<b>Combined Total</b>					

**0** = Not at All    **1** = Somewhat    **2** = Moderately    **3** = A Lot





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Name \_\_\_\_\_ Date \_\_\_\_\_

## The Burns Depression Checklist

Instructions: Put a check in the space to the right to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

**0 = Not at All    1 = Somewhat    2 = Moderately    3 = A Lot    4 = Extremely**

<b>Thoughts and Feelings</b>		0	1	2	3	4
1.	Feeling sad or down in the dumps					
2.	Feeling unhappy or blue					
3.	Crying spells or tearfulness					
4.	Feeling discouraged					
5.	Feeling hopeless					
6.	Low self-esteem					
7.	Feeling worthless or inadequate					
8.	Guilt or shame					
9.	Criticizing yourself or blaming others					
10.	Difficulty making decisions					
Subtotal from Section I						
<b>Activities and Personal Relationships</b>		0	1	2	3	4
11.	Loss of interest in family, friends, or colleagues					
12.	Loneliness					
13.	Spending less time with family or friends					
14.	Loss of motivation					
15.	Loss of interest in work or other activities					
16.	Avoiding work or other activities					
17.	Loss of pleasure or satisfaction in life					
Subtotal from Section II						
<b>Physical Symptoms</b>		0	1	2	3	4
18.	Feeling tired					
19.	Difficulty sleeping or sleeping too much					
20.	Decreased or increased appetite					
21.	Loss of interest in sex					
22.	Worrying about your health					
Subtotal from Section III						
<b>Suicidal Urges</b>		0	1	2	3	4
23.	Do you have any suicidal thoughts?					
24.	Would you like to end your life?					
25.	Do you have a plan for harming yourself?					
Subtotal from Section IV						
<b>Combined Total</b>						

**0 = Not at All    1 = Somewhat    2 = Moderately    3 = A Lot    4 = Extremely**