Date: Case:

BETTY HARDWICK CENTER – Eligibility Assessment Form – Adult

Please have the following items with you for your appointment: Driver's License, Social Security Card, Proof of Household Income, and Insurance Information.

Who referred you to us today? _____

Name:_____SS#_____
First Middle Last

Address: _____
Street city state zip county

Marital Status: Single_____ Married_____ Divorced_____ Never Married _____ Other_____

Phone: Home_____ Cell_____ Email_____

Date of Birth _____ Age _____ Sex: F M Highest Grade Completed_____

Have you been here before?_____ Another MHMR?_____

EMERGENCY CONTACT Name: _____

Address/City/Zip: _____ Phone _____

INCOME INFORMATION: Are you employed? Yes___ No ___ Do you have insurance?_____

Insurance Provider: _____ Primary Care Dr._____

Medicaid ID#_____ Carrier:_____

Medicare #_____ Part A _____ Part B_____ Other:_____

This is a two-sided form, please complete both sides

↓

Reason for Visit

What brings you in today?

_____

_____

Check below what services you are seeking.

- **Case Management** (assistance with resources within the community)
- **Counseling**
- **Clinic** (Mental Health Medications)

_____

Have you received treatment in the past? (if so, where?)

_____

_____

_____

_____

Please complete the following pertaining to substance use:

____I have used drugs or alcohol in the last 2 days
____I think I have a problem abusing drugs
____I think I have a problem abusing alcohol
____Last use of drugs/alcohol: _____

Legal Information:

___ I am currently on probation. PO's name_____

___ I am currently on parole. PO's name_____

TDCJ #_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 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

For office coding 0 + _____ + _____ + _____

=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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues with an educational grant from Pfizer Inc. No permission required to reproduce, translate display, or distribute.

PTSD PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then choose one to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:

1 Repeated, disturbing, and unwanted memories of the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

2 Repeated, disturbing dreams of the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

3 Suddenly feeling or acting as if the stressful experience were actually happening again?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

4 Feeling very upset when something reminded you of the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

5 Having strong physical reactions when something reminded you of the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

6 Avoiding memories, thoughts, or feelings related to the to the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

7 Avoiding external reminders of the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

8. Trouble remembering important parts of the stressful experience?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

9. Having strong negative beliefs about yourself, other people, or the world?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

10. Blaming yourself or someone else for the stressful experience or what happened after it?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

11. Having strong negative feelings such as fear, horror, anger guilt or shame?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

12. Loss of interest in activities that you used to enjoy?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

13. Feeling distant or cut off from other people?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

14. Trouble experiencing positive feelings?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

15 Irritable behavior, angry outbursts, or acting aggressively?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

This is a two-sided form, please complete both sides

15 Taking too many risks or doing things that could cause you harm?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

17 Being "superalert" or watchful or on guard?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

18 Feeling jumpy or easily startled?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

19 Having difficulty concentrating?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

20 Trouble falling or staying asleep?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

Total Score: 0

Staff Completing Form

Name Date Time Pending

Generalized Anxiety Disorder
(GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious or on edge

O Not at all O Several days O More than half the days O Nearly every day

2. Not being able to stop or control worrying

O Not at all O Several days O More than half the days O Nearly every day

3. Worrying too much about different things

O Not at all O Several days O More than half the days O Nearly every day

4. Trouble relaxing

O Not at all O Several days O More than half the days O Nearly every day

5. Being so restless that it is hard to sit still

O Not at all O Several days O More than half the days O Nearly every day

6. Becoming easily annoyed or irritable

O Not at all O Several days O More than half the days O Nearly every days

7. Feeling afraid as if something awful might happen

O Not at all O Several days O More than half the days O Nearly every day

GAD7 Total Score 0

If you checked off any problem on this questionnaire so far, 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?

O Not at all O Several days O More than half the days O Nearly every day

Scoring: Add the resultes for question number one through secen to get a total score.
If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,

2. Contact a local mental health care provider or

3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

Developed by Drs. Robert L. Spitzer, Janet B W. Williams, Kurt Kroenke and colleagues, with an

Betty Hardwick Center

AUDIT - C Questionnaire

These questions refer to the past 12 months

1. How often do you have a drink containing alcohol?
    a. Never
    b. Monthly or less
    c. 2-4 times a month
    d. 2-3 times a week
    e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
    a. 1 or 2
    b. 3 or 4
    c. 5 or 6
    d. 7 or 9
    e. 10 or more

3. How often do you have six or more drinks on one occasion?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

Total:

Score: a = 0; b = 1; c = 2; d = 3; e = 4

DRUG USE QUESTIONNAIRE (DAST - 10)

Betty Hardwick Center

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question if you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

1.	Have you used drugs other than those required for medical reason?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you always able to stop using drugs when you want to?	Yes	No
4.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (memory, loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

FINANCIAL ASSESSMENT QUESTIONNAIRE

1. How many people are in the household? **(Your family, spouse and dependents, etc.)**

2. Who are the people in the household? **Spouse, children, etc.**

3. Do you or your spouse work? If so, where at?

4. What is the hourly pay rate?

5. How many hours per week are worked on average?

6. Do you or does anyone in the household receive SSI, SSDI or Retirement benefits? If so, how much and who?

7. Does anyone in the family receive food stamps? If so, how much?

8. Does the family receive HUD housing assistance? If so, how much do they help pay?

9. Have you ever applied for SSI? If so, what was the outcome?

10. Does the client want to apply for SSI benefits?

11. If there is no income in the household, how are the daily needs for the family met?