Client Name:_____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated

Pregnant
- ☐ Yes
- ☐ No
- ☐ N/A

Ethnicity
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic - Specific Origin Not Given
- ☐ Hispanic or Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Not of Hispanic Origin
- ☐ Other Specific Hispanic
- ☐ Puerto Rican
- ☐ Unknown

Race
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black/African-American
- ☐ Other single race
- ☐ Pacific Islander
- ☐ Two or more races
- ☐ Unknown
- ☐ White

Sex
- ☐ Male
- ☐ Female

Primary Language:

_____

PRIMARY CARE PHYSICIAN:

_____

Phone:_____

Military Status:
- ☐ NONE
- ☐ Active
- ☐ discharged
- ☐ disabled vet

Annual household income:

$_____

# of dependents: _____

in Household: _____

Employer:_____

County of Residence:

_____

Employment Status:
- ☐ Full time
- ☐ part time
- ☐ unemployed/ seeking
- ☐ unemployed/ not seeking
- ☐ disabled
- ☐ retired
- ☐ Homemaker
- ☐ student

Living Situation:
- ☐ Private Residence- adult
- ☐ Private Residence- child
- ☐ Permanent supportive housing
- ☐ Residential care/group home
- ☐ Community residence
- ☐ Temporary housing
- ☐ Foster care
- ☐ DD Licensed/operated facility
- ☐ Correctional facility
- ☐ Homeless
- ☐ Other
- ☐ unknown

EDUCATION STATUS
- ☐ Highest grade completed: _____
- ☐ HS Diploma/GED
- ☐ Tech School
- ☐ Some College
- ☐ 2-year College Degree
- ☐ 4-year College Degree
- ☐ Graduate Degree

Communication preference:
- ☐ Email
- ☐ text
- ☐ phone

Emergency contact:

First name: _____ Last name:_____

Phone:_____ Relation:_____

PAIN ASSESSMENT/NUTRITIONAL ASSESSMENT **Maumee Valley Guidance Center**

Client Name	Date

Please answer the following questions.

PAIN ASSESSMENT:

Are you currently having any pain symptoms? ___YES ____NO If yes, explain:
Have you previously received treatment for pain symptoms? ___YES ___ NO If yes, explain:

NUTRITIONAL ASSESSMENT:

Do you have FOOD Allergies? ____YES ____NO IF YES List:
Have you had a weight loss or gain of 10 pounds in last 3 months? _____YES _____NO If YES explain:
Have you had a decrease in food intake and/or appetite? ____YES _____NO If YES explain:
Do you have any Dental Problems? _____YES _____NO If YES explain:
Do you Binge eat or induce Vomiting? _____YES _____NO If YES explain:

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

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**
☐	☐	☐	☐

GAD7

Over the last two weeks, how often have you been bothered by the following problems?	Not at ALL	Several Days	More than Half the Days	Nearly Every Day
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 irritable				
7. Feeling afraid as if something awful might happen				
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? *Circle One:* **Not Difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**				

PCL5

In the past month, how much were you bothered by:	Not at All	A Little Bit	Moderate	Quite a Bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?					
2. Repeated, disturbing dreams of the stressful experience?					
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4. Feeling very upset when something reminded you of the stressful experience?					
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6. Avoiding memories, thoughts, or feelings related to the stressful experience?					
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?					
8. Trouble remembering important parts of the stressful experience?					
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10. Blaming yourself or someone else for the stressful experience or what happened after it?					
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12. Loss of interest in activities that you used to enjoy?					
13. Feeling distant or cut off from other people?					
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15. Irritable behavior, angry outbursts, or acting aggressively?					
16. Taking too many risks or doing things that could cause you harm?					
17. Being "superalert" or watchful or on guard?					
18. Feeling jumpy or easily startled?					
19. Having difficulty concentrating?					
20. Trouble falling or staying asleep?					