DOCTORS' VOLUNTEER CLINIC

PATIENT INFORMATION

TODAY'S DATE: _____/_____/_____

Last Name:

First Name:

Middle Name:

Date of Birth:

SSN#:

Address:

Zip Code:

City: **State:**

if patient is a minor, the information below will be the

parent or guardian's information

Emergency Contact:

Name:

Relationship:

Phone:

Race: Alaska Native: ☐

American Indian: ☐ Asian: ☐

African American/Black: ☐ Hawaiian: ☐

Pacific Islander: ☐ White: ☐

Other: ☐

Hispanic, Latino, Spanish? Yes: ☐ No: ☐

Marital Status: Single/Separated/Divorced: ☐

Married/Partner: ☐ Prefer not to say: ☐

How were you referred to us?

Self/Family/Friends: ☐ Emergency Room: ☐

Online: ☐ Court: ☐ Behavioral Medicine: ☐

Switchpoint: ☐ LDS: ☐ Family Healthcare: ☐

Other: _____

Home Phone:

Mobile Phone:

Consent to Text: Yes: ☐ No: ☐

Email:

Sex: Male: ☐ Female: ☐

Consent to leave voicemail with medical information?

Yes: ☐ No: ☐

Consent to discuss medical information with family?

Yes: ☐ No: ☐

If yes, who?

Family Size (circle one): 1 2 3 4 5 6 7 8 9

Monthly Household Income: $_____.00

US Citizen: Yes: ☐ No: ☐

Disabled: Yes: ☐ No: ☐

Highest Education Level: K12: ☐

High School/GED: ☐

Higher Education: ☐

Employment: Part Time: ☐

Full Time: ☐

Retired: ☐

Unemployed: ☐

Homeless: Yes: ☐ No: ☐

Insurance / Medicaid: Yes: ☐ No: ☐

If yes, what type?

Military Veteran: Yes: ☐ No: ☐

⇨SEE BACK SIDE⇦

The Doctors' Volunteer Clinic Patient Consent Form

Healthcare Providers at the Doctors' Volunteer Clinic do not receive any compensation or remuneration for providing services and are volunteering their time. Therefore, in accordance with the Utah Health Care Malpractice Act and Health Care Providers Immunity for Liability Act, *Section 58-133* , The Doctors' Volunteer Clinic is not liable for any civil damages for acts or omission except for those acts or omissions that are willful and wanton.

I have read and understand the above and give my consent to treatment and consent to waive any right to sue for professional negligence except for acts or omission which are grossly negligent or are willful and wanton.

Signature:_____ Date: _____

Declaration of Eligibility for Diagnostic Services Voucher

This form serves as documentation for the Doctors' Volunteer Clinic and Intermountain Healthcare to determine my eligibility for a Diagnostic Services Voucher to be used at an Intermountain Healthcare facility. I understand that if I am not eligible for a voucher I am expected to pay the full cost of the diagnostic services at the Intermountain Healthcare Facility. I understand that if I need help paying my bills, I can meet with an Intermountain Healthcare Eligibility Counselor.

I hereby state that the information given herein is true and correct. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services from Intermountain Healthcare.

Signature:_____ Date: _____

Health Information Exchange

A Health Information Exchange ("HIE") shares health information among participating doctors' offices, hospitals, diagnostic centers, pharmacies, and other health care providers through a secure, electronic means. The Doctors' Volunteer Clinic participates in the CommonWell/ Careequality Network. Your health care information is available to particpating healthcare providers where and when they need it for your care without delay. This allows your providers to have the benefit of your most recent health information from other participating providers who are taking care of you.

By signing, I affirm my approval for my data to be shared with providers at connected care locations and medication history with pharmacy benefit managers.

Signature:_____ Date: _____

DOCTORS' VOLUNTEER CLINIC

1036 E. Riverside Dr. St. George, UT 84790 Phone: 435.656.0022 Fax: 435.634.8166 volunteerclinic.org

Mental Health Client Informed Consent

Please read this sheet carefully and sign the agreement below.

Office Hours: The Clinic office hours are Monday through Thursday 9:00 – 4:00 and Fridays from 9:00 – 2:00. Each counseling session is by appointment only and is typically 50 minutes long. In the event you experience a life-threatening emergency and are unable to reach your counselor, please engage the emergency medical system by dialing 911 or go to the Emergency Department.

Crisis Appointments: The Clinic offers an open appointment daily at 12:00pm for people who are having severe symptoms or who are suicidal. If you feel you are having an emergency or cannot wait until your next appointment, please feel free to walk-in or contact the clinic for an emergency appointment.

Payments and Fees: A $10.00 donation is requested for counseling and medication management services. If the client cannot pay this at the time of the visit, it can be paid at a later date or in some cases the fee can be waived. We will accept any amount the client is able to pay. Clients must also meet the displayed required income guidelines and have no health insurance.

Cancellation Policy: One hour is reserved for counseling appointments. If the client is unable to make the appointment, notice of 24 hours must be given. Cancellations without notice will be considered a no-show. If the appointment is on a recurrence and is no-showed, all remaining appointments will be cancelled if contact cannot be made. Permission from the counselor must be obtained in order to reschedule new appointments after 2 no-shows.

Insurance: We do not bill health insurance and in most cases do not accept clients who have health insurance or Medicaid. Please discuss exceptions with the office manager.

Counselors in Training: The Doctors' Volunteer Clinic works with colleges and universities who train counselors and nurse practitioners to provide mental health services; therefore, the counselor assigned to you may be a student intern or associate who is in the process of completing coursework and fulfilling state and national licensing requirements. All student interns and associates are supervised in accordance to Utah State Law by a licensed mental health professional to ensure quality service. Please feel free to ask your counselor about their training and experience. Please direct any concerns about your counselor to the office manager.

Confidentiality: All communications between client and therapist will be held in confidence and will not be revealed unless authorized by you and/or required by law such as situations of child abuse or threats of physical harm to self or others. We reserve the right to discuss information regarding your counseling/therapy with clinical peers, and/or clinical supervisors relative to case review.

Outcome Measurement Questionnaire: Each time you visit your counselor you will be directed to take a questionnaire called the OQ45. This questionnaire is designed to help your counselor understand what you have been experiencing between sessions and whether or not you are responding to treatment.

Workability Reports, SSI/SSDI, and Medicaid Paperwork, Mental Health Assessments: We do not complete SSI/SSDI or Medicaid Disability paperwork regarding mental status. A licensed provider can however fill out the short term workability report. For those applying for disability or Medicaid, we will gladly fax the records we generate while working with you upon your written consent.

In accordance with Utah Health Care and Malpractice Act & Health Care Providers Immunity from Liability Act section 58-13-3 in exchange for uncompensated health care, I give my consent to treatment and waive my right to sue for professional negligence, except for acts or omission which are grossly negligent or are willful and wanton.

I have read and agree to the policies as listed above.

Client Name (Please Print) Date of Birth

Client Signature Today's Date

Client Name: _____ Date of Birth: _____ Gender: ____ Today's Date: _____

Doctors' Volunteer Clinic
Healthcare with Heart

1036 E. Riverside Dr. St. George, UT 84790
Phone: 435.656.0022 Fax: 435.634.8166
doctorsvolunteerclinic.org

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

PRESENTING PROBLEM

Please describe what brings you in today? _____

_____

How long have you been experiencing this problem? □ Less than 30 days □ 1-6 months □1-5 years □5+years

Rate the intensity of the problem 1 to 5 (1 being mild and 5 being severe): □ 1 □ 2 □ 3 □ 4 □ 5

Is the problem interfering with your day-to-day functioning?
□ no
□ yes, please describe: _____

Are you currently or have you in the last 30 days experienced any of the following symptoms? (Check all that apply)

□ Sadness	□ Hopeless/Helpless	□ Sleep Too Much	□ Fatigue/ No Energy	□ Poor memory
□ No Motivation	□ Lack of Interest	□ Thoughts of Dying	□ Guilt	□ Feel Worthless
□ Not Hungry	□ Prefer Being Alone	□ Irritable/Angry	□ Can't Sleep	□ Too Much Energy
□ No Need for Sleep	□ Talk Too Fast	□ Impulsive	□ Have Special Powers	□ Restless/Can't Sit Still
□ Suspicious	□ Hearing Things	□ Seeing Things	□ Panic attacks	□ People Watching Me
□ People Out to Get Me	□ Feeling Nervous	□ Fearful		□Can't be in Crowds
□Easily startled	□ Avoidance	□ Reoccurring Nightmares		

How can we best help you today?_____

_____

TREATMENT HISTORY

Have you had previous psychotherapy? □ yes □ no
If yes, please list: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □ yes □ no
If yes, please list:_____

_____

Have you ever been in the hospital for the treatment of mental illness? IF NO SKIP TO NEXT SECTION □ yes □ no
Where were you admitted? □ BMED □ ED □ Access □ Other_____
When were you in the hospital? _____
How long were you in the hospital? _____
How many times have you been in the hospital for the treatment of mental illness? _____

SUBSTANCE ABUSE / ADDICTION HISTORY

Do you smoke cigarettes or use other tobacco products? □ yes □ no
If yes, how much daily? _____

Do you drink alcohol? □ yes □ no
If yes, how much and how frequently in the past 30 days?_____

Do you use illegal drugs? □ yes □ no
If yes, what drugs do you use?_____
How much and how frequently in the past 30 days? _____

Do you use prescribed narcotics? □ yes □ no
If yes, what prescribed narcotics do you use?_____
How much and how frequently do you use them? _____

Would you or someone you know say you are having problems with other addictions, i.e. gambling, pornography or shopping? □ now □in the past

Are you at risk for HIV/AIDS/Sexually transmitted infections (unsafe sex, using needles)? □ yes □ no

MEDICAL HISTORY

Are you currently being treated for any of the items listed below that might be affecting your current condition?

□ Past surgery	□ Head injury	□ Epilepsy
□ Cancer	□ Coronary heart disease	□ Multiple sclerosis
□ Stroke	□ Alzheimer's disease	□ HIV/AIDs
□ Parkinson's disease	□ Systemic lupus erythematosus	□ Rheumatoid arthritis
□ Other (please describe):		

PERSONAL, FAMILY, AND RELATIONSHIPS

Describe your current living situation and your family layout: _____

_____

Describe the family you grew up in:_____

_____

Describe the relationships in your family:_____

_____

Describe the relationships in your support system (friends, extended family, etc.?)_____

_____

What is your marital status now? □ single □ married □ living as married □ divorced □ widowed

Are you currently employed? □ yes □ no
If yes, who is your current employer/positon?_____

What is your highest level of education?
□K-12 (did not complete high school) □ High School Graduate/ GED or Higher □ Bachelor's Degree or Higher

Do you currently attend school? □ yes □ no
If yes, where and what level? _____

As a child were you (or are you currently) enrolled in any special education services? □ yes □ no
If yes, pleas describe: _____

FAMILY MENTAL HEALTH HISTORY
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	

LEGAL
Have you ever been arrested? IF NO SKIP TO NEXT SECTION □ yes □ no
How many times? _____
How recently? □ in the past month □ in the past year □ in the past 2-4 years □ 5+ years
What were you arrested for?
_____
Were you ever sentenced for a crime? □ yes □ no
Are you currently or have you ever been on probation or parole? □ currently □ in the past
Name of Parole Officer: _____

INCOME, BASIC NEEDS AND HOUSING
Do you have an income? □ yes □ no
If yes, is it enough to meet your basic needs? □ yes □ no
Are you currently homeless? □ yes □ no
If yes, how long have you been homeless? □ Less than 30 days □ 1-6 months □ 1-5 years □5+ years
Have you ever been homeless in the past? □ yes □ no
If yes, when and for how long? _____
How well do you do at caring for yourself (bathing, eating right, etc.)? □ good □ fair □ poor

For staff use only:

DIAGNOSIS:

INITIAL TREATMENT RECOMMENDATIONS:

Counselor Signature:_____ Date:_____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): As opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) Suicide Behavior Question:	**YES**	**NO**
Have you ever done anything, started to do anything, or prepared to do anything to end your life?		
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?		**Not bothered (0)**	**Bothered a little (1)**	**Bothered a lot (2)**
1.	Stomach pain	☐	☐	☐
2.	Back pain	☐	☐	☐
3.	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
4.	Feeling tired or having little energy	☐	☐	☐
5.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐
6.	Menstrual cramps or other problems with your periods	☐	☐	☐
7.	Pain or problems during sexual intercourse	☐	☐	☐
8.	Headaches	☐	☐	☐
9.	Chest pain	☐	☐	☐
10.	Dizziness	☐	☐	☐
11.	Fainting spells	☐	☐	☐
12.	Feeling your heart pound or race	☐	☐	☐
13.	Shortness of breath	☐	☐	☐
14.	Constipation, loose bowels, or diarrhea	☐	☐	☐
15.	Nausea, gas, or indigestion	☐	☐	☐

PHQ-15 Score ☐ **=** _____ **+** _____

B. 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.	Feeling nervous anxiety 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 ……	☐	☐	☐	☐

GAD-7 Score ☐ **=** _____ **+** _____ **+** _____

C. Questions about anxiety attacks.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?……..		
If you checked "NO", go to question E.	☐	☐
b. Has this ever happened before?……	☐	☐
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?……	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?……	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?……	☐	☐

D. 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 beter off dead of or hurting yourself in some way……..	☐	☐	☐	☐

PHQ-9 Score ☐ **=** _____ **+** _____ **+** _____

E. If you checked off any problems on this questionnaire, 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
☐	☐	☐	☐

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.