Empower Recovery Services
Adult History Questionnaire

Name: _____Preferred Name:_____

Today's Date_____ Age: _____ Gender: _____ Date of Birth_____Race: _____

Address: _____ Phone: _____

OK to leave Message? _____

Emergency Contact: _____

Phone: _____

Were you referred to Empower (if yes who)? _____

What led you to seek our services? _____

_____

_____

_____

When did this begin? _____ How often this occurring? _____

Family concerns: _____

_____

Primary Household (who currently lives in house)

Name	Age	Relationship	Quality of relationship

Highest level of education? _____

Belief or religion practiced? _____

Physical health issues and medications? _____

_____

Legal history or under probation? _____

_____

Past mental health diagnoses or services? _____

_____

_____

Psychiatric hospitalizations, when and where? _____

_____

Trauma History (did you experience any of the following:

Trauma history	Yes	No	If yes, still occurring?	Therapy over this?
Physical abuse				
Witnessed or victim of domestic violence/abuse				
Physical neglect				
Emotional abuse				
Sexual abuse/molestation				
Community violence				
Bulling				
Child protection services involved with family				
Other traumatic experiences or losses				

Other traumatic experiences? _____

_____

_____

_____

Family history of medical issues? _____

Family history of addiction? _____

Family history of mental health issues? _____

Family history of legal issues? _____

Do you have any concerns over your use of alcohol or drugs? Yes_____ No _____

Do other people have concerns over your drinking or drug use? _____

Substance	1st time using/ Last time used	How much/ How often
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Methamphetamine/ Stimulants		
Heroin		
Cocaine		
Prescription drugs		
Synthetic drugs		
Other:		

Has you ever participated in chemical dependency treatment programming? _____

Where and when? _____

_____

Any past suicide attempts? _____

If yes, when? _____

Any past self injurious behaviors (cutting or burning)? _____

If yes, when was last time? _____

Complications with your mother's pregnancy or your birth? _____

_____

Are you employed? _____Where? _____Past jobs?_____

_____

Ever been in the military? _____

Sleep issues? _____ Appetite changes? _____

Allergies? _____ Surgeries? _____

Do you smoke? _____ How much and how often? _____

Do you see or hear things others do not? _____

What do you think would be helpful for you? _____

_____

_____

Anything else that it would be helpful for us to know? _____

_____

_____

Presenting Symptoms

Depression

- ☐ sadness most of the time
- ☐ irritability
- ☐ anhedonia
- ☐ appetite increase/decrease
- ☐ psychomotor agitation
- ☐ fatigue/loss of energy
- ☐ worthlessness or guilt
- ☐ poor concentration
- ☐ indecisiveness
- ☐ sleep disturbance
- ☐ crying spells
- ☐ withdrawal/isolation
- ☐ low self esteem
- ☐ restlessness
- ☐ muscle tension
- ☐ hyposomnia

Manic

- ☐ inflated self esteem
- ☐ decreased need for sleep
- ☐ more talkative
- ☐ racing thoughts
- ☐ distractability
- ☐ increased goal directed activity
- ☐ increased agitation
- ☐ psychomotor agitation
- ☐ impulsivity(pleasurable activities)
- ☐ muscle tension

Anxiety

- ☐ excessive anxiety and worry
- ☐ difficulty controlling the worry
- ☐ heart palpitations
- ☐ increased heart rate
- ☐ sweating
- ☐ trembling/shaking
- ☐ shortness of breath or smothering
- ☐ feelings of choking
- ☐ chest pain
- ☐ nausea
- ☐ dizziness
- ☐ derealization
- ☐ restless
- ☐ easily fatigued
- ☐ difficulty concentrating
- ☐ irritability
- ☐ muscle tension
- ☐ sleep problems
- ☐ fear of social performance
- ☐ exposure creates panic
- ☐ depersonalization
- ☐ loss of control of feelings
- ☐ fear of dying
- ☐ tumbling or tingling sensations
- ☐ chills
- ☐ hot flashes

Agoraphobia

- ☐ anxiety in situation where escape is not easy
- ☐ avoidance of feared situation-lifestyle is severely limited

PTSD

- ☐ experienced major event or death
- ☐ intense fear or helplessness
- ☐ distressing recollections
- ☐ distressing dreams
- ☐ acting or feeling trauma reoccurring
- ☐ intense reactions to cues or reminders
- ☐ physiological reactivity to cues
- ☐ avoid thoughts or feelings with trauma
- ☐ failure to recall parts of trauma
- ☐ diminished interests
- ☐ feeling detached from others
- ☐ sense of shortened future
- ☐ sleep problems
- ☐ irritability or anger outburst
- ☐ difficulty concentrating
- ☐ hypervigilance
- ☐ exaggerated startle response

ADHD/Inattention

- ☐ poor attention or careless mistakes
- ☐ difficulty sustaining attention
- ☐ not listening when spoken to
- ☐ limited follow through
- ☐ difficulty organizing tasks
- ☐ avoidance requiring sustained attention
- ☐ loses things
- ☐ easily distracted
- ☐ forgetful

ADHD/Hyperactivity or Impulsivity

- ☐ blurts out/interrupts
- ☐ fidgety
- ☐ difficulty staying quiet
- ☐ on the go
- ☐ talks excessively
- ☐ leaves seat often

Conduct Disorder

- ☐ initiated physical fights
- ☐ bullies or intimidates others
- ☐ uses weapons on others
- ☐ physically cruel to people
- ☐ physically cruel to animals
- ☐ stolen with confrontation
- ☐ forced someone into sex
- ☐ deliberate fire starting
- ☐ deliberate destruction of property
- ☐ broken into house/building/car
- ☐ often lies or cons
- ☐ stolen without confrontation
- ☐ truant before age 13

WHODAS 2.0
WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

12-item version, self-administered

Patient Name: **Age:** **Sex:** ☐Male ☐Female **Date:**

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please select only **one** response.

							Clinician Use Only
Numeric scores assigned to each of the items:		0	1	2	3	4	Raw Item Score
In the last 30 days, how much difficulty did you have in:							
S1	Standing for long periods such as 30 minutes?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S2	Taking care of your household responsibilities?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S3	Learning a new task, for example, learning how to get to a new place?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S4	How much of a problem did you have joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S5	How much have you been emotionally affected by your health problems?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S6	Concentrating on doing something for ten minutes?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S7	Walking a long distance such as a kilometre [or equivalent]?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S8	Washing your whole body?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S9	Getting dressed?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S10	Dealing with people you do not know?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S11	Maintaining a friendship?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
S12	Your day-to-day work?	☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty ☐Extreme Difficulty or cannot do					0
						Total Item Score	0/48
						Total Percentage	0%

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days***
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days***
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days***

Client: .

Date:
Client:
Date of Birth:

Patient Health Questionnaire (PHQ-9)

A. Over the last 2 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. Little interest or pleasure in doing things.	☐0	☐1	☐2	☐3
2. Feeling down, depressed, or hopeless.	☐0	☐1	☐2	☐3
3. Trouble falling asleep, 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 badly about yourself, feeling that you are a failure, or feeling that you 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

Total Score: 0

B. 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

Interpretation of Total Score

Total Score	Depression Severity
0 - 4	None - Minimal
5 - 9	Mild
10 - 14	Moderate
15 - 19	Moderately Severe
20 - 27	Severe

Clinician Signature: _____

GAD-7 Anxiety

Name:
Date:

Over the last 2 weeks, how often have you been bothered by the following problems? (check to indicate your answer)	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
Column Totals:	0 +	0 +	0 +	0
= Total Score:	0			

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

Client Signature: _____ Date: _____

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ).
The PHQ was developed by Drs. Robert L. Pitzer, janet B.W. Williams, Kurt Kroenke and collegues. For research.

CAGE-AID Questionnaire

Patient Name: _____ Date of Visit: _____

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Client Signature: _____ Date: _____

Source: Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol & drug abuse. *Wisconsin Medical Journal* 94: 135-140, 1995.

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   or
   Act in a way that made you afraid that you might be physically hurt?

3. Did an adult or person at least 5 years older than you ever ...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?

4. Did you often feel that...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?

5. Did you often feel that...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

10. Did a household member go to prison?

ACE Score 0