Patient Health Questionnaire (PHQ-9)

Name _____ Phone # Date

Over the *last two 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**
	Add Columns			
(Healthcare professionals: For interpretation of TOTAL, please refer to accompanying scoring card.)	**TOTAL**			

10. 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 _____

Thank you for answering these questions. Your answers help us ensure the best care for your visit. Suicidal thoughts and substance use and mental health problems are common. If you currently feel unsafe due to your mental health, please call or text one of the following numbers now, or go to the emergency room for evaluation: Suicide & Crisis Lifeline 988 and Crisis Text Line (text "START" to 741741) for free, confidential support 24/7. These numbers may be important for you to keep for future use for yourself or someone else you care about.

16808 (10/2022)

CAGE Screening Tool

For Adults

CAGE-AID

☐ Yes ☐ No 1. Have you ever felt you ought to **cut** down on your drinking or drug use?

☐ Yes ☐ No 2. Have you ever had people **annoy** you by criticizing your drinking or drug use?

☐ Yes ☐ No 3. Have you ever felt bad or **guilty** about your drinking or drug use?

☐ Yes ☐ No 4. Have you ever had a drink or used drugs as an **eye opener** first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?

For Adolescents 12-18

Kiddie-CAGE

☐ Yes ☐ No 1. Have you used more than one **chemical** at the same time in order to get high?

☐ Yes ☐ No 2. Do you **avoid** family activities so you can use?

☐ Yes ☐ No 3. Do you have a **group** of friends who also use?

☐ Yes ☐ No 4. Do you use to improve your emotions such as when you feel sad or depressed?

Generalized Anxiety Disorder Questionnaire (GAD-7)

Name _____ Date _____

Over the *last two 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. 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**
	Add Columns		+	+
	TOTAL			

8. 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

Score: 5-9 = mild anxiety; 10-14 = moderate anxiety; 15-21 = severe anxiety

Adolescent/Adult Initial Assessment

Whenever possible please have the individual completing the assessment fill out this form. The following information will assist our clinical staff with getting to know you and completing the initial assessment appointment. **It is very important to fill this out as completely as possible prior to your initial appointment**. Providers may ask you to fill this out prior to being seen. Please use black ink.

Date	Legal name	Preferred name

What sex were you assigned at birth?	Gender identity
□ Male □ Female	

What pronouns should we use to refer to you while you are in our care?

□ He/Him □ She/Her □ They/Them □ Other _____

What prompted you to schedule an Eating Disorder Assessment at Melrose Center? _____

Please list the name of who referred you to Melrose Center? What is their relationship to you?

I have heard about Melrose Center from (check all that apply):

- ☐ Friend/Family/Neighbor
- ☐ Advertisement (Radio, print, billboard)
- ☐ Online (Facebook, website, search)
- ☐ Medical or Mental Health Provider
- ☐ School Social Worker or Counselor
- ☐ Other _____

PLEASE COMPLETE FOR 18 YEARS AND YOUNGER

Current living arrangements

- ☐ Lives with both parents (biological or adoptive) in same household
- ☐ Single parent
- ☐ Shared custody (parents in different households) primary residence _____
- ☐ Relative/guardian's home
- ☐ Other, describe _____
- ☐ Hospital
- ☐ Residential care
- ☐ Temporary housing
- ☐ Friend's home
- ☐ Homeless

Is your child adopted? ☐ No ☐ Yes. If yes, how old was your child at the time of adoption? _____

Is your child aware of the adoption? ☐ No ☐ Yes

FAMILY ENVIRONMENT/RELATIONSHIPS

Are any other issues seriously affecting your family of which you would like us to be aware?

Has your child ever experienced or witnessed any of the following?

☐ Domestic violence/abuse ☐ Emotional abuse ☐ Physical abuse
☐ Community violence ☐ Physical neglect ☐ Fire
☐ Sexual assault/molestation ☐ Natural disasters ☐ Other _____

☐ Yes ☐ No Have you or your child been involved with any of the following county resources?

☐ PCA (Personal Care Assistance) ☐ PACER (Parent Advocacy Coalition for Educational Rights)
☐ Foster care ☐ The ARC
☐ County social worker ☐ Developmental disorder social worker
☐ Respite care ☐ Other _____

☐ Yes ☐ No Does your child have a history of legal charges? Please describe.

_____

☐ Yes ☐ No Is your child currently on probation?

☐ Yes ☐ No Has your child ever been on probation?

☐ Yes ☐ No Has your child ever been court-ordered into chemical health or mental health treatment?

☐ Yes ☐ No Has your child ever had involvement with Child Protection Services (CPS)? Please describe.

_____

Name of CPS caseworker(s) assigned to family (if applicable)

☐ None reported _____

Name of guardian ad litem (GAL) or court appointed special advocate (CASA) assigned to family?

☐ None reported

END 18 YEARS AND YOUNGER SECTION

What eating – related symptoms or behaviors do you experience?

	Current & Frequency	Past & Frequency
Overeating/Emotional Eating/Binge eating		
Purging (self-induced vomiting)		
Restricting food / under-eating		
Compulsive or excessive exercise		
Diet pills / supplements or weight loss programs		
Hiding food		
Excessively Picky eater		
Laxative use		

Please list your highest and lowest weights:

Highest weight _____ Age at highest weight _____
Lowest weight _____ Age at lowest weight _____

When did you first notice you had a problem with your eating and what was going on in your life then?

_____

_____

_____

_____

Eating Pattern (over past 1 month)

Breakfast _____

Snack (a.m.) _____

Lunch _____

Snack (p.m.) _____

Dinner _____

Snack (evening) _____

Fluid intake _____

What foods do you avoid? _____

What rules do you follow around eating? _____

☐ Yes ☐ No Have you experienced any negative incidents in your life related to weight, diets, or eating? Please explain:

What percent of the waking day do you spend thinking about food, weight and/or body image?

- ☐ 75-100% All day
- ☐ 50-74% Over half your day
- ☐ 25-49% Quarter to half of your day
- ☐ Less than 25% of each day

How many times a week do you exercise and for how long? _____

Who do you live with? _____

☐ Single ☐ Married, how long: _____ ☐ Widowed, how long: _____
☐ Domestic partnership ☐ Divorced, how long: _____

Sexual orientation? _____ Do you have children? _____

Employment status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

If applicable, occupation/type of work/jobs: _____

☐ Yes ☐ No Do you consume alcohol? If yes, how many drinks per day? _____

☐ Yes ☐ No Have you ever felt you should cut down on your drinking?

☐ Yes ☐ No Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

☐ Yes ☐ No Have you ever had head trauma that resulted in loss of consciousness?

☐ Yes ☐ No Have you ever used street drugs or illicit? If yes, are you currently using? ☐ Yes ☐ No

☐ Yes ☐ No Do you smoke cigarettes? If yes, how much per day? _____

☐ Yes ☐ No Have you ever used other tobacco products?

☐ Yes ☐ No Do you drink caffeine products? If yes, how many drinks per day? _____

Please list all of your medications, or bring a list with you of all prescribed, over the counter drugs, vitamins and/or herbal supplements that you currently take:

_____

_____

_____

_____

_____

Who is your primary health care provider (physician/PA/NP)? _____

_____

☐ Yes ☐ No Any history of medical problems? Please explain: _____

_____

_____

☐ Yes ☐ No Any history of surgeries? Please explain: _____

_____

_____

☐ Yes ☐ No Have you ever been hospitalized? Please explain: _____

_____

_____

When was your last physical? _____

☐ Yes ☐ No Any known drug, environmental or food allergies? Please list: _____

_____

Date of last bowel movement? _____

If female, date of last menstrual period: _____ Age of first menses? _____

Are you on hormonal contraception (IUD, implant, other)? ☐ Yes ☐ No ☐ N/A

Do your periods occur monthly? ☐ Yes ☐ No If no, how often do they occur? _____

Have you experienced any of the following in the past 3 months? Check all that apply.

Medical

- ☐ Lightheadedness
- ☐ Dizziness/fainting
- ☐ Chest pain
- ☐ Sensitivity to cold
- ☐ Leg cramps
- ☐ Shortness of breath
- ☐ Irregular pulse
- ☐ Heart racing
- ☐ Neck/back pain
- ☐ Excessive sweating
- ☐ Blueness of lips/fingers
- ☐ Chronic pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel problems
- ☐ Stomach problems
- ☐ Trouble swallowing
- ☐ Appetite change
- ☐ Heartburn
- ☐ Cough
- ☐ Vomiting blood
- ☐ Dry mouth
- ☐ Visual disturbances
- ☐ Seizures

Mood

- ☐ Depressed mood/unhappy
- ☐ Little interest or pleasure in most activities
- ☐ Appetite or weight changes
- ☐ Trouble falling asleep
- ☐ Waking up in the middle of the night
- ☐ Sleeping too much
- ☐ Fatigue
- ☐ Feelings of worthlessness/guilt
- ☐ Problems concentrating
- ☐ Problems making decisions
- ☐ Thoughts of death
- ☐ Too much energy
- ☐ Impulsive behaviors
- ☐ Have gone days without sleeping

Anxiety

- ☐ Worry about a number of things
- ☐ Feel anxious majority of the time
- ☐ Difficult to control the worry
- ☐ Anxiety or fear in social situations
- ☐ Fear others are judging you
- ☐ Worry you will embarrass yourself
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Feeling restless
- ☐ Obsessive thinking
- ☐ Rituals to lower anxiety
- ☐ Nightmares
- ☐ Intrusive memories/ flashbacks
- ☐ Avoid people or places that bring up memories

General Life Concerns

- ☐ Financial problems
- ☐ Relationship/marital concerns
- ☐ Housing problems
- ☐ Problems completing daily tasks
- ☐ Hygiene issues
- ☐ Work concerns
- ☐ Legal issues

☐ Yes ☐ No Have you ever contemplated suicide in the past or ever engaged in any kind of self-harm behavior (suicide attempt or self-harm)? If yes, please describe:

_____

_____

_____

☐ Yes ☐ No Have you ever talked with a psychologist, therapist, counselor, chaplain or other professional about emotional or personal concerns? If yes, please complete the following:

Reason for treatment Setting (outpatient) Dates Who did you talk to?

_____

_____

_____

☐ Yes ☐ No Have you ever been hospitalized for emotional problems or for substance abuse?

Reason for inpatient treatment Dates For how long? Hospital name

_____

_____

_____

Place an “X” in appropriate boxes to identify all illnesses/conditions in your blood relatives:

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Depression								
Anxiety								
Bipolar/manic depression								
Schizophrenia/psychosis								
Eating disorder								
Psychiatric hospitalization								
Alcohol/drug abuse								
Suicide/suicide attempt								

Where were you born? _____ Where did you grow up? _____

I have _____brothers and _____sisters. I was born (check one) ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ other _____

Parents are (check all that apply): ☐ Never married ☐ Still married ☐ Separated ☐ Divorced ☐ Unknown

If parents are divorced, how old were you? _____ Who raised you? _____

While you were growing up, during your first 18 years of life: (check one for each)

☐ Yes ☐ No Did a parent or other adult in the household often or very 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?

☐ Yes ☐ No Did a parent or other adult in the household often or very often…Push, grab, slap or throw something at you? **or** Ever hit you so hard that you had marks or were injured?

☐ Yes ☐ No Did anyone ever…Touch or fondle you or have you touch their body in a sexual way? **or** Attempt or actually have oral, anal or vaginal intercourse with you?

☐ Yes ☐ No Did you often or very 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?

☐ Yes ☐ No Did you often or very often feel that…You didn’t have enough to eat, had to wear dirty clothes or 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?

☐ Yes ☐ No Were your parents separated or divorced?

☐ Yes ☐ No Was your mother or stepmother or a parent figure...Often or very often pushed, grabbed, slapped or had something thrown at her? **or** Sometimes, often or very often kicked, bitten, hit with a fist or hit with something hard? **or** Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

☐ Yes ☐ No Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

☐ Yes ☐ No Was a household member depressed or mentally ill or did a household member attempt suicide?

☐ Yes ☐ No Did a household member go to prison?

What is your highest level of education? _____

If you are in school, where do you go to school? _____

☐ Yes ☐ No Do you have any learning disabilities?

☐ Yes ☐ No Were you ever suspended or expelled from school?

☐ Yes ☐ No Have you ever served in the military?

What extracurricular activities are/were you involved with during school? _____

What activities or hobbies do you enjoy for fun or leisure time? _____

Are you currently facing, or do you have a history of legal problems? _____

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your service preferences:

Please indicate your ethnicity or cultural identification and their impact, if any, on your service preferences:

Is there anything else you feel it is important for us to know right now? _____

What do you want to achieve with eating disorder treatment? _____

Signature of person filling out the form	Printed name	Date

Informed Consent and Notice of Rights for Psychological Services

(Check one box)

☐ Bring this copy to your appointment ☐ Keep this copy for your records

The care team at the Melrose Center is made up of a multidisciplinary group of professionals dedicated to helping women and men reclaim their lives from eating disorders. Psychotherapy services for the program are provided by licensed psychologists, licensed clinical social workers and licensed marriage and family therapists.

The following information covers many questions that may arise about psychotherapy and includes a listing of client's rights and psychologist's obligations. Any questions not covered should be brought to the attention of your psychologist.

The Bill of Rights for clients obtaining psychological services is posted in the waiting room. This provision is not a legal bill of rights, but a statement of what you can reasonably expect from a therapist.

Clients seeking psychological services have the right to know the following information.

1. Information about the availability of the therapist. Clients are invited to ask when the therapist is available and where to call during off-hours in case of emergency.

2. Information about the structure of the therapeutic relationship. Clients are invited to ask the following.
    - The manner in which the therapist conducts sessions around intake, treatment and termination. Clients may take an active part in their therapeutic process by asking questions about issues relevant to therapy, specifying therapeutic goals and renegotiating goals, when necessary.
    - The perspective(s) the therapist typically uses to structure therapy and treatment methods. Clients may refuse any intervention or treatment strategy. It is essential, however, that therapist and client work together on a mutually agreed-upon treatment plan.
    - The purpose of and risks involved in psychological treatment. Clients have a right to know, for example, that during the process of therapy, emotional pain and distress can arise that may be uncomfortable.
    - The anticipated length and frequency of treatment and limitations that may arise due to difficulties in financing.
    - The liberty of clients to discuss any aspect of their therapy with others outside the therapy situation, including consulting another therapist.

3. Information about fees and billing arrangements. Clients are invited to inquire about the amount of the fee, the time frame for payment, the method of payment, the access to billing statements and billing for missed appointments and late cancellations.
4. Information about the therapist's status including the therapist's training, credentials and years of experience.
5. Information about informed consent and exceptions to confidentiality. Clients are invited to inquire about the following.
    - The therapist's duty to maintain confidentiality by not releasing information to others unless authorized to do so by the client. Information about your psychotherapy treatment sessions will be discussed with members of your multidisciplinary care team at the Melrose Center to ensure integrated care. Information about your psychotherapy treatment sessions may be disclosed with an outside consultant to ensure quality care.
    - The circumstances under which confidentiality is limited. The therapist's duty is to:
        - warn another in case of potential suicide, homicide or the threat of imminent, serious harm to another individual
        - report knowledge of a child being neglected, physically or sexually abused
        - report knowledge of a vulnerable adult being mistreated
        - report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine and amphetamine or their derivatives
        - report the misconduct of other health care professionals
        - provide to a spouse or the parents of a deceased client access to their child's or spouse's records
        - release records if subpoenaed by the courts
        - provide to parents of minor children (under age 18) access to their children's records. There are situations in which minors can give consent for their own treatment without parental consent. Under these circumstances, the minor alone may authorize release of records. The minor also assumes financial responsibility for health care services when she or he consents to treatment.
        - to release records if subpoenaed by the courts
6. Information about counseling records. Clients are invited to inquire about the following.
    - Record maintenance, including the security and length of time they are kept. Files are stored in a secure, locked location and are kept a minimum of 10 years. For adolescents, records are kept 10 years after the client reaches age 18.
    - Client's right to access personal records.
    - Release policies and procedures.
7. Information about referral questions. Clients are invited to inquire about the client's right to request a referral and the right to require the current therapist to send a written report about services rendered to the qualified referred therapist or organization, upon the client's written authorization.

My signature indicates that I have read this document and have had the opportunity to have my questions answered. I consent to receive psychotherapy services.

Client signature: _____ Date: _____ Time: _____

Parent signature: _____ Date: _____ Time: _____
(if client is a minor)

Support Questionnaire

This is an optional form to help Melrose Center gather additional information about the individual coming in for an Initial Assessment. This form can be filled out by a parent, spouse, friend or other concerned person.

1) Name of person receiving assessment for an eating disorder at Melrose Center?

_____

2) Who is filling out this form and what is your relationship to the person getting an assessment?

_____

3) Please check any of the areas that concern you about this individual:

- ☐ Fights over food or during family meals
- ☐ Restricting, not eating, cutting food into small bits, hiding food
- ☐ Compulsive or excessive exercise; injuries due to this
- ☐ Hiding during meals, fears around eating with others
- ☐ Excessive eating / Binge Eating
- ☐ Purging (vomiting or laxative use)
- ☐ Supplements of any kind: diet pills, protein powders, hormone injections
- ☐ Physical appearance
- ☐ Depression, anxiety, isolation, irritability or other mood changes
- ☐ Compulsive behaviors
- ☐ Self-injurious behavior or suicidal thoughts
- ☐ Difficulty sleeping
- ☐ Alcohol or drug use
- ☐ Lack of resources for basic needs
- ☐ Legal issues
- ☐ Other _____

4) Describe any changes or events in the person's environment (new school, move, job loss, death in family, changes with friends, any changes in their relationships)?

_____

_____

5) Has the individual had significant changes in their academic, social or work performance in the past 6 months?

☐ No ☐ Yes, if yes, please describe: _____

_____

_____

6) Is anyone in the individual's household on a special diet including weight loss programs?

☐ No ☐ Yes, if yes, type of diet and reason for the special diet: _____

7) Has anyone in the family received eating disorder treatment?

☐ No ☐ Yes If yes, who? _____

8) Does anyone in the family have a history of an eating disorder?

☐ No ☐ Yes If yes, when and where? _____

9) Additional comments or concerns? Anything else you want us to know in order to help with our assessment?

Signature of person filling out the form	Printed name	Date

Outside Providers Contact Information

The Melrose Treatment team would like to communicate and best coordinate care with any outside providers you may be working with currently. Please list the names and contact information below of any outside providers you or your loved one have currently established care.

Do you attend the University of Minnesota?

☐ Yes ☐ No

Primary Medical Doctor

Name	
Clinic name	Phone number

Therapist

Name	
Clinic name	Phone number

Psychiatrist

Name	
Clinic name	Phone number

Other (for example: social worker, other medical provider, school counselor, legal, etc.)

Name	
Role	Phone number

Other (for example: social worker, other medical provider, school counselor, legal, etc.)

Name	
Role	Phone number

Melrose Center
3525 Monterey Drive
St. Louis Park, MN 55416

Melrose Center- Maple Grove
Suite 110
9600 Upland Lane N.
Maple Grove, MN 55369

Melrose Center – St. Paul
Suite 2165
2550 University Ave. W.
St. Paul, MN 55114