NORTHERN PINES
Mental Health Center

Date: _____

Dear_____,

Welcome to Northern Pines Mental Health Center. Recently you requested an appointment at our _____ location. This appointment is scheduled on _____ at _____.

****We ask that you arrive 30 minutes prior to your scheduled appointment to complete/sign any paperwork, and to meet with a care coordinator to obtain vitals.**

If you need to change the date or time of this appointment, or if you need to cancel, please call the office 24 hours in advance.

Please bring your **insurance card, Social Security card** and a **picture ID** to this first appointment.

If you have a family member working at Northern Pines, please contact the Director of Outpatient Services at (218)829-3235, to discuss the appropriateness of being a client at our agency.

If you have any other questions or concerns, please feel free to call 320-639-2025 or 1-833-316-0698, and we will be happy to assist you.

Thank you for choosing Northern Pines Mental Health Center. We look forward to meeting you.

Sincerely,

NPMH Outpatient Offices

NORTHERN PINES
Mental Health Center

Name: _____

Date: _____

Please list all of the prescribed and over the counter medications that you are taking. This includes Eye Drops, Inhalers/Nebulizer, Creams/Ointments, Oxygen, Contraceptives, Patches that contain medication, Aspirin, Antacids, Vitamins, Laxatives, etc.

Medication Name and Dosage	Prescriber Name
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 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	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

Total Score: ☐ = **Add Columns** _____+_____+_____

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 at all	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**
_____	_____	_____	_____

Interpreting the Score:

Total Score	**Interpretation**
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

The Fagerstrom Test for Nicotine Dependence

Questions	Answers	Points	
1. How soon after you wake up to you smoke your first cigarette?	Within 5 minutes 6-30 minutes 31-60 minutes After 60 minutes	3 2 1 0	
2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, at the library, in cinema, etc)?	Yes No	1 0	
3. Which cigarette would you hate most to give up?	The first one in the morning All others	1 0	
4. How many cigarettes/day do you smoke?	10 or less 11-20 21-30 31 or more	0 1 2 3	
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes No	1 0	
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes No	1 0	
		Office Use Only	Total_____

How to interpret Nicotine Dependency Score:

Score of 6 or higher: Indicates high nicotine dependency and represents individuals who would be particularly likely to benefit from tapering and/or the prescription of nicotine replacement therapy (gum or patch) to decrease nicotine withdrawal symptoms as an adjunct to standard counseling.

Score of 5 or less: Suggests low to moderate nicotine dependency and represents individuals who may be less likely to require tapering and/or the prescription of nicotine replacement ther4apy (gum or patch). Standard counseling is most appropriate.

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

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 to 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

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

Name: _____

Date: _____

12-item version, self-administered

This questionnaire asks about difficulties due to 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 circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or Cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or Cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or Cannot do
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?	None	Mild	Moderate	Severe	Extreme or Cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or Cannot do
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or Cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or Cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or Cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or Cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or Cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or Cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or Cannot do

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* _____

This completes the questionnaire. Thank you

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last* 2 weeks, how often have you been bothered by any of the following problems? *(circle a number 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 professional: For interpretation of TOTAL, Please refer to accompanying score 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 ____

*****Chart # _____ DXS: _____ ****

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 circle one of the numbers to the right 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:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
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)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4