Patient Name: _____

Clinic Number: _____

GUNDERSEN HEALTH SYSTEM®

DEPARTMENT OF BEHAVIORAL HEALTH
CONSENT FOR TREATMENT

I voluntarily consent to treatment through Gundersen Behavioral Health.

I have received and had explained to me:

- Description of Services
- My Rights and Responsibilities
- The Grievance Procedure
- The Cost of Services
- Emergency Procedures

I understand that Gundersen Behavioral Health uses a multi-disciplinary care team that includes psychiatrists, psychologists, and other mental health and substance abuse care providers.

We are committed to protecting your health information. We create a record of the care and services you receive in our department. In accordance with the 2014 Mental Health Care Coordination Bill, we may disclose your health and/or mental health information to providers who are involved in taking care of you at our facility. Two exceptions are: 1) reporting either suspected or actual child abuse to the appropriate authorities as required by law, or 2) when not disclosing information would pose a clear threat of physical harm to one's self or others.

I will participate in the development of my treatment plan and care. As part of my treatment plan development, I will discuss the benefits of treatment, time frame of treatment, modality of treatment, possible side effects or risks, alternative modes or services, and consequences of not receiving treatment. I understand that the signing of my treatment plan indicates my consent to treatment as described by the plan and my provider.

I understand that I will need to attend regularly scheduled appointments as defined by my treatment plan. Failure to do so may result in discharge from care. If you do not have an appointment with your therapist or counselor in six months, that could be considered reason for discharge. If you do not have an appointment with your Psychiatry Prescriber in 12 months, that could be considered reason for discharge.

I understand that I can withdraw my consent for treatment at any time in writing. By signing below, this consent will remain in effect for 15 months from the date of my (patient/parent/legal guardian) signature.

Patient Signature (required if 12 or over)	Date
Parent/Legal Guardian (If patient is unable to sign or is under age of 18, please complete.)	Date
Staff Member	Date
Care Provider	Date

Check if Applicable:

☐ **I understand that my provider is not currently licensed in the State of Wisconsin and is practicing under the supervision of another licensed provider according to any/all applicable laws and professional standards.**

Patient Name:_____

Medical Record Number:_____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

ADULT INTAKE SCREENING FORM

Who referred you to our clinic? _____

Do you wish others to be involved in your care? If so, please give name(s) and relationship to you:

_____

Please describe the reason you are seeking services: _____

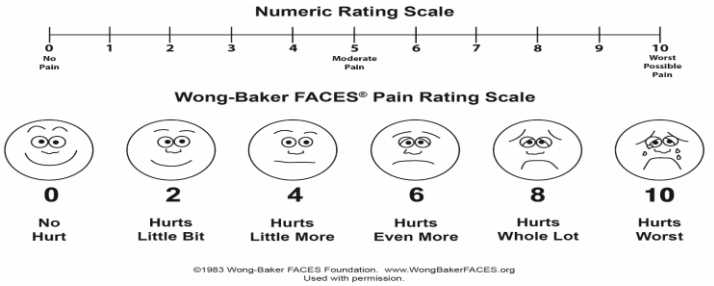
_____

Please list any prior mental health treatment: _____

Please circle any of the following that apply to you:

- ☐ Family problems
- ☐ Social Problems
- ☐ School/Work Problems
- ☐ Physical abuse (current/past)
- ☐ Emotional abuse (current/past)
- ☐ Thoughts of ending your life
- ☐ Spirituality/religious concerns
- ☐ Learning problems
- ☐ Problems with appetite
- ☐ Weight Loss or Gain
- ☐ Others concerned about your eating/weight
- ☐ Sexual abuse (current/past)
- ☐ Legal Issues
- ☐ Thoughts of hurting yourself or others
- ☐ Feelings of hopelessness
- ☐ Past suicide attempt(s)

Physical pain: ☐ Yes ☐ No If yes, please rate:



Medical History

Primary Care Physician: _____

Current Medications: _____

_____

AODA

Have you ever felt you should cut down on your drinking?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
Have you ever felt guilty about drinking?	☐ Yes	☐ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No

Are you currently using tobacco? ☐ Yes ☐ No If yes, do you desire help with quitting? ☐ Yes ☐ No

Are you currently or have you ever served in the military? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

GENERALIZED ANXIETY DISORDER – 7 (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" 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**

FOR OFFICE CODING *0* + _____ + _____ + _____

= Total Score :

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GUNDERSEN HEALTH SYSTEM®

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

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**

FOR OFFICE CODING *0* + _____ + _____ + _____

= Total Score : _____

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
1	2	3	4

Addressograph

GUNDERSEN HEALTH SYSTEM®

PATIENT HEALTH QUESTIONNAIRE – 2 (PHQ-2)

PATIENT HEALTH QUESTIONNAIRE – 2 (PHQ- 2)

Over the <u>last 2 weeks</u>, 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**

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score : _____

Gundersen Health System Trauma Informed Care

Name: **Date:**

Your Childhood:

The questions below are about situations which may have happened while you were growing up and could be affecting your health. To improve your healthcare, this information will become part of your health record and available to your medical care team. We encourage you to ask any additional questions you may have.

Please check *yes* or *no* to the following questions. If you are distressed by answering these questions, please let us know. We are here to help.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household swear at you, insult you, put you down, or act in a way that made you afraid that you might be physically hurt?
   NO___ YES ___
2. Did a parent or other adult in the home push, grab, slap, or throw things at you or hit you so hard that there were marks or were injured?
   NO ___ YES ___
3. Did an adult or person at least 5 years older than you ever touch you sexually or try to make you touch them sexually?
   NO ___ YES ___
4. Did you feel that no one in the family loved you or thought you were special or that your family was not a source of strength, support, and protection for you?
   NO ___ YES ___
5. Did you feel that you didn't have enough to eat, had to wear dirty clothes, had no one to take you to the doctor or were your parents too drunk or high to take care of you?
   NO ___ YES __
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?
   NO ___ YES___
7. Was your mother or stepmother pushed, grabbed, slapped, had things thrown at her, kicked, bitten, hit with a fist, or hit with something hard or repeatedly hit for a few minutes or threatened with a gun or knife?
   NO ___ YES ___
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   NO___ YES ___
9. Was a household member was depressed or mentally ill, or attempted suicide?
   NO___ YES___
10. Did anyone you lived with go to prison?
    NO___ YES ___

***Note:** There are, of course, many other types of childhood trauma – watching a sibling being abused, losing a caregiver, being bullied, homeless, surviving and recovering from a severe accident, etc. If you experienced other types of toxic stress over month or years, then those would likely increase you risk of health consequences.

Please note other stressful experiences for your child here:

Office Use Only – Number of questions answered **YES** _____

Instructions for scoring

- The ACE score is calculated by adding up the total of **YES** responses

How to interpret

- An ACE score of 0 suggests there are no reported childhood events which link to poor health outcomes in adulthood
- An ACE score of 1, 2, or 3 suggests that stressful events in childhood may be a factor in poor health outcomes in adulthood. As the score increases, there is a cumulative higher risk of poor health outcomes.
- An ACE score of 4 or more is correlated with significantly poorer long term health outcomes

What to say

- For long term health and well-being, it is important to keep significantly stressful experiences to a minimum, particularly during the childhood years, but also in adulthood for family and community health

References-

Felitti, V.J., Nordenberg, D. et.al (1998) The relationship of adult health status to childhood abuse and houseold dysfunction. American Journal of Preventive Medicine, 14, 245-258

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O'Connor, C., Finkbiner, C., & Watson, L. (2012) Adverse Childhood Experiences in WI: Findings from the 2010 Behavioral Risk Factor Survey. Madison, WI: WI Children's Trust Fund and Child Abuse Prevention Fund of Children's Hospital & Health System.