

Kuna Counseling Center

190 W. Main, Kuna, Idaho 83634
(208) 922-9001

FOR OFFICE USE ONLY

ID # _____

FAMILY MEMBER _____

TODAY'S DATE _____

Age _____ Sex _____ (Male/Female)

Ethnic/Racial Group:

- African American Caucasian
 Native American Hispanic
 Asian American Other

Ever Treated For: (Check all that apply)

- Depression Anxiety
 Bipolar Disorder Post-Traumatic
Stress Disorder

- Marital Status:** Married
 Divorced/Separated Never Married
 Living With Partner Widowed

Ever Seriously Considered Suicide?

- Yes No

Please list any medical conditions: _____

CADIC Depression Questionnaire

For the questions below, select one option for each question that comes closest to your answer. Over the past two weeks, how often have you:

	None or little of the time	Some of the time	Most of the time	All of the time	Staff Use Only
1. experienced sadness, weepiness, or crying spells?					
2. felt hopeless, pessimistic or discouraged about the future?					
3. not been able to enjoy things?					
4. felt tired, slowed down, or had no energy?					
5. felt no interest in doing things.					
6. had difficulty falling asleep or with sleeping too much?					
7. had difficulty with concentrating, or making decisions?					
8. had no appetite, or found yourself eating when not hungry?					
9. felt guilty or worthless?					
10. felt like you wanted to die or wished you were dead?					
11. felt restless, worried, or nervous?					
12. had physical problems such as headaches, stomachaches, or chronic pain?					

The CADIC Depression Screening Questionnaire is the property of Kuna Counseling Center and may not be copied or used without express permission.

Total Score:

The GAM Assessment

	YES	NO	Staff Use Only
In your lifetime have you <u>ever</u> had a week where you:			
1. felt excessive energy to the point of being hyper, overexcited, or giddy?			
2. had such an unusually high or good mood that others thought you were not yourself?			
3. felt like your mind was flooded with ideas and your thoughts were racing?			
4. did not need as much sleep as you normally do?			
5. acted impulsively by participating in risky or irresponsible behavior (i.e. wild shopping sprees, excessive speeding)?			
6. felt more interest in exciting, pleasurable activities than you usually do?			
7. felt more outgoing, rowdy, or socially open than you regularly do?			
8. found yourself easily distracted by the things going on around you?			
9. felt easily irritated or annoyed by regular everyday things?			

Score:

10. **If you checked "yes" to more than one of the questions above, did they occur in combination with each other?			
11. How big of a problem did these cause you? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			

Have you ever had any direct blood relative (parent, child, sister, brother) with depression, manic-depression, or who was psychiatrically hospitalized?			
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Total Score:

Please turn this form over and complete the backside. Thank you.

CAAP Anxiety and Panic Questionnaire			
During the past <u>six months</u> for a <u>majority of the days</u> have you:	YES	NO	Staff Use Only
1. felt nervous and anxious about things at work, home, or school?			
2. had difficulty controlling worries or fears?			
3. felt restless, nervous, or on edge?			
4. felt tired, exhausted, or easily worn out?			
5. had difficulty concentrating?			
6. felt easily annoyed, irritated or frustrated?			
7. had difficulty with tense or tight muscles?			
8. had trouble falling asleep or with frequent waking during the night?			
9. worried excessively about the usual issues in your every day life?			
10 had others notice that you worry or been told that you worry too much?			
11. had these worries cause noticeable problems in your daily life or caused a lot of distress for you?			
Total Score:			
12. **Additionally, have you ever had a distinct moment in time where you felt intense fear and distress, and experienced at least 3 of the following: shaking or trembling, sweating, loss of breath, feeling dizzy or out of control, chills or hot flushes, rapid heart beat, nausea, or fear of dying?			
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TASA Trauma and Stress Assessment			
Have you ever had or seen a traumatic event where possible loss of life, severe injury or threat of physical well-being was involved?	YES	NO	
Did you feel fear or helpless during or after the event?	YES	NO	
If you answered "Yes" to questions 1 & 2, please proceed to the next Section			
During the past week for most days have you?	YES	NO	Staff Use Only
1. experienced reoccurring and unwanted flashbacks, nightmares, or reminders of the event?			
2. have you made efforts to avoid thinking or talking about this event, or doing things that remind you of it?			
3. have you felt less interest in people and things, a feeling numbness, or trouble experiencing emotions?			
4. have you felt nervous, jumpy, or had a sense of heightened alertness?			
5. have you had trouble with irritability, falling or staying asleep, or with concentrating?			
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THANK YOU FOR COMPLETING THIS FORM. PLEASE RETURN IT TO A STAFF MEMBER TO BE SCORED.

RESULTS AND RECOMMENDATIONS-FOR OFFICE USE ONLY		
Follow up is needed for: (Check all that apply)		
<input type="checkbox"/> Depression	<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Generalized Anxiety Disorder
<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Post-Traumatic Stress Disorder	<input type="checkbox"/> No follow-up needed