

**CONTACT INFORMATION**

<p><b>Legal Name:</b> _____  <small>First Middle Last</small></p> <p><b>Preferred Name</b> _____</p> <p><b>Primary Language</b> _____</p>	<p><b>Date:</b> _____ / _____ / _____</p>
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<p><b>Address:</b></p> <p>Street _____</p> <p>City _____</p> <p>State _____</p> <p>Zip _____</p> <p>County _____</p>	<p><b>Phone/Email:</b> Check boxes if it's ok to Call (C) and/or Leave Messages (LM) C LM</p> <p>Home _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>Cell _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>Work _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>OK to Send Info?</p> <p>Email _____ <input type="checkbox"/></p>
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<p><i>I understand that in the event Aging Center staff are concerned about my safety because he or she was unable to get a hold of me at our scheduled appointment time, I give my permission for my therapist to contact my Emergency Contact as listed above. I understand that no information will be released other than that related to the concern about my safety, unless legal requirements relating to the reporting of threats of violence, harm or child or elder abuse or neglect apply.</i></p>	<p><b>Referred By:</b> _____</p> <p><b>How did you hear about our services?</b> _____</p>
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<p><b>Emergency Contact:</b> _____  <small>First Last</small></p> <p>Relationship _____</p> <p>Phone _____</p>	<p><b>Are you receiving other services in this building?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, List Clinics _____</p>
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**DEMOGRAPHIC INFORMATION**

<b>1. Date of Birth:</b> _____ / _____ / _____	<b>2. Age:</b> _____
<b>3. Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	<b>4. Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to answer
<b>5. Education Level:</b> <input type="checkbox"/> Less than High School <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> Bachelor’s Degree <input type="checkbox"/> Graduate or Professional Degree	<b>6. Race:</b> (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer
<b>7. Marital and Partner Status:</b> <input type="checkbox"/> Never Married or Partnered <input type="checkbox"/> Married <input type="checkbox"/> Committed Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<b>8. Sexual Orientation:</b> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual/Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer
<b>9. Employment Status:</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Volunteering <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Not Employed	<b>10. Annual Household Income:</b> <input type="checkbox"/> \$0-15,000 <input type="checkbox"/> \$15,001-45,000 <input type="checkbox"/> \$45,001-75,000 <input type="checkbox"/> \$75,001+  <b>10b. # of people supported:</b> _____
<b>11. Type of work</b> <input type="checkbox"/> Desk job/sedentary <input type="checkbox"/> Physical labor <input type="checkbox"/> Standing or light walking <input type="checkbox"/> Not currently working <input type="checkbox"/> Other: _____	<b>12. Disability Income:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, List disability: _____ _____ _____
<b>13. Military:</b> <input type="checkbox"/> No Military Background <input type="checkbox"/> Active Duty Service Member <input type="checkbox"/> Retired Service Member <input type="checkbox"/> Active Duty Family Member <input type="checkbox"/> Retired Family Member <input type="checkbox"/> Reserves <input type="checkbox"/> Former Military <input type="checkbox"/> Former Military Family Member	<b>14. Family changes in last 12 months?</b> (check all that apply) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Births <input type="checkbox"/> Deaths <input type="checkbox"/> Other, List: _____

15. Children (including step-children) and Others living in your home:					
First Name & Relationship	Age	Live with you?	First Name & Relationship	Age	Live with you?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

**YOUR HEALTH**

Check the health providers who have been involved in your health in the *past year*:

Provider Type	Name	Prescribes?	Provider Type	Name	Prescribes?
<input type="checkbox"/> Primary Care or Family Medicine Provider		<input type="checkbox"/>	<input type="checkbox"/> Personal Trainer		<input type="checkbox"/>
<input type="checkbox"/> Mental or Behavioral Health Clinician (counselor, psychotherapist, psychiatrist)		<input type="checkbox"/>	<input type="checkbox"/> Health Coach		<input type="checkbox"/>
<input type="checkbox"/> Neurologist		<input type="checkbox"/>	<input type="checkbox"/> Dietitian		<input type="checkbox"/>
<input type="checkbox"/> Ophthalmologist/Optomtrist		<input type="checkbox"/>	<input type="checkbox"/> Acupuncturist		<input type="checkbox"/>
<input type="checkbox"/> Audiologist		<input type="checkbox"/>	<input type="checkbox"/> Chiropractor		<input type="checkbox"/>
<input type="checkbox"/> Gastroenterologist		<input type="checkbox"/>	<input type="checkbox"/> Naturopath		<input type="checkbox"/>
<input type="checkbox"/> Physical Therapist		<input type="checkbox"/>	<input type="checkbox"/> Home Health		<input type="checkbox"/>
<input type="checkbox"/> Massage Therapist		<input type="checkbox"/>	<input type="checkbox"/> Other: _____		<input type="checkbox"/>
			<input type="checkbox"/> Other: _____		<input type="checkbox"/>
			<input type="checkbox"/> Other: _____		<input type="checkbox"/>

**Allergies**

1. Do you have any medical allergies?     No     Yes    If yes, List:

\_\_\_\_\_

\_\_\_\_\_

**SYMPTOM/PROBLEM**

2. Do you currently have symptoms or problems that led you to come in today?     No     Yes

3. If yes, Please list any symptoms or problems you have and rate the frequency and intensity for each.

3.a.	Frequency	Rare						Almost constant
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
	Intensity	Barely noticeable				Very intense		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
3.b.	Frequency	Rare						Almost constant
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
	Intensity	Barely noticeable				Very intense		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
3.c.	Frequency	Rare						Almost constant
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
	Intensity	Barely noticeable				Very intense		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
3.d.	Frequency	Rare						Almost constant
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	
	Intensity	Barely noticeable				Very intense		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	

**ALCOHOL AND DRUG USE**

1 drink of alcohol is defined as any one of the following:

- 12 fl oz of beer
- 5 fl oz of table wine
- 1 shot of liquor



1. Alcohol (drinks per week): \_\_\_\_\_

2. Have you used alcohol excessively *in the past year*?  No  Yes

3. Have you *ever* used alcohol excessively?  No  Yes

4. Has anyone in your family *ever* used alcohol excessively?  No  Yes

5. Caffeine (cups or cans per day) \_\_\_\_\_ Caffeine is contained in: Coffee, Tea, Soda and Energy Drinks

6. Tobacco (amount per day): \_\_\_\_\_

7. Has anyone in your family *ever* used tobacco?  No  Yes

8. E-cigarette or Vaporizer (amount per day): \_\_\_\_\_

9. Do you use marijuana?  No  Yes Frequency: \_\_\_\_\_

Purpose: \_\_\_\_\_

10. Have you used recreational drugs (drugs not prescribed to you) *in the past year*?  No  Yes List: \_\_\_\_\_

11. Have you *ever* used recreational drugs?  No  Yes List: \_\_\_\_\_

12. Has anyone in your family *ever* used recreational drugs?  No  Yes List: \_\_\_\_\_

**PRESCRIBED MEDICATIONS** (include those prescribed by a health provider)

PRESCRIPTION MEDICATIONS			OVER-THE-COUNTER MEDICATIONS OR NATURAL SUPPLEMENTS		
Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

**PROMIS – Global Health**

Please respond to each item by marking one box per row.

	Excellent	Very good	Good	Fair	Poor															
1. In general, would you say your health is:	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1															
2. In general, would you say your quality of life is:	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1															
3. In general, how would you rate your physical health?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1															
4. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1															
5. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1															
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1															
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	Completely <input type="checkbox"/> 5	Mostly <input type="checkbox"/> 4	Moderately <input type="checkbox"/> 3	A little <input type="checkbox"/> 2	Not at all <input type="checkbox"/> 1															
8. In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never <input type="checkbox"/> 5	Rarely <input type="checkbox"/> 4	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 2	Always <input type="checkbox"/> 1															
9. In the past 7 days, my sleep quality was	Very poor <input type="checkbox"/> 1	Poor <input type="checkbox"/> 2	Fair <input type="checkbox"/> 3	Good <input type="checkbox"/> 4	Very good <input type="checkbox"/> 5															
10. In the past 7 days, how would you rate your fatigue on average?	None <input type="checkbox"/> 5	Mild <input type="checkbox"/> 4	Moderate <input type="checkbox"/> 3	Severe <input type="checkbox"/> 2	Very Severe <input type="checkbox"/> 1															
11. In the past 7 days, how would you rate your pain on average?	No Pain										Worst imaginable Pain									
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10									

12. Location of Pain:

**DSM-5 Level 1**

**Instructions:** The questions below ask about things that might have bothered you.

During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
1. Little interest or pleasure in doing things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Feeling more irritated, grouchy, or angry than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Sleeping less than usual, but still have a lot of energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Starting lots more projects than usual or doing more risky things than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
6. Feeling nervous, anxious, frightened, worried, or on edge?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Feeling panic or being frightened?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Avoiding situations that make you anxious?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Feeling that your illnesses are not being taken seriously enough?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. Thoughts of actually hurting yourself?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. Hearing things other people couldn't hear, such as voices even when no one was around?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
14. Problems with sleep that affected your sleep quality over all?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. Feeling driven to perform certain behaviors or mental acts over and over again?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. Not knowing who you really are or what you want out of life?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. Not feeling close to other people or enjoying your relationships with them?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
21. Drinking at least 4 drinks of any kind of alcohol in a single day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

**PC-PTSD**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you . . .

- |  |                            |     |                            |    |
|--|----------------------------|-----|----------------------------|----|
| 1. Have had nightmares about it or thought about it when you did not want to?                            | <input type="checkbox"/> 1 | Yes | <input type="checkbox"/> 0 | No |
| 2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? | <input type="checkbox"/> 1 | Yes | <input type="checkbox"/> 0 | No |
| 3. Were constantly on guard, watchful, or easily startled?   | <input type="checkbox"/> 1 | Yes | <input type="checkbox"/> 0 | No |
| 4. Felt numb or detached from others, activities, or your surroundings?                                  | <input type="checkbox"/> 1 | Yes | <input type="checkbox"/> 0 | No |

**SCREEN IIAB**

For each question, check only one box that describes you best. Your response should reflect your typical eating habits. Feel free to write comments beside any question.

1. Has your weight changed in the past 6 months?

No/Unsure

8 No, my weight stayed within a few pounds.

0 I don't know how much I weigh or if my weight has changed.

Yes, I **gained** . . .

0 More than 10 pounds

2 6 to 10 pounds

4 About 5 pounds

Yes, I **lost** . . .

0 More than 10 pounds

2 6 to 10 pounds

4 About 5 pounds

2. Do you skip meals?

Never or rarely

8

Sometimes

4

Often

2

Almost every day

0

3. How would you describe your appetite?

Very good

8

Good

4

Fair

2

Poor

0

4. Do you cough, choke or have pain when swallowing food OR fluids?

Never

8

Rarely

4

Sometimes

2

Often or always

0

5. How many pieces or servings of fruit and vegetables do you eat in a day?

*Fruit and vegetables can be canned, fresh, frozen, or juice.*

Five or more

4

Four

3

Three

2

Two

1

Less than two

0

6. How much fluid do you drink in a day?

*Examples are water, tea, coffee, herbal drinks, juice, and soft drinks, but not alcohol.*

Eight or more cups

4

Five to seven cups

3

Three to four cups

2

About two cups

1

Less than two cups

0

7. Do you eat one or more meals a day with someone?

Never or rarely

8

Sometimes

4

Often

2

Almost always

0

8. Which statement best describes meal preparation for you?

4

I enjoy cooking most of my meals.

2

I *sometimes* find cooking a chore.

0

I *usually* find cooking a chore.

4

I'm *satisfied* with the quality of food prepared by others.

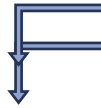
0

I'm *not satisfied* with the quality of food prepared by others.

**PHYSICAL ACTIVITY**

1a. Are you regularly physically active for approximately 150 mins/week or 30 mins/day on most days?

- Yes: I have been physically active for more than 6 months
- Yes: I have become physically active within past 6 months
- Yes: I am physically active once in a while, not consistently
- No: I have been thinking about becoming physically active, not yet
- No: I am not physically active, nor planning to become physically active



1b. If no, how long has it been since you have been physically active? \_\_\_\_\_ (months)

2. When are you physically active?

- At work
- At home
- Transportation
- Leisure time
- Other, describe:

3. What type of physical activities are you currently performing? (Check all that apply)

- Not physically active
- Walking
- Hiking
- Jogging/running
- Stretching
- Team sports
- Pilates
- Group fitness class
- Yoga
- Golf
- Strength training
- Cycling
- Tennis
- Pickleball
- Tai Chi
- Meditation
- Other, Describe:

4. In the past 7 days, how often did you do the following types of activities . . .

Number of days you did this activity

Average number of minutes/day?

4. In the past 7 days, how often did you do the following types of activities . . .	Number of days you did this activity	Average number of minutes/day?
4a. Vigorous physical activity		
4b. Walking		
4c. Sitting		

5. What time of day are you typically physically active?

- Not physically active
- Morning
- Afternoon
- Evening

6. Which social context do you prefer for workouts?

- Not currently active
- Myself/alone
- Trainer/coach
- Friend
- Family member
- With a small group/team
- With a large group/team

7. Has a healthcare professional suggested physical activity for any of the following symptoms: (Check all that apply)

- Arthritis
- Anxiety
- Fatigue
- Depression
- Stress
- Weight gain
- Pain
- Poor sleep
- Other, Describe: \_\_\_\_\_





