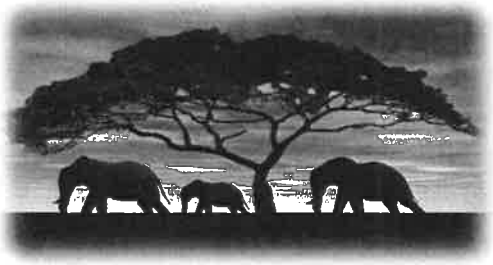

Acacia Wellness Center

A Comprehensive Approach
To Health & Wellness

217 W. Georgia Suite 120 Nampa, Id 83686 P:(208) 498.1760 / F:(208) 498.1769

Welcome to Acacia Wellness Center!

We look forward to meeting you. We are dedicated to offering a comprehensive approach to wellness; treating the mental, physical and spiritual health of each person. We strive to offer the best possible care for you, partnering with you and making a commitment to prevention, early intervention education and wellness.

Enclosed are the Patient Intake forms for you to fill out. Please arrive at least 15 minutes prior to your scheduled appointment to check in. If you need any further assistance, please contact Acacia Wellness Center at 498-1760.

Please bring the following to your appointment:

1. **Completed Patient Intake forms.**
2. **Health Insurance Cards (i.e.: Medicaid, Medicare, Blue Cross, etc.)**
3. **Prescription plan cards.**

Directions: From I-84, take exit 35; turn towards Nampa. Take a left onto Northside Rd. Continue onto Nampa Blvd, continue onto N. Yale St. Turn Right onto 12th Ave So. Turn Right onto W. Georgia Ave we will be the last building complex on your left hand side, as you enter the parking lot, we are in the building in the far right at the back of the building Suite 120.

We look forward to seeing you soon.

Deo Peppersack DNP, PMHNP-BC, FNP

Jana W. Duncan, NP-C

Julie Schmidt, LCSW

Rachel Fabbi, LMFT, CADC

Gloria Turner, LMSW

Amanda Duerre, LMSW

Acacia Wellness Center

A Comprehensive Approach to Mental Health

Health History

All information is strictly confidential

Name: _____ **DOB:** _____ **Date:** _____

(Check symptoms you currently have or have had in last year)

General

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Weight
- ☐ Numbness
- ☐ Sweats

Women Only

- ☐ Abnormal Pap Smear
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Bleeding between cycles
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Date of last Period: (/ /)
- ☐ Have you had a Mammogram?
- ☐ Are you pregnant Y N
- ☐ Number of Children ( )

Men Only

- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on penis

Gastrointestinal

- ☐ Excessive thirst
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Nausea
- ☐ Bowel changes
- ☐ Bloating
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Rectal bleeding

Cardiovascular

- ☐ Chest Pain
- ☐ High / Low blood pressure
- ☐ Irregular / Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Other:

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Eye/Ear/Nose/Throat

- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Hay fever
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision-Flashes / Halos
- ☐ Earache / Ear discharge
- ☐ Loss of hearing
- ☐ Ringing in ears

Skin

- ☐ Bruise easily
- ☐ Hives / Itching / Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

Muscle/Joint/Bone

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Please list any Surgeries/ Other Conditions/ Or Past Hospitalizations (Regular or Psychiatric):

Health History Continued: **Medications/Allergies**

List medications you are currently taking:

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

Name:______________________

Dose:__________ Frequency: __________
Why do you take this medication?

If you need additional space to include medications, please attach a separate sheet of paper.

Name and Location of Pharmacy:

List allergies to medications or substances:

Health Habits

Check which you use and how much:

- ☐ Caffeine: __________
- ☐ Alcohol: __________
- ☐ Street Drugs: __________
- ☐ Tobacco: __________
- ☐ Other: __________

Check if your work exposes you to:

- ☐ Stress
- ☐ Heavy lifting
- ☐ Hazardous Substances
- ☐ Other :

Signatures: To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my provider if I, or my minor child, ever have a change in health.

____ __________
Signature of Patient, Parent, Guardian or Personal Representative **Date**

____ __________
Reviewed by: Provider Signature **Date**

Patient Name: _____ DOB: _____ Date: _____

PITTSBURGH SLEEP QUALITY INDEX (PSQI)

INSTRUCTIONS: The following questions relate to your usual sleep habits during the past month only.
Your answers should indicate the most accurate reply for the majority of days and nights in the past month.
Please answer all questions.

1. **During the past month, when have you usually gone to bed at night?** USUAL BED TIME_____
2. **During the past month, how long (in minutes) has it usually taken you to fall asleep each night?** NUMBER OF MINUTES_____
3. **During the past month, when have you usually gotten up in the morning?** USUAL GETTING UP TIME_____
4. **During the past month, how many hours of actual sleep did you get at night?**
(This may be different than the number of hours you spend in bed.) HOURS OF SLEEP_____

INSTRUCTIONS: For each of the remaining questions, please check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you...	**Not during the past month**	**Less than once a week**	**Once or twice a week**	**Three or more times a week**
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Had bad dreams				
i. Have pain				
Other reason(s), please describe:_____				
How often during the past month have you had trouble sleeping because of this?				
6. During the last month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
	Very good	**Fairly Good**	**Fairly Bad**	**Very Bad**
8. During the past month, how would you rate your sleep quality overall?				
	Not a problem at all	**Only a very slight problem**	**Somewhat of a problem**	**A very big problem**
9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?				
	No bed partner or roommate	**Partner/ roommate in other room**	**Partner in same room, but not same bed**	**Partner in same bed**
10. Circle one of the following and answer the following questions, unless "No partner or roommate is checked."				
If you have a roommate or bed partner, ask him/her how often in the past month you have had....	**Not during the past month**	**Less than once a week**	**Once or twice a week**	**Three or more times a week**
a. Loud snoring				
b. Long pauses between breaths while asleep				
c. Legs twitching or jerking while you sleep				
d. Episodes of disorientation or confusion during sleep				
Other restlessness while you sleep; please describe: _____				

Patient Name: _____ DOB: _____ Date: _____

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*** *(Staff: Score each column with:)*	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking 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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

FOR OFFICE USE: **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
☐	☐	☐	☐

Patient Name: _____ DOB: _____ Date: _____

GAD – 7

Over the last 2 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
Use ✓ to indicate your answer *(Staff: Use the following to score:)*	0	1	2	3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

FOR OFFICE USE: 0 + ____ + ____ + ____

≥ 10 = Possible DX, confirm by further eval, 5 = Possible Anxiety, = TOTAL SCORE: _____
10 = Moderate Anxiety, 15 = Severe Anxiety

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
_____	_____	_____	_____

Patient Name: _____ DOB: _____ Date: _____

Adult ADHD Self-Report Scale

(ASRS-v1.1)

Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you enter each question, place and "X" in the box that best describes how you felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

PART A

	Never	Rarely	Sometimes	Often	Very Often
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

PART B

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center.

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

Name: _____ DOB: _____ Date: _____

Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week, how satisfied have you been with your…

		Very Poor	Poor	Fair	Good	Very Good
1	….physical health?	1	2	3	4	5
2	….mood?	1	2	3	4	5
3	….work?	1	2	3	4	5
4	….household activities?	1	2	3	4	5
5	….social relationships?	1	2	3	4	5
6	….family relationships?	1	2	3	4	5
7	….leisure time activities?	1	2	3	4	5
8	….ability to function in daily life?	1	2	3	4	5
9	….sexual drive, interest and/or performance? *	1	2	3	4	5
10	….economic status?	1	2	3	4	5
11	….living/household situation? *	1	2	3	4	5
12	….ability to get around physically without feeling dizzy or unsteady or falling? *	1	2	3	4	5
13	….your vision in terms of ability to do work or hobbies? *	1	2	3	4	5
14	….overall sense of well-being?	1	2	3	4	5
15	….medication? (If not taking any, check here____ and leave item blank.)	1	2	3	4	5
16	….How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of sensation.

FOR OFFICE USE ONLY

_____ TOTAL RAW SCORE _____ - 14 (minimum raw score)

Scoring the Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-SF)

The scoring of the Q-LES-Q-SF involves summing only the first 14 items to yield a raw total score. The last two items are not included in the total score but are stand-alone items. The raw total score ranges from 14 to 70. The raw total score is transformed into a percentage maximum possible score using the following formula:

$$\frac{\text{(raw total score – minimum score)}}{\text{(Maximum possible raw score-minimum score)}}$$

The minimum raw score on the Q-LES-Q-SF is 14, and the maximum score is 70. Thus the formula for % maximum can also be written as (raw score – 14)/56. The table below converts total raw scores into % maximum scores.

Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum
14	0	28	25	42	50	56	75
15	2	29	27	43	52	57	77
16	4	30	29	44	54	58	79
17	5	31	30	45	55	59	80
18	7	32	32	46	57	60	82
19	9	33	34	47	59	61	84
20	11	34	36	48	61	62	86
21	13	35	38	49	63	63	88
22	14	36	39	50	64	64	89
23	16	37	41	51	66	65	91
24	18	38	43	52	68	66	93
25	20	39	45	53	70	67	95
26	21	40	46	54	71	68	96
27	23	41	48	55	73	69	98
						70	100

Citation: Endicott J, Nee J, Harrison W, Blumenthal R. Quality of Life Enjoyment and Satisfaction Questionnaire: A New Measure. Psychopharmacology Bulletin 1993; 29:321-326