

Adult Walk-In Visit Information

Full Name:

Today's Date:

Preferred Name:

Preferred Pronouns:

What can we help you with today?

How did you hear about the walk-in clinic?

Have you visited the walk-in clinic before?

☐ Yes

☐ No

☐ Unsure

If you have seen us before, you do not have to fill out the rest of the form, unless there are changes.

Do you have a therapist or counselor now?

Name: _____

If so, are they at UNMH? ☐ Yes ☐ No

Phone: _____

Do you have a psychiatrist now?

Name: _____

If so, are they at UNMH? ☐ Yes ☐ No

Phone: _____

Do you have a primary care doctor?

Name: _____

If so, are they at UNMH? ☐ Yes ☐ No

Phone: _____

If no primary care provider, would you like to establish with one? ☐ Yes ☐ No

Medical Information

Do you now have, or have you been told that you have, any of the following medical conditions? (Check yes or no based on your health)

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually transmitted infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medications

Please list your prescribed or over-the-counter medications

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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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GAD-7

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

(Use "✓" to indicate your answer)

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: Total Score T ____ = ____ + ____ + ____)

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