Dr. Electra Allenton's Specific Intake
(Addendum to Kwan Yin Healing Arts Center)

Your Name on Your Insurance Card or ID:	What do you want me to call you?	Your pronouns:
Phone # where I can leave a voicemail	Today's Date:	What is the date of your upcoming appointment?

I focus on mental / emotional / behavioral health. I do not provide primary care.

What are your top mental / emotional / behavioral health concerns?
If someone recommended you see me, what is their name? (Who referred you?)
Who is your primary care provider?
Please be ready to sign a release of information to coordinate care with your other providers.
In a few words or phrases, what are your hopes and expectations for care?
(Walsh protocol, med management, second opinion on diagnosis or treatment, etc)

If you have any recent labs (last 6-12 months) ordered by other providers, please bring a copy or be prepared to sign a release of information to request them.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____

File to attn. of Electra Allenton, ND, LAc

Today's Date: _____

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. 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'd be better off dead, or of hurting yourself.	0	1	2	3
	add columns		+	+

(Healthcare professional: for interpretation of TOTAL, please refer to accompanying scoring card

TOTAL:

10. If you checked off *any* of these 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	_____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Name: _____
File to attn. of Electra Allenton, ND, LAc
Today's Date: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.