BOISE STATE UNIVERSITY
HEALTH SERVICES

Comprehensive Diagnostic Assessment (CDA)

Please fill out ALL forms included in their entirety and provide to Health Services BEFORE your first intake session. If forms are not received or have not been filled out to their entirety your appointment will be rescheduled.

_____ _____ _____

First Name Last Name Date of Birth

_____ _____ _____

University ID Number (if applicable) Phone Number Relationship Status

_____

Address (include city, state and zip code)

Employment & School Information
Name of Employer:
School Information (school name, year, grades, performance issues, etc.):_____

Collaborator Information
Collaborator's First and Last Name:
Collaborator's relationship to you:
Collaborator's email address:
Collaborator's phone number:
Collaborator's age?

Background & Preferences
Where were you raised?
What is your primary language?
Do you need an interpreter?
What is your relationship status (single, married, separated, divorced, widowed)?
What is your sexual orientation?
What is your religious preference?
What are your spiritual practices? _____

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How do you anticipate your religion or spiritual practices will impact your counseling treatment?_____
_____
_____

Social & Past Treatment History

Do you have a history with physical, sexual, or emotional abuse (yes or no)?_____
If yes, please briefly describe:_____
_____
_____
_____

Do you have a history of trauma (yes or no):_____
If yes, please briefly describe:_____
_____
_____
_____

Describe your family of origin's **behavioral health history** (include any mental health diagnoses): _____
_____
_____
_____
_____

Describe your family of origin's **medical health history**:_____
_____
_____
_____
_____

Current medical diagnoses:_____
_____
_____
_____

Current medical treatment for diagnoses:_____
_____
_____
_____

List any allergies you are aware of:_____
_____
_____

1910 University Drive Boise, Idaho 83725-1351
Phone (208) 426-1459 Fax (208) 426-3005

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List all medications (past and present) for both physical and mental health conditions:_____

Who is your current Primary Care Provider:

Please describe any current and/or past use of: (mark N/A if you've never used any of the substances listed below):

Alcohol:_____

Illicit Drugs:_____

Prescription Medication:_____

Nicotine:_____

Please describe any current and/or past criminal history (include dates and arrests including misdemeanors and felony charges):_____

Briefly describe the primary issue that brings you to counseling:_____

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GAD-7 Form

Last name	First name	Middle initial
Date of birth	University ID number	Today's date

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
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 ☐
Total Score_____= _____ + _____ + _____ + _____				

If you checked off any problems, how difficult have these problems made it for you to do your work, take card of things at home, or get along with other people?

Not difficult at all ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult** ☐

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PHQ-9 Form

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
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 ☐
Total Score_____= _____ + _____ + _____ + _____				

If you checked off any problems, how difficult have these problems made it for you to do your work, take card of things at home, or get along with other people?

Not difficult at all ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult** ☐