Primary Location
707 N. 7th Avenue, Suite D
Pocatello, Idaho 83201
Phone: (208) 242-3044
Fax: (208) 904-0494

CR
COGNITIVE RESTRUCTURING, LLC

Let us help you along the path of life's challenges

Date:

Client Name:

- Where do you work?
- How long have you worked there?
- What are your duties?
- Have you had to miss work due to your current situation?
- Do you lose sleep over your job?
- Do you have a family, kids, etc.?
- Tell me about your support system.
- Are you disconnected from family, friends, or relatives due to your job?
- Have you ever been hospitalized for a mental issue?
- Have you attended counseling before?
- Are you currently seeing a counselor?
- Are you at risk of self-harm, suicidal, or homicidal?
- Have you had any trauma or experiences that are affecting you?
- Are you taking any medications at this time?
- When was your last physical?
- Do you have any issues of concern at this time?

Drug Usage:

Indicate answers by circling Yes or No

- Are you concerned about your alcohol or drug usage?

  Yes No

- Are others concerned about your alcohol or drug usage?

  Yes No

- Have you experienced negative consequences as a result of your use?

  Yes No

During the last 12 months indicate how OFTEN and how MUCH you used per episode:

Indicate answers by checking the according box and specify how much used

Usage:	Never	Less than 1 time per month	1-3 times per month	1-2 times per week	3 times per week or more
Alcohol					

SPECIFY:

Usage:	Never	Less than 1 time per month	1-3 times per month	1-2 times per week	3 times per week or more
Cannabis					

SPECIFY:

Usage:	Never	Less than 1 time per month	1-3 times per month	1-2 times per week	3 times per week or more
Cocaine					

SPECIFY:

Usage:	Never	Less than 1 time per month	1-3 times per month	1-2 times per week	3 times per week or more
Prescription Meds					

SPECIFY:

Usage:	Never	Less than 1 time per month	1-3 times per month	1-2 times per week	3 times per week or more
Tobacco					

SPECIFY:

Usage:	Never	Less than 1 time per month	1-3 times per month	1-2 times per week	3 times per week or more
Other Drugs					

SPECIFY:

PATIENT HEALTH QUESTIONNAIRE- 9
(PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? **Please Circle your response**	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 circled 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?

Please check your response below:

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

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by 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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Client Support Sheet

Client Name:_____ Phone: ( ) _____-_____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth:_____/_____/_____Social Security Number: _____-_____-_____ Age:_____ Gender:_____

Date Completed: _____ Employer/School: _____

Emergency Contact Name:_____ Phone: ( ) _____-_____ Relationship: _____

Emergency Contact Name: _____ Phone: ( ) _____-_____ Relationship: _____

Legal Guardian/POA Name (If applicable): _____ Phone: ( ) _____-_____

Outside Agency Contacts:			**ROI:**	Refused	None
Counselor/Therapist: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Case Manager: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Peer Support Specialist: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Psychiatrist/Psychologist:_____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Primary Care Physician: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Probation Officer: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Family Member: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Other Medical Provider: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐
Other: _____	Phone: (___)_____-_____	Email: _____	Y N Date: Faxed: _____	☐	☐

Primary Insurance Company_____ **Member ID #** _____**Group#**_____

Insurance Company_____ **Member ID #** _____**Group#**_____

Reason(s) for starting Services:_____

Comments:_____

_____

Revised 07/12/2024