I, the undersigned, authorize treatment by the Student Health & Wellness (SHW) psychiatrists and other licensed or certified behavioral health clinicians. I understand:

- Treatment may include prescription and monitoring of psychotropic medications, lab monitoring, referral, psychoeducation, sleep hygiene, brief psychotherapy.
- Medications may be recommended for my symptoms. If so, my provider and I will discuss and decide together. With any medication, there are risks of side effects which we will discuss.
- The practice of psychiatry is not an exact science and I acknowledge SHW makes no guarantees to me as to the results of tests, treatments or any other services rendered.
- I have the right to terminate treatment at any time.
- I have the right to ask questions.

I am aware I have the right to confidential treatment of disclosures and records and an opportunity to approve or refuse their release as described in the University of Iowa Health Care Privacy Notice. I am aware there are exceptions to confidentiality as described in the Privacy Notice and these include but are not limited to:

- The SHW staff work as a team. My psychiatrist and psychiatric nurse may consult with another SHW psychiatrist or family practice provider to provide the best possible care.
- If I pose a threat of harm to myself and/or others, SHW will take steps necessary to comply with applicable laws.

I will promptly arrive for my appointments and if I need to cancel, call 24 hours prior to my appointment time. This allows SHW time to use the appointment slot for others. If I do not cancel at least 24 hours prior to my appointment, I may be charged a fee.

I understand my continued treatment at SHW is contingent on enrollment at University of Iowa. Prior to graduation or leaving University of Iowa I will work with my treatment team to transfer my care if indicated.

Signature: ________________________________ Date: __________________
(Patient or person authorized to consent for patient)

Printed Name: ____________________________
(Patient or person authorized to consent for patient)

IF THE PATIENT IS A MINOR A PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT A MINOR CHILD FORM MUST ALSO BE COMPLETED.
PSYCHIATRY HEALTH HISTORY FORM

This information will be considered protected health information and will become part of your medical record subject to the conditions stated in the University of Iowa Health Care’s Privacy Notice.

Today’s Date: ______________ Preferred Name if different from above: ________________________ Pronouns_______________________

☐ Undergraduate  ☐ Graduate  Major: ______________________________  Graduation Date: ___________  Current GPA: ____________

Did anyone refer you today?  ☐ University Counseling Service  ☐ Student Health & Wellness  ☐ Self  ☐ Other _____________________

Briefly describe the problem that prompted you to make the appointment.

Past Medical History:
History of surgeries: ____________________________________________________________
History of medical problems: _____________________________________________________
Current medical conditions: ______________________________________________________
Current medications: _____________________________________________________________
Allergies – Drug ___________________________________________  Food/Environmental __________________________________

Past Psychiatric History:
History of counseling/therapy: (Indicate when, where, name of counselor) ______________

Previous trials of psychiatric medications:

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dates Taken</th>
<th>Maximum Dose</th>
<th>Side Effects</th>
<th>Was it helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Previous psychiatric hospitalization: (Indicate when and where) ______________________________

History of past suicide attempts: ☐ No ☐ Yes Details: ____________________________________

-- PLEASE FLIP OVER FOR SIDE 2 --
### Social History:

Please describe your primary parental figures.

<table>
<thead>
<tr>
<th>Parent name:</th>
<th>Parent name:</th>
</tr>
</thead>
</table>

How related to you

Education

Occupation

Parent’s marital status  
- Married
- Never married
- Divorced (when) _____________
- Separated (when) ___________

What town(s) did you grow up in?

Siblings:  
- Brothers (list name, age)
- Sisters (list name, age)

Describe past/current family difficulties:

ACT Scores (or SAT scores):  
- Composite_________
- English_________
- Math_________
- Reading_________
- Science_________

Education:  
- High School ___________
- Year Graduated ___________
- GPA/Rank ___________

Previous college / community college:

Legal: Have you ever been arrested/convicted of a crime?

Relationship Status:  
- Single
- Dating
- Married
- Divorced
- Partnered
- Other:

Living Situation:  
- On Campus
- Off Campus
- With Family - How Many roommates? ___________

How much do you exercise, what form? ___________

Any nicotine use?  
- Smokeless (chewing, snuff)  
  - Never
  - In the past, not now
  - Current
- Cigarettes  
  - Never
  - In the past, not now
  - Current
- Vaporized  
  - Never
  - In the past, not now
  - Current

Any additional information you would like us to know?

Signature ___________________________  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)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**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?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
### Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _______________ Name: _____________________________________ DOB: _______________

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*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 ________