BEHAVIORAL WELLNESS CENTER (BWC) INTAKE ASSESSMENT

**Please note that information collected from this assessment is utilized for data collection to ensure that the BWC services meet the needs of the diverse trainee population. All identifiers are excluded from any collected data.*

Once this form is complete, please email it to bwc@mednet.ucla.edu, or fax it to our secure and confidential line, (310) 206-2072.

BWC Intake Assessment

Today's Date: _____/_____/_____

BACKGROUND INFORMATION

Date of Birth: _____/_____/_____ Age: _____

Country of Birth: _____

If not US born at what age did you immigrate to U.S.: _____

Your current zip code: _____ Did you relocate for your current position: Yes/No

Ethnicity:

- ☐ African/African American
- ☐ Chicano/Mexican American
- ☐ Chinese/Chinese American
- ☐ East Indian/Pakistani
- ☐ Filipino
- ☐ Korean/Korean American
- ☐ Latino/Hispanic
- ☐ Middle Eastern
- ☐ Multiracial
- ☐ American/Alaskan Native
- ☐ Pacific Islander
- ☐ Polynesian/Micronesian
- ☐ Vietnamese
- ☐ White/Caucasian
- ☐ Other: _____
- ☐ Prefer Not to Answer

Religious/Spiritual affiliation (if any): _____

Gender: _____

Sexual Orientation:

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Questioning
- ☐ Bisexual
- ☐ Other
- ☐ Prefer not to answer

Please check any that apply to you:

- ☐ Never Married
- ☐ Legally Married
- ☐ Domestic Partnership
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Engaged

Which of the following BEST describes your current relationship status:

- ☐ Not currently dating at all
- ☐ Dating or going out casually
- ☐ In an intimate relationship with a boyfriend or girlfriend
- ☐ In a permanent relationship with my life partner

Number of Dependents (e.g., children, aging parents): ____ How many live with you? ____

BWC Intake Assessment

What is your current training status:

☐ Medical Student ☐ Graduate Student ☐ Intern/Resident ☐ Fellow

Year of study or post-graduate year: _____ Department (if applicable) _____

Current academic standing (if applicable):

☐ Good Academic/Professional Standing ☐ Academic/Professional Probation

☐ Experiencing Academic/Professional Difficulty

Are you registered with the University for Students with Disabilities Programs? ☐ Yes ☐No
Do you currently have any physical disabilities that limit your mobility? ☐ Yes ☐No
If yes, please describe here:

Which of the following best describes your financial situation at this time?

- ☐ My basic needs like food and shelter are not always met.
  If not, which are you struggling with: _____
- ☐ My basic needs are met (food, shelter, clothing) but no extras
- ☐ I have everything I need and a few extras.
- ☐ I am able to purchase many of the things I want.
- ☐ Within limits, I am able to have luxury items like international vacations, new cars, etc.
- ☐ I can buy nearly anything I want, anytime I want.
- ☐ Prefer not to answer

In US dollars, what was your approximate annual household income during the past year?

- ☐ Less than $25,000
- ☐ $25,000-$50,000
- ☐ $50,000-$100,000
- ☐ $100,000-$250,000
- ☐ $250,000-$500,000
- ☐ More than $500,000
- ☐ Prefer not to answer

What is your burden of debt?

- ☐ None
- ☐ Less than $25,000
- ☐ $25,000-$50,000
- ☐ $50,000-$100,000
- ☐ $100,000-$250,000
- ☐ $250,000-$500,000
- ☐ More than $500,000
- ☐ Prefer not to answer

BWC Intake Assessment

FAMILY INFORMATION

Parents	**Age**	**Deceased**
Father	_____	_____
Mother	_____	_____
Step-Father	_____	_____
Step-Mother	_____	_____
Other Parent/Caretaker	_____	_____

Country where your mother was born: _____ your father was born: _____

Do you have contact with any of the following?

Father	Yes	No
Mother	Yes	No
Step-Father	Yes	No
Step-Mother	Yes	No
Other Parent/Caretaker	Yes	No

Parents' relationship:

☐ Currently married ☐ Domestic partners ☐ Separated ☐ Divorced ☐ Never married ☐ Widowed

Number of siblings: _____ Your place in birth order: _____

Do you have any family living near you currently? ☐ Yes ☐No

On a scale of 0 (no support at all) to 10 (ideal amount of support), how would you rate your current social support: _____

Any family history of:

☐ Hypertension	☐ Heart Disease	☐ Heart Attack
☐ Stroke	☐ Cancer	☐ Diabetes
☐ Alcohol use	☐ Drug use	☐ Depression
☐ Bipolar Disorder	☐ Schizophrenia/Psychosis	☐ Anxiety Disorder
☐ Attention Deficit Disorder	☐ Suicide	☐ Dementia

☐ Other: _____

BWC Intake Assessment

CURRENT ISSUES

Presenting concerns (briefly describe the concerns that led you to come to BWC today):

Approximately how long has this concern been bothering you? _____

How much do your concerns interfere with your:
(1=Low Intensity, 5=High Intensity)

	1	2	3	4	5
Academic Performance	☐	☐	☐	☐	☐
Social Relationships/Social Activities	☐	☐	☐	☐	☐
Emotional Well-Being	☐	☐	☐	☐	☐
Daily Routine	☐	☐	☐	☐	☐

BEHAVIORAL HEALTH

Are you currently enrolled in psychiatric or psychological counseling elsewhere? ☐ Yes ☐No
If yes, please list the contact information for the mental health provider(s):

Name and title: _____
Phone number: _____
Date last seen: _____

Have you been seen by a therapist or psychiatrist in the past? *If so, please describe:*

Please list ALL the medications you are currently taking (including over-the-counter medications, vitamins, birth control pills and alternative medications):

Medication	Dosage	Frequency	Indication

BWC Intake Assessment

Please list any psychiatric medications you have been prescribed in the past:

Medication	Dosage/Frequency	Duration of Treatment	Side Effects

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐No
If yes, please specify when, where and circumstances:

_____
_____

Have you ever had thoughts of harming yourself? ☐ Yes ☐No
Have you ever intentionally injured yourself without suicidal intent? ☐ Yes ☐No
Have you ever made a suicide attempt? ☐ Yes ☐No
Have you had any suicidal thoughts in the past seven (7) days? ☐ Yes ☐No
If you answered "yes" to any of the above, please elaborate:

_____
_____
_____
_____

Have you ever had serious thoughts of harming another person? ☐ Yes ☐No
Have you ever intentionally physically harmed another person? ☐ Yes ☐No
Do you currently have thoughts of harming another person? ☐ Yes ☐No
If you answered "yes" to any of the above, please elaborate:

_____
_____
_____
_____

Do you currently own or possess any firearms? ☐ Yes ☐No

BWC Intake Assessment

SUBSTANCE USE

Do you currently use any tobacco products? ☐ Yes ☐No

How often did you have a drink containing alcohol in the past year? (please check one)
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐2-3 times per week
☐ 4-5 times per week ☐ 6 or more times per week

How many drinks did you have on a typical occasion in the question above? (please check one)
☐ 0 drinks ☐ 1-2 drinks ☐ 3-4 drinks ☐5-6 drinks ☐7-9 drinks ☐ 10 or more drinks

How often did you have 5 or more drinks on one occasion in the past year? (please check one)
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost every day

Regarding alcohol use, have you ever experienced:
☐ "blackouts" ☐ symptoms of withdrawal ☐ desire to cut back use
☐ legal issues pertaining to use (e.g. driving under the influence, public intoxication)

In the past year, have you regularly or recreationally used any of the following substances (for prescription medications, have you used without a prescription or at a frequency other than directed by your prescribing physician):

☐ Cannabis	☐ Cocaine	☐ Amphetamines/ methamphetamine
☐ Prescription stimulants (e.g. methylphenidate, amphetamine)	☐ Prescription opiates (e.g. hydrocodone, oxycodone)	☐ Prescription sedatives (e.g. benzodiazepines, barbiturates)
☐ LSD	☐ Ecstasy/MDMA	☐ Psilocybin
☐ Inhalants	☐ Synthetic/designer substances (e.g. spice, K2, bath salts)	☐ Non-prescription opiates (e.g. heroin, opium)
☐ Dextromethorphan	☐ Ketamine	☐ PCP
☐ Other: _____		

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Are you currently being treated for any medical problems: ☐ Yes ☐No
If yes, please describe:

_____

_____

_____

Any previous surgeries or medical hospitalizations: ☐ Yes ☐No
If yes, please describe:

_____

_____

BWC Intake Assessment

Constitutional Symptoms:
☐unexplained weight loss ☐night sweats ☐excess perspiration ☐fatigue/malaise/lethargy
☐sleep changes ☐appetite changes ☐fever

Eyes, Ears, Nose, and Throat:
☐visual changes ☐double vision ☐blurry vision ☐runny nose ☐nose bleeds ☐sinus pain
☐ear pain ☐ringing in ears ☐sore throat ☐pain with swallowing ☐lumps or masses
☐hoarseness/voice changes

Cardiovascular/Respiratory:
☐chest pain ☐shortness of breath ☐ reduced exercise tolerance ☐palpitations ☐edema/swelling ☐ faintness ☐cough ☐sputum ☐wheeze ☐hemoptysis

Gastrointestinal:
☐abdominal pain ☐indigestion ☐bloating ☐cramping ☐food avoidance ☐nausea/vomiting
☐diarrhea ☐constipation ☐blood in vomit (hematemesis) ☐ blood in stool

Genitourinary/Reproductive:
☐ urinary urgency ☐increased urinary frequency ☐blood in urine ☐urinary hesitancy
☐pain with urination
Women: ☐ vaginal discharge ☐vaginal pain ☐change in menstrual frequency
Men: ☐ penile discharge ☐ testicular pain ☐testicular lumps or masses

Musculoskeletal:
☐pain ☐stiffness ☐joint swelling ☐decreased range of motion ☐weakness

Integumentary and/or Breast:
☐pruritus ☐rashes ☐striae ☐excessive dryness ☐discoloration ☐hair loss
☐change in hair distribution ☐nipple discharge ☐breast pain/tenderness
☐breast lumps or masses

Neurological:
☐headache ☐changes in sight, smell, hearing and/or taste ☐seizures ☐faints ☐falls ☐dizziness ☐ numbness/tingling ☐poor balance ☐speech problems ☐tremor

Hematologic/Lymphatic:
☐anemia ☐purpura ☐petechia ☐excessive bleeding ☐easy bruising

Generalized Anxiety Disorder (GAD-7)

Over the <u>last 2 weeks</u>, 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**
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 at difficult at all** ☐	**Somewhat difficult** ☐	**Very difficult** ☐	**Extremely difficult** ☐

Patient Health Questionnaire (PHQ-9)

	Not at all	Several days	More than half the days	Nearly every day
How often during the <u>past 2 weeks</u> were you bothered by…				
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**
If you checked off any problem on this questionnaire so far, 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 at difficult at all** ☐	**Somewhat difficult** ☐	**Very difficult** ☐	**Extremely difficult** ☐

Primary Care PTSD Screen (PC-PTSD)

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES / NO

3. Were constantly on guard, watchful, or easily startled?
   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?
   YES / NO

AUDIT-C Questionnaire

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have a six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

****Please fill out if you are currently treating patients. If you are not treating patients, please proceed to the next page.**

Abbreviated Maslach Burnout Inventory

How often do the following statements describe the way you feel about working in this field? (if not applicable do not answer)

	Every day	A few times a week	Once a week	A few times a month	Once a month or less	A few times a year	Never
1. I deal very effectively with the problems of my patient	☐	☐	☐	☐	☐	☐	☐
2. I feel I treat some patients as if they were impersonal objects	☐	☐	☐	☐	☐	☐	☐
3. I feel emotionally drained from my work	☐	☐	☐	☐	☐	☐	☐
4. I feel fatigued when I get up in the morning and have to face another day on the job	☐	☐	☐	☐	☐	☐	☐
5. I've become more callous towards people since I took the job	☐	☐	☐	☐	☐	☐	☐
6. I feel I'm positively influencing other people's lives through my work	☐	☐	☐	☐	☐	☐	☐
7. Working with people all day is really a strain for me	☐	☐	☐	☐	☐	☐	☐
8. I don't really care what happens to some patients	☐	☐	☐	☐	☐	☐	☐
9. I feel exhilarated after working closely with my patient	☐	☐	☐	☐	☐	☐	☐

Maslach Burnout Inventory - Students

How often do the following statements describe the way you feel about working in this field? (if not applicable do not answer)

	Every day	A few times a week	Once a week	A few times a month	Once a month or less	A few times a year	Never
1. I feel emotionally drained by my studies	☐	☐	☐	☐	☐	☐	☐
2. I feel used up at the end of a day at school	☐	☐	☐	☐	☐	☐	☐
3. I feel burned out from my studies	☐	☐	☐	☐	☐	☐	☐
4. I feel tired when I get up in the morning and I have to face another day at school	☐	☐	☐	☐	☐	☐	☐
5. Studying our attending a class is really a strain for me	☐	☐	☐	☐	☐	☐	☐
6. I have become less interested in my studies since my enrollment at school	☐	☐	☐	☐	☐	☐	☐
7. I have become less enthusiastic about my studies	☐	☐	☐	☐	☐	☐	☐
8. I have become more cynical about the potential usefulness of my studies	☐	☐	☐	☐	☐	☐	☐
9. I doubt the significance of my studies	☐	☐	☐	☐	☐	☐	☐
10. I can effectively solve the problems that arise in my studies	☐	☐	☐	☐	☐	☐	☐
11. I believe that I make an effective contribution to the classes that I attend	☐	☐	☐	☐	☐	☐	☐
12. In my opinion, I am a good student	☐	☐	☐	☐	☐	☐	☐
13. I have learned many interesting things during the course of my studies	☐	☐	☐	☐	☐	☐	☐
14. I feel stimulated when I achieve my study goals	☐	☐	☐	☐	☐	☐	☐
15. During class I feel confident that I am effective in getting things done	☐	☐	☐	☐	☐	☐	☐

Brief Resilience Scale (BRS)

Please respond to each item by marking <u>one box per row</u>	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
• I tend to bounce back quickly after hard times	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
• I have a hard time making it through stressful events.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
• It does not take me long to recover from a stressful event.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
• It is hard for me to snap back when something bad happens.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
• I usually come through difficult times with little trouble.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
• I tend to take a long time to get over set-backs in my life.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Cognitive and Affective Mindfulness Scale – Revised (CAMS-R)

Please respond to each item by marking <u>one box per row</u>	**Rarely/ Not at All**	**Sometimes**	**Often**	**Almost always**
1. It is easy for me to concentrate on what I am doing.	☐ 1	☐ 2	☐ 3	☐ 4
2. I can tolerate emotional pain.	☐ 1	☐ 2	☐ 3	☐ 4
3. I can accept things I cannot change	☐ 1	☐ 2	☐ 3	☐ 4
4. I can usually describe how I feel at the moment in considerable detail.	☐ 1	☐ 2	☐ 3	☐ 4
5. I am easily distracted.	☐ 1	☐ 2	☐ 3	☐ 4
6. It's easy for me to keep track of my thoughts and feelings.	☐ 4	☐ 3	☐ 2	☐ 1
7. I try to notice my thoughts without judging them.	☐ 1	☐ 2	☐ 3	☐ 4
8. I am able to accept the thoughts and feelings I have.	☐ 1	☐ 2	☐ 3	☐ 4
9. I am able to focus on the present moment.	☐ 1	☐ 2	☐ 3	☐ 4
10. I am able to pay close attention to one thing for a long period of time.	☐ 1	☐ 2	☐ 3	☐ 4

Thank you for your time!