



MD-HC, INC · MULTIMEDRX

Mind & Wellness Intake

Behavioral Health Patient Questionnaire · LMFT Counseling
"Where faith meets care, and hearts find rest."

800.787.9659

1000 Quail St. #260

Newport Beach, CA 92660



In crisis or thinking about hurting yourself?

Call or text **988** (Suicide & Crisis Lifeline) any time, 24/7. In danger now? Call **911**.

Please do not wait for us to read this form — reach out now.

Thank you for reaching out. Take your time — there are no right or wrong answers. Your answers are private and shared only with your care team. Check one box per row unless it says "check all".



1 · About you

Please print clearly. You may skip any question except those marked ★.

★ Full legal name	Preferred name	★ Date of birth (MM/DD/YYYY)	
Street address	City	ZIP	State
★ Phone	Email	OK to leave a voicemail?	
		☐ Yes ☐ No	
Sex assigned at birth			
☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say			
Gender identity			
☐ Woman ☐ Man ☐ Non-binary ☐ Other / self-describe ☐ Prefer not to say			
Marital status			
☐ Single ☐ Married / partner ☐ Divorced / separated ☐ Widowed			
Preferred language	Need an interpreter?	In California right now?	
	☐ Yes ☐ No	☐ Yes ☐ No	
Emergency contact — name	Relationship	Phone	
Is someone helping you fill this out?		If yes — their name and relationship	
☐ No ☐ Yes			

2 · Insurance coverage

Not sure? That's fine — we'll check your coverage before your visit. Coverage is not guaranteed until it is verified.

Which coverage do you have? (check all that apply)

☐ Medicare (Original)

☐ Medicare Advantage

☐ Medi-Cal

☐ CalOptima Health

☐ Medi-Medi (Medicare + Medi-Cal)

☐ Other / not sure

Medicare (MBI) number

Medi-Cal / CalOptima CIN or member ID

Plan name (if Advantage / other)

Policy holder (if not you)

Primary care doctor & phone

3 · Reason for your visit

In your own words, what brings you here today? What would you like help with?

Which feel true lately? (check all that apply)

☐ Feeling down or sad

☐ Worry or anxiety

☐ Stress

☐ Grief or loss

☐ Sleep problems

☐ Relationship / family

☐ Loneliness

☐ Eating / weight

☐ Alcohol or drug use

☐ Memory / focus

☐ Anger

☐ Trauma

☐ Other

How long has this been going on?

☐ Under 1 month

☐ 1–6 months

☐ 6–12 months

☐ Over 1 year

What would you prefer?

☐ Phone

☐ Video

☐ In person

☐ No preference

**4 · How you have been feeling (PHQ-9)**

Over the LAST 2 WEEKS, how often have you been bothered by any of the following?

Over the last 2 weeks...	Not at all	Several days	More than half the days	Nearly every day
A1 Little interest or pleasure in doing things	☐	☐	☐	☐
A2 Feeling down, depressed, or hopeless	☐	☐	☐	☐
A3 Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
A4 Feeling tired or having little energy	☐	☐	☐	☐
A5 Poor appetite or overeating	☐	☐	☐	☐
A6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
A7 Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
A8 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	☐	☐	☐	☐
A9 Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

A10 If you checked any problems, how difficult have they made it 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
**5 · Worry and nerves (GAD-7)**

Over the LAST 2 WEEKS, how often have you been bothered by the following?

Over the last 2 weeks...	Not at all	Several days	More than half the days	Nearly every day
B1 Feeling nervous, anxious, or on edge	☐	☐	☐	☐
B2 Not being able to stop or control worrying	☐	☐	☐	☐
B3 Worrying too much about different things	☐	☐	☐	☐
B4 Trouble relaxing	☐	☐	☐	☐
B5 Being so restless that it is hard to sit still	☐	☐	☐	☐
B6 Becoming easily annoyed or irritable	☐	☐	☐	☐
B7 Feeling afraid, as if something awful might happen	☐	☐	☐	☐

**6 · Your safety**

We ask everyone these questions. Many people have had these thoughts during hard times. Answering “Yes” will not get you in trouble and does not stop your care — it means a caring member of our team will call you the same day to talk and help.

In the past month...	Yes	No	Not sure
L1 In the past month, have you wished you were dead, or wished you could go to sleep and not wake up?	☐	☐	☐
L2 In the past month, have you actually had any thoughts of killing yourself?	☐	☐	☐

If you answered YES or NOT SURE to L2, please answer L3-L5. Otherwise skip to L6.

	Yes	No	Not sure
L3 Have you been thinking about how you might do this?	☐	☐	☐
L4 Have you had these thoughts and had some intention of acting on them?	☐	☐	☐
L5 Have you started to work out, or worked out, the details of how to kill yourself?	☐	☐	☐
L5b Do you intend to carry out this plan?	☐	☐	☐
	Yes	No	Not sure
L6 Have you ever done anything, started to do anything, or prepared to do anything to end your life? (For example: collected pills, got a gun, gave away valuables, wrote a will or note, or tried to hurt yourself.)	☐	☐	☐
L6a If yes — was this within the past 3 months?	☐	☐	☐
L7 In the past year, have you hurt yourself on purpose without wanting to die (for example, cutting, burning, or hitting yourself)?	☐	☐	☐
L8 Do you have access to a gun or other firearm at home?	☐	☐	☐

**7 · Alcohol and other substances**

One drink = 12 oz beer, 5 oz wine, or 1.5 oz liquor (one shot).

H1 How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2–4× a month ☐ 2–3× a week ☐ 4+ × a week

H2 How many drinks on a typical day when you drink?

☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

H3 How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily / almost daily

H4 Do you use tobacco or vaping products?

☐ Never ☐ Former ☐ Current

H5 · Times in the past year you used an illegal drug or a prescription medicine for non-medical reasons (0 if never) **If more than 0 — which ones?**

H6 Do you ever use alcohol, marijuana, or pills to calm down, sleep, or cope with feelings?

☐ No ☐ Yes ☐ Not sure

**8 · Hard experiences (PC-PTSD-5)**

Sometimes things happen that are unusually frightening, horrible, or traumatic — e.g. a serious accident or fire, physical or sexual assault or abuse, a disaster, war, seeing someone killed or seriously injured, or losing a loved one to homicide or suicide. You do not need to tell us what happened.

I0 Have you ever experienced this kind of event?

☐ Yes ☐ No

If YES, answer I1–I5. In the PAST MONTH, have you...

In the past month, have you...		Yes	No
I1	had nightmares about the event(s) or thought about them when you did not want to?	☐	☐
I2	tried hard not to think about the event(s) or gone out of your way to avoid reminders?	☐	☐
I3	been constantly on guard, watchful, or easily startled?	☐	☐
I4	felt numb or detached from people, activities, or your surroundings?	☐	☐
I5	felt guilty or unable to stop blaming yourself or others for the event(s)?	☐	☐

9 · Eating and weight (SCOFF)

There are no right or wrong answers.

	Yes	No
C1 Do you make yourself sick because you feel uncomfortably full?	☐	☐
C2 Do you worry you have lost control over how much you eat?	☐	☐
C3 Have you recently lost more than 14 lb in a 3-month period?	☐	☐
C4 Do you believe yourself to be fat when others say you are too thin?	☐	☐
C5 Would you say that food dominates your life?	☐	☐
D1 In the last 3 months, did you have episodes of eating much more than most people would in a similar time?	☐	☐
D2 If yes — do you feel distressed about these episodes?	☐	☐

If you answered YES to D1, how often during these episodes did you...

During these episodes...	Never	Sometimes	Often	Always
D3 feel you had no control over your eating (could not stop, felt you had to eat)?	☐	☐	☐	☐
D4 keep eating even though you were not hungry?	☐	☐	☐	☐
D5 feel embarrassed by how much you ate?	☐	☐	☐	☐
D6 feel disgusted with yourself or guilty afterward?	☐	☐	☐	☐
	Never	Sometimes	Often	Always
D7 In the last 3 months, how often did you make yourself vomit to control your weight or shape?	☐	☐	☐	☐

★ 10 · Eating certain foods (past 12 months)

Think about foods like sweets, starches (white bread, pasta), salty snacks, fatty foods or sugary drinks. Check how often each was true.

In the past 12 months...	Never	Monthly or less	Weekly	Daily
E1 I ate to the point where I felt physically ill.	☐	☐	☐	☐
E2 I tried and failed to cut down on or stop eating certain foods.	☐	☐	☐	☐
E3 I spent more time feeling sluggish or tired from overeating.	☐	☐	☐	☐
E4 I avoided work, school or social activities because I was afraid I would overeat there.	☐	☐	☐	☐
E5 I kept eating the same way even though it caused emotional problems.	☐	☐	☐	☐
E6 Eating the same amount did not give me as much enjoyment as it used to.	☐	☐	☐	☐
E7 If I felt bad from not eating certain foods, I ate them to feel better.	☐	☐	☐	☐
E8 My friends or family were worried about how much I overate.	☐	☐	☐	☐
E9 My overeating got in the way of caring for my family or doing chores.	☐	☐	☐	☐
E10 I was so distracted by eating that I could have been hurt (e.g. driving, crossing the street, using machinery).	☐	☐	☐	☐
E11 I had such strong urges to eat certain foods that I could not think of anything else.	☐	☐	☐	☐
E12 I had significant problems in my life because of food and eating.	☐	☐	☐	☐
E13 My eating caused me much distress.	☐	☐	☐	☐

**11 · Feelings and food (past 3 months)**

Food and feelings are often connected — that is very common.

How often...	Never	Rarely	Sometimes	Often	Almost always
F1 I eat when I feel sad, down, or depressed.	☐	☐	☐	☐	☐
F2 I eat when I feel hurt, rejected, or let down.	☐	☐	☐	☐	☐
F3 I eat when I feel lonely.	☐	☐	☐	☐	☐
F4 I eat when I feel worried, nervous, or stressed.	☐	☐	☐	☐	☐
F5 I eat when I feel bored or have nothing to do.	☐	☐	☐	☐	☐
F6 I eat when I feel angry or upset with someone.	☐	☐	☐	☐	☐
F7 I eat to comfort myself, even when not hungry.	☐	☐	☐	☐	☐
F8 I eat when very tired or can't sleep, or get up at night to eat.	☐	☐	☐	☐	☐
F9 I eat in private, or hide food or wrappers.	☐	☐	☐	☐	☐
F10 Food is how I get through painful memories or feelings.	☐	☐	☐	☐	☐

F11 Have you ever eaten a lot — or stopped eating — on purpose to punish or hurt yourself?

☐ No ☐ Yes ☐ Not sure

F12 · Is there a time of day, place, or feeling when eating is hardest to control?

**12 · Hopes, worries and feelings about your body**

Starting a weight program can bring up hope and worry at the same time. How true is each sentence for you?

How true...	Not true	A little true	Mostly true	Very true
G1 I am afraid I will fail at losing weight again.	☐	☐	☐	☐
G2 I have tried to lose weight many times, and I feel discouraged.	☐	☐	☐	☐
G3 When I slip up, I tend to give up ("I already blew it").	☐	☐	☐	☐
G4 I worry about letting down my doctor, my family, or myself.	☐	☐	☐	☐
G5 I feel ashamed of my body or my weight.	☐	☐	☐	☐
G6 I put off doctor visits, photos, or social events because of my weight.	☐	☐	☐	☐
G7 I have been treated unfairly, teased, or judged because of my weight (including by health care workers).	☐	☐	☐	☐
G8 I am hard on myself or call myself names because of my weight.	☐	☐	☐	☐

**13 · History and treatment**

J0 Have you ever been diagnosed with a mental health condition?

☐ No ☐ Yes ☐ Not sure

If yes, which? (check all)

- ☐ Depression
 ☐ Anxiety / panic
 ☐ Bipolar disorder
 ☐ PTSD
- ☐ ADHD
 ☐ Schizophrenia / psychosis
 ☐ Eating disorder
 ☐ Substance use disorder
- ☐ Dementia / memory
 ☐ Other

If an eating disorder, which?

- ☐ Anorexia
 ☐ Bulimia
 ☐ Binge eating disorder
 ☐ ARFID
 ☐ Other / not sure

J1 Have you ever been hospitalized for mental health or substance use?

☐ No ☐ Yes

J2 Have you ever had treatment for an eating disorder?

☐ No ☐ Yes

If yes, what kind? (check all)

- ☐ Counseling
 ☐ Dietitian
 ☐ Day / intensive outpatient
- ☐ Residential or hospital
 ☐ Medicine

About when did it end?

In treatment now?

☐ No ☐ Yes

Provider name / phone

J3 · In the past 3 months, have you done any of these to control your weight? (check all)

- ☐ Made myself throw up ☐ Laxatives or water pills
- ☐ Diet pills not prescribed to me ☐ Gone a day+ without eating on purpose
- ☐ Exercised very hard to “make up” for eating ☐ Skipped / lowered insulin to lose weight
- ☐ None of these

J4 · Most you have weighed as an adult (not pregnant) — lb & year

Least — lb & year

J5 How many times have you seriously tried to lose weight?

☐ Never ☐ 1-2 ☐ 3-5 ☐ 6 or more

What helped, and what did not?

J6 Has a doctor or family member ever said you were too thin, or worried you were not eating enough?

☐ No ☐ Yes ☐ Not sure

Family history of: (check all)

- ☐ Depression / anxiety ☐ Bipolar disorder ☐ Suicide
- ☐ Alcohol / drug problems ☐ Eating disorder ☐ None / unknown

**14 · Medications, allergies and health**

List all medicines, including for mood, anxiety, sleep, memory or pain, plus vitamins and supplements.

Medicine	Dose	How often	Prescribed by

Drug allergies & reactions

Major health conditions (e.g. diabetes, heart, pain)

**15 · Support and check-in preferences****K1** Who do you live with?
☐ Alone
 ☐ Spouse / partner
 ☐ Family
 ☐ Friend / roommate
 ☐ Care home
 ☐ Other

Who can you count on for support? (check all)

☐ Spouse / partner
 ☐ Family
 ☐ Friends
☐ Faith community
 ☐ Support group
 ☐ No one right now

In the past year, any big loss or change? (check all)

☐ Death of a loved one
 ☐ Divorce / separation
 ☐ Moving
 ☐ Retiring
☐ New illness
 ☐ Caring for someone
 ☐ Money worries
 ☐ None
K4 Do you see a counselor, therapist, psychologist, or psychiatrist now?
☐ No
 ☐ Yes
If yes — name / phone. (A signed release is needed for us to share information.)

K5 Would a short weekly check-in call with a counselor help you?
☐ Yes
 ☐ No
 ☐ Not sure
Best day(s) / time for check-ins**Any help needed (technology, hearing, vision)?**

K6 Do you have a private, quiet place to take calls?
☐ Yes
 ☐ No
 ☐ Sometimes
**16 · Consent and signature**

I understand these questions are part of my care at MD-HC, Inc / MultiMedRX. My answers are private and will be seen only by my care team (my doctor or nurse practitioner, the Medical Director, and a licensed counselor). If my answers show I may not be safe, a member of my care team will contact me the same day and may call 911 to help keep me safe. I may skip any question I do not want to answer. I consent to behavioral health services, including by phone or video (telehealth), and I understand coverage is not guaranteed until it is checked.

☐ ★ I have read and agree to the statement above.
★ Patient signature**Printed name****Date**

Helper (if any) — signature, name & relationship**Date**

OFFICE USE ONLY**PHQ-9 score****GAD-7 score****Safety flag / action taken****Reviewed by / date**

**In crisis or thinking about hurting yourself?**Call or text **988** (Suicide & Crisis Lifeline) any time, 24/7. In danger now? Call **911**.

Please do not wait for us to read this form — reach out now.