Arise Menopause & Mental Health

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This addendum includes PHQ-9, GAD-7, Sexual Wellness/HSDD Screening, and Consent sections to complement your comprehensive intake packet.

PHQ-9 Depression Screening

Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble falling or staying asleep, or sleeping too much

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling tired or having little energy

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Poor appetite or overeating

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling bad about yourself

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving/speaking slowly or being fidgety/restless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead or hurting yourself

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

GAD-7 Anxiety Screening

Feeling nervous, anxious, or on edge

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Not being able to stop or control worrying

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Worrying too much about different things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble relaxing
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Being so restless that it is hard to sit still
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Becoming easily annoyed or irritable
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling afraid as if something awful might happen
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Sexual Wellness / HSDD Screening

Have you experienced a decrease in sexual desire/libido? ☐ Yes ☐ No

Has this concern been present for more than 6 months? ☐ Yes ☐ No

Does this concern cause distress or affect your quality of life? ☐ Yes ☐ No

Does it affect your relationship or intimacy? ☐ Yes ☐ No

Do you experience vaginal dryness or discomfort with intimacy? ☐ Yes ☐ No

Would you like to discuss treatment options regarding sexual wellness? ☐ Yes ☐ No

Medication List

1. Medication: _____ Dose: _____ Frequency: _____ Reason: _____

2. Medication: _____ Dose: _____ Frequency: _____ Reason: _____

3. Medication: _____ Dose: _____ Frequency: _____ Reason: _____

4. Medication: _____ Dose: _____ Frequency: _____ Reason: _____

5. Medication: _____ Dose: _____ Frequency: _____ Reason: _____

Consent and Acknowledgement

I certify that the information provided is true and complete to the best of my knowledge. I understand that menopause and wellness care may involve discussions regarding hormonal health, mental health, sexual wellness, preventive care, and lifestyle management.

I consent to evaluation, education, and treatment provided by Arise Menopause & Mental Health

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____