Medivive Comprehensive Mental Health Survey (Adults)

Empowering Health, One Connection at a Time

Welcome to Medivive

We commend you for taking this important step toward improving your mental health. This survey will help us better understand your mental health needs and provide personalized care tailored to you. Remember, you are not alone in this journey. Your health is our priority, and we are here to support you every step of the way.

Privacy and Confidentiality Statement

Your responses to this survey will be kept **confidential** and **secure**. Medivive follows all applicable privacy laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). All information collected will only be used to assist in your care, and no information will be shared with third parties without your explicit written consent, except where required by law.

Consent for Data Use

By completing this survey, you are consenting to the collection and use of your information by Medivive for the purpose of providing mental health care and support. This information will be stored securely and accessed only by authorized healthcare providers involved in your care. You have the right to request a copy of your responses and withdraw your consent at any time by contacting our office.

- **Signature**: _____
- **Date**: _____

HIPAA Privacy Notice (US-Based)

Your Rights Under HIPAA:
Medivive complies with all applicable HIPAA regulations. Under HIPAA, you have the right to:

- Access and request copies of your medical records.
- Request corrections to your personal health information.
- Request a list of disclosures of your health information.
- File a complaint if you believe your privacy rights have been violated.

Emergency Intervention Clause

If, at any point, Medivive believes that there is an immediate risk to your safety or the safety of others, we may be required to intervene and share your information with emergency services. This will be done to ensure the safety of everyone involved and is in accordance with applicable law.

Crisis Disclosure

If you are experiencing a mental health emergency, please seek help immediately by calling 911 or a local crisis hotline. This survey is not intended to provide immediate crisis support. **Your safety is our top priority.**

Limitation of Liability Disclaimer

Medivive is not liable for any damages, loss, or injury arising from the use of this survey. This tool is designed to assist in mental health care and does not replace professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition.

Consent to Obtain Medical Records

I authorize Medivive to obtain any necessary medical records related to my mental health, substance use, or treatment history from the following providers:

- Facility/Provider Name: _____
- Contact Information: _____
- **Signature**: _____
- **Date**: _____

Have you been treated for any mental health, alcohol, or substance use concerns in the past?

- Yes ☐ No ☐
  If yes, please provide the following details:
- Name of Facility/Provider: _____
- Contact Information: _____

Section 1: Personal Information

We appreciate you sharing this information—it helps us understand you better!

- Full Name: _____
- Date of Birth: _____
- Gender: Male ☐ Female ☐ Non-Binary ☐ Prefer not to say ☐
- Marital/Relationship Status:
  - Married ☐ Dating ☐ Single ☐ Separated/Divorced ☐
- Living Situation:
  - Alone ☐ With Spouse/Partner ☐ With Family ☐ With Roommates ☐
- Children? Yes ☐ No ☐
  - If yes, how many and what are their ages? _____
- Email: _____ | Phone Number: _____

Section 2: Primary Mental Health Concern

Your honesty here is crucial for us to provide you with the best support possible!

1. Please describe your main mental health concern (e.g., depression, anxiety, mood swings): _____
2. How long have you been experiencing these symptoms?
   _____
3. How would you rate the severity of your symptoms on a scale from 1 to 10?
   - Mild ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ Severe ☐ 10
4. How often do your symptoms affect your daily activities (work, relationships, personal responsibilities)?
   - Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐
5. Do you notice any patterns that trigger these symptoms?
   - Yes ☐ No ☐
   - If yes, please describe: _____

Section 3: Emotional and Psychological Well-Being

It's important to reflect on these feelings; we're here to listen and help!

1. Feeling nervous, anxious, or on edge
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐
2. Little interest or pleasure in doing things you once enjoyed
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐
3. Feeling sad, empty, or hopeless
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐
4. Excessive worry or fear about various situations
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐
5. Irritability, frustration, or outbursts of anger
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐
6. Feeling guilt, shame, or worthlessness
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐
7. Feeling overwhelmed or out of control
    - Not at all ☐ 1-2 Days ☐ Several Days ☐ Nearly Every Day ☐

Section 4: Relationships & Support Networks

Strong connections are vital for mental health; let's explore yours!

1. How would you describe the quality of your relationship with your spouse/partner?
    - Supportive ☐ Strained ☐ Distant ☐ Neutral ☐ Not Applicable ☐
2. How would you describe your relationship with your children (if applicable)?
    - Close ☐ Strained ☐ Neutral ☐ Not Applicable ☐
3. Do you feel emotionally supported by your partner or close family members?
    - Yes ☐ No ☐ Sometimes ☐
4. How do you typically communicate about feelings or challenges with your spouse/partner?
    - Openly ☐ Rarely ☐ Never ☐
5. Do you have close friends or a trusted support system outside your family for emotional help?
    - Yes ☐ No ☐
6. How often do you reach out to your support network for emotional help?
    - Frequently ☐ Occasionally ☐ Rarely ☐ Never ☐
7. How often do you feel isolated or alone?
    - Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Always ☐
8. If you feel isolated, what are the main reasons?
    - Lack of support ☐ Geographical distance ☐ Personal choice ☐ Other: _____
9. Do you engage in social activities or hobbies that bring you joy or relaxation?
    - Frequently ☐ Sometimes ☐ Rarely ☐ Never ☐

10. Are there hobbies or activities that you share with others that positively affect your mental health?

- Yes ☐ No ☐

11. Do you feel you have someone to turn to in case of a mental health crisis?

- Yes ☐ No ☐ Sometimes ☐

12. Do you have an emergency contact who is aware of your mental health needs?

- Yes ☐ No ☐

13. When conflicts arise in your relationships, how do you typically resolve them?

- Talking it out ☐ Avoiding the issue ☐ Other: _____

Section 5: Sleep Patterns

Getting a good night's sleep is essential for mental health—let's assess yours!

1. How many hours of sleep do you get on average per night?
    - Less than 4 hours ☐ 4-6 hours ☐ 6-8 hours ☐ More than 8 hours ☐
2. Do you have difficulty falling asleep or staying asleep?
    - Yes ☐ No ☐ Sometimes ☐
3. Do you wake up frequently throughout the night?
    - Yes ☐ No ☐
4. Do you feel rested when you wake up?
    - Yes ☐ No ☐ Sometimes ☐
5. Do you have any recurring dreams or nightmares?
    - Yes ☐ No ☐

Section 6: Cognitive Functioning

Understanding how you think and process information is important—let's dive in!

1. Have you experienced difficulty concentrating or remembering details?
    - Yes ☐ No ☐ Sometimes ☐
2. Do you feel that your thoughts are racing or that you struggle to slow them down?
    - Yes ☐ No ☐ Sometimes ☐

3. Do you have difficulty making decisions or organizing tasks?
    - Yes ☐ No ☐ Sometimes ☐

Section 7: Stress & Coping

Identifying your coping mechanisms can be a vital part of your healing process!

1. How would you rate your stress levels?
    - Low ☐ Moderate ☐ High ☐ Overwhelming ☐
2. How do you typically cope with stress? (Check all that apply)
    - Exercise ☐ Talking to Friends/Family ☐ Meditation ☐ Substance Use ☐ Journaling ☐
      Other: _____
3. Do you find it difficult to identify your emotions?
    - Yes ☐ No ☐ Sometimes ☐
4. Have you ever used self-harm (cutting, burning, etc.) to cope?
    - Yes ☐ No ☐

Section 8: Substance Use

It's important to be honest about your substance use; we're here to support you!

1. Do you use alcohol or substances to cope with stress or mental health symptoms?
    - Yes ☐ No ☐
2. If yes, how often do you use them?
    - Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐
3. Has anyone ever told you that you have a problem with alcohol or drugs?
    - Yes ☐ No ☐
4. Have you ever had to drink or use drugs to start your day?
    - Yes ☐ No ☐
5. Have you ever tried to quit using substances?
    - Yes ☐ No ☐
6. Do you feel that your substance use is affecting your relationships or health?
    - Yes ☐ No ☐
7. If you've been seen for alcohol or drug use previously, please provide the facility or practice information:
    - Name of Facility: _____
    - Contact Information: _____

Section 9: Trauma History

Discussing trauma can be challenging, but it's a crucial step toward healing.

1. Have you experienced any traumatic events in your past (physical, emotional, sexual)?
    - Yes ☐ No ☐
2. Would you like to discuss these events with your provider?
    - Yes ☐ No ☐
3. Have these events contributed to your current mental health concerns?
    - Yes ☐ No ☐

Section 10: Suicidal Thoughts and Safety

Your well-being is our priority—let's address any thoughts of self-harm together.

1. Have you had thoughts of harming yourself or others in the past month?
    - Yes ☐ No ☐
2. Do you have a safety plan in place if these thoughts arise?
    - Yes ☐ No ☐
3. Do you have a trusted person you can contact during a crisis?
    - Yes ☐ No ☐
4. Do you feel you have adequate access to mental health support in case of an emergency?
    - Yes ☐ No ☐
5. Do you have a written safety plan in place if you experience thoughts of self-harm?
    - Yes ☐ No ☐
6. Would you like help in developing a safety plan?
    - Yes ☐ No ☐

Section 11: Physical Health & Wellness

Physical health is intertwined with mental health; let's explore yours!

1. How often do you engage in physical activity (e.g., walking, running, sports)?
    - Daily ☐ Weekly ☐ Occasionally ☐ Never ☐
2. Do you have any chronic health conditions that affect your mental health?
    - Yes ☐ No ☐ If yes, please specify: _____
3. Do you feel your physical health and mental health are connected?
    - Yes ☐ No ☐ Sometimes ☐

Section 12: Technology Use and Impact

Understanding your relationship with technology can help us support you better.

1. How often do you use technology for entertainment or work (e.g., video games, social media)?
    - Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐
2. Do you feel your use of social media affects your mood or self-esteem?
    - Positively ☐ Negatively ☐ No effect ☐

Section 13: Mindfulness & Self-Care

Practicing self-care is essential for mental well-being; let's assess yours!

1. Do you currently practice any mindfulness techniques (e.g., meditation, yoga, breathing exercises)?
    - Yes ☐ No ☐
2. If yes, how often?
    - Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐
3. Do you practice any self-care routines (e.g., exercise, journaling, hobbies)?
    - Yes ☐ No ☐
4. If yes, please describe your routine:
    - _____

Section 14: Personal Growth & Aspirations

Your goals are important, and we're here to help you achieve them!

1. What personal goals or aspirations are you currently working toward?
    - _____
2. Do you feel your mental health affects your ability to achieve these goals?
    - Yes ☐ No ☐ Sometimes ☐
3. How can Medivive support you in reaching these goals?
    - _____

Section 15: Family Mental Health History

Understanding your family history can help us provide better care for you.

1. Do you have any family members who have been diagnosed with mental health disorders?

- Yes ☐ No ☐
2. If yes, please specify the relation and diagnosis: _____

Section 16: Childhood & Developmental History

Reflecting on childhood can be important for your healing journey.

1. Did you experience any significant challenges during childhood (e.g., family conflict, abuse)?
   - Yes ☐ No ☐
2. Would you like to discuss these experiences with your provider?
   - Yes ☐ No ☐

Section 17: Employment & Financial Stress

Financial stress can weigh heavily on mental health—let's talk about it.

1. Are you currently employed?
   - Yes ☐ No ☐
2. Do financial concerns affect your mental health?
   - Yes ☐ No ☐
3. Do you feel secure in your current job situation?
   - Yes ☐ No ☐ Sometimes ☐

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- **Date**: _____

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- Yes ☐ No ☐
  If yes, please provide the following details:
- Name of Facility/Provider: _____

- Contact Information: _____

Section 19: Crisis Resources & Emergency Contacts

In case of a crisis, please contact:

- **National Suicide Prevention Lifeline**: 1-800-273-8255 (https://suicidepreventionlifeline.org/)
- **Crisis Text Line**: Text "HELLO" to 741741 (https://www.crisistextline.org/)
- **Substance Abuse and Mental Health Services Administration (SAMHSA) Hotline**: 1-800-662-HELP (https://www.samhsa.gov/find-help/national-helpline)
- **The Trevor Project (LGBTQ+ Support)**: 1-866-488-7386 (https://www.thetrevorproject.org/)
- **Local Emergency**: Dial 911

Thank You for Your Participation!

Thank you for taking the time to complete this survey as part of your onboarding process with Medivive. Your responses will help us understand your needs and prepare for your consultation.

If you have any questions about the survey or your mental health, please make a note of them and review them with your provider during your consultation.

We look forward to supporting you on your journey to better mental health!