

The Montana Family Center
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ESA Interview Packet

When completed email to anne@mtfamilycenter.org or fax to 406-493-0809

Your Legal Name: _____ Preferred Name: _____

Preferred Pronouns: _____ Your Date of Birth: _____

Your Current Address _____
Street City State zip

Phone: _____ Email: _____

Today's Date: _____ Your Landlords Name: _____

Species of animal () Cat () Dog () Other: _____ Name: _____

Please describe the nature of your disability or condition that you expect will be assisted by having an Emotional Support Animal.

In the left column below, please briefly list the symptoms or difficulties that you experience like: "trouble falling asleep," "I get caught in repetitive hurtful thought loops," "I feel fearful when alone."
In the second column, please state how the presence of your animal reduces or eliminates each symptom.

Symptom or Condition	How animal presence reduces each Symptom

Your Name _____

Date: _____

Adverse Childhood Experiences Survey

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**... Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt? If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often**... Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured? If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you? If yes enter 1 _____
4. Did you **often or very often** feel that no one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other? If yes enter 1 _____
5. Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? If yes enter 1 _____
6. Were your parents **ever** separated or divorced? If yes enter 1 _____
7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her? **or Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **or Ever** repeatedly hit at least a few minutes or threatened with a gun or knife? If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? If yes enter 1 _____
10. Did a household member go to prison? If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite or overeating.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Not being able to stop or control worrying.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Worrying too much about different things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Trouble relaxing.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Being so restless that it's hard to sit still.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Becoming easily annoyed or irritable.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Feeling afraid as if something awful might happen.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult