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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: Today's Date:

Your Current Address
Street City State Zip

Email: Your Landlords Name:

Your ESA animal ( ) Cat Cat's Age: Cat's Name:
( ) Dog Name: Age: Breed: Weight

In your own words please describe in the space below why you require an ESA 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.	☐ 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
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? Please check the circle to the Right of your response.

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.	☐ 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's 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
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? Check the box following your response.

Not difficult at all ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult** ☐

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