



Mental Health Division

## PALOUSE RIVER COUNSELING GAIN-SS FORM

Section Completed by Clinician	
Intake/Admission [ ]	Tx Plan Session [ ]
Crisis Episode [ ]	
Declined [ ]	Unable to complete [ ]

Staff ID	RU	Location	SAC	Dur	Start Time	Refer/LOF
			5063 GAIN-SS	5 min	: am /pm	
			5064 Co-Occurring Assess	5 min	: am /pm	

**Demographic Information and GAIN-SS (Self-Report) Complete by Consumer**

DATE	LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	GENDER
					<input type="checkbox"/> Male <input type="checkbox"/> Female

By answering the questions in this checklist, you will help your treatment provider understand what treatment you may need. This information will help you and your treatment provider develop the best possible plan of treatment for you. Your answers will also help to improve the mental health care in your community.

Completing the checklist is optional. If you are willing to answer the questions, please complete the survey and sign your name at the bottom of this page. If you do not wish to answer the questions, please tell your treatment provider and give the checklist back to your treatment provider.

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions Yes or No.

**Global Appraisal of Individual Needs-Short Screener (GAIN-SS)**

During the past 12 months, have you had significant problems. . .

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. when something reminded you of the past, you became very distressed and upset?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. with thinking about ending your life or committing suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IDS Sub-scale **Total** (0 to 5) \_\_\_\_\_

During the past 12 months, did you do the following things two or more times?

a. Lie or con to get things you wanted or to avoid having to do something?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have a hard time paying attention at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have a hard time listening to instructions at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Been a bully or threatened other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Start fights with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EDS Sub-scale **Total** (0 to 5) \_\_\_\_\_

During the past 12 months did. . .

a. you use alcohol or drugs weekly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SDS Sub-scale **Total** (0 to 5) \_\_\_\_\_

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Client Signature : \_\_\_\_\_ Date \_\_\_\_\_

# OFFICE USE ONLY

List the scores from the front of the GAINS in these areas:

\_\_\_\_\_  IDS score  
\_\_\_\_\_  EDS score  
\_\_\_\_\_  SDS score

**NOTE: A score of 2 or more in any one of the 3 sections indicates a positive screen and should be addressed in the next section of Quadrant placement.**

## Quadrant Placement

- 9 – no quadrant placement needed, service will be provided by:
  - No Service Recommended – No score more than 2 on IDS, EDS, or SDS.
  - Recommend CD Evaluation – Score only on SDS 2 or more.
  - Recommend MH Request for Service / Intake – Scored 2 or more on IDS, SDS or both IDS and EDS.
  
- 1 – Quadrant I: Less Severe Mental Health and Less Severe Chemical Dependency Placement.
- 2 – Quadrant II: More Severe Mental Health and Less Severe Chemical Dependency Placement.
- 3 – Quadrant III: More Severe Chemical Dependency and Less Severe Mental Health Placement.
- 4 – Quadrant IV: More Severe Chemical Dependency and More Severe Mental Health Placement.

If test indicates a quadrant placement explain why if No Quadrant Placement is chosen:

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If Quadrant Score is given please list recommendations for service for this decision:

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Please list referrals made at this point and contact information:

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\_\_\_\_\_  
Name of Screener

\_\_\_\_\_  
Date