PLEASE COMPLETE THIS SHEET FIRST

PATIENT INFORMATION **Today's Date____/____/_____**

Last Name:	Middle Initial:		First Name:
Address:			Land Line Home Phone:
Address:			Cell Phone:
City:			County:
State/Zip:			Social Security:
Date of Birth:			Gender (circle): M F Other
Ethnicity: ☐ NOT Spanish, Hispanic, Latino or Mexican ☐Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic or Latino ☐ Unknown			Race: ☐ Caucasian ☐ Black/African American ☐ American Indian ☐ Asian ☐ Alaskan Native ☐ Hawaiian or Pacific Islander ☐ Unknown
*When possible I prefer to be contacted via: ○ Home Phone ○ Cell Phone ○ Email ○ Text Msg			
*Appointment reminders choice: ○ Home Phone ○ Cell Phone ○ Email ○ Text Msg ○ None			
Email:			
Referral Source: ☐ Court Ordered ☐ Probation/Parole* ☐ DHS* ☐ Employer ☐ Hospital ☐ Self ☐ OWI/Zero Tolerance *PO Worker Name _____ *DHS Worker Name _____			
Reason for Seeking Assessment (circle all that apply): Mental Health Substance Abuse Gambling Physical Health			
Have you been seen at Prairie Ridge under a different name (ex: Maiden name)?			
Communication Method: ○ Communication Device ○ Sign Language ○ Verbal			

EMERGENCY CONTACT

Last Name:	First Name:
Address:	Primary Phone:
Address:	Secondary Phone:
City:	Relationship to you:
State/Zip:	

Patient ID:_____

Welcome to Prairie Ridge! Thank you for taking the time to answer the following questions. If there are any questions that you are unsure how to answer or that you would prefer to answer verbally, please feel free to leave them blank. If you have any questions or if you would like assistance completing this form, please let us know and we will be happy to assist you.

****Please note, Federal Law prohibits us from serving any person who is currently serving as a Confidential Informant. If this statement applies to you, please privately advise your counselor so that alternative services can be provided.***

Today's Date____/____/_____

Last Name:	Middle Initial:		First Name:
Gender (circle): M F Other			
Ethnicity: ☐ NOT Spanish, Hispanic, Latino or Mexican ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic or Latino ☐ Unknown			
Race: ☐ Caucasian ☐ Black/African American ☐ American Indian ☐ Asian ☐ Alaskan Native ☐ Hawaiian or Pacific Islander ☐ Unknown			

1. Do you have a DHS case worker or are you currently involved with DHS? ☐ Yes ☐ No
2. If so, have your children been removed from the home? ☐ Yes ☐ No
3. Is there an open Child in Need of Assistance (CINA)? ☐ Yes ☐ No
4. Was the CINA filed within the last 6 months? ☐ Yes ☐ No
5. Do you live in Cerro Gordo, Worth, Winnebago, or Hancock County? ☐ Yes ☐ No

HEALTH INFORMATION

How would you rate your general health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you have any medical conditions that interfere with your daily life or may impact your treatment? ☐ No ☐ Yes

If "yes", please specify: _____

_____

Allergies: _____

Do you participate in alternative medical practices (i.e. chiropractic care, yoga, essential oils, etc.)?_____

_____

_____

Current Health Care Providers

Name of Primary Care Physician:	Practice/Facility Name and City:
Name of Dentist:	Practice/Facility Name and City:
Name and Specialty of Specialist:	Practice/Facility Name and City:
Name and Specialty of Specialist:	Practice/Facility Name and City:

Current Medications

Medication Name	Dose and Frequency	Reason	How long?

Hospitalizations

Date	Reason

Infectious Disease (Diagnosed or Suspected) and STD Risk

Disease	Past	Current	Receiving Treatment	Not Receiving Treatment	No or Not Applicable
Hepatitis Type:					
HIV or AIDS *(optional)*					
IV Drug Use					
Tuberculosis (TB)					
TB Exposure					
Sexually Transmitted Disease (STD)					
Other					

Sexually Transmitted Disease (STD) Risk

Sexual Contact without barrier protection? ☐ No ☐ Yes

Blood transfusion? ☐ No ☐ Yes

Yellow jaundice /hepatitis? ☐ No ☐ Yes

Share needles/works? ☐ No □ Yes

Exchanged sex with money or drugs? ☐ No ☐ Yes

Been involved in a sexual assault? ☐ No ☐ Yes

TOBACCO USE

Do you use tobacco? □ No □Yes - Please specify type and amount per day: _____

Would you like assistance to quit? ☐ No ☐ Yes

EDUCATION

What is the last grade you completed? _____ Do you have your GED? ☐ No ☐ Yes

Did you ever receive special education services? ☐ No ☐ Yes ☐ Unknown

Do you have difficulties reading and writing? ☐ No ☐ Yes ☐ Unknown

Do you have a history of developmental delay? ☐ No ☐ Yes ☐ Unknown

EMPLOYMENT

Employer	Estimated Start Date	Estimated End Date	Job Duties / Reason for Leaving/ Comments
Current:			
Previous:			
Previous:			
Previous:			

FINANCES

What are your current sources of income? ☐ Employment ☐ Partner's Income ☐ Family/Friends ☐ Pension ☐ Food Stamps ☐ Disability Benefit ☐ Other: _____

Are you on Medicaid (Title 19)? ☐ No ☐ Yes

Are you currently in need of food, clothing, or shelter? ☐ No ☐ Yes

Do you have any financial concerns at this time? ☐ No ☐ Yes ☐ Not Applicable

CURRENT LIVING SITUATION

Household Members

Name	Relationship to You	Age

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you satisfied with your current living situation? ☐ No ☐ Yes

Are there any family issues that you would like to have addressed in treatment? ☐ No ☐ Yes - Please explain: _____

_____

Does anyone in your household currently use alcohol or drugs? ☐ No ☐ Yes

Does anyone in your household currently have a mental health condition? ☐ No ☐ Yes

TRAUMA/ABUSE HISTORY

	Past	**Current**
Have you ever been a victim or witness of physical abuse?	☐ No ☐ Yes	☐ No ☐ Yes
Have you ever been a victim or witness of emotional abuse?	☐ No ☐ Yes	☐ No ☐ Yes
Have you ever been a victim or witness of sexual abuse?	☐ No ☐ Yes	☐ No ☐ Yes
Have you ever been a victim or witness of domestic violence?	☐ No ☐ Yes	☐ No ☐ Yes
Have you ever experienced a traumatic event of any type? ☐ No ☐ Yes If yes, please describe the event, when it occurred, and your reaction:		

Do you have a Durable Power of Attorney for Healthcare Decisions/Psychiatric Advance Directive (PAD)?

☐ No ☐ Yes

If you do not have a Durable Power of Attorney for Healthcare Decisions/Psychiatric Advance Directive (PAD), would you like more information about how to secure one?

☐ No ☐ Yes

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

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

LEGAL

Is this assessment court ordered? Do you have a pending court date?	☐ No ☐ Yes – If yes, what county? _____ ☐ No ☐ Yes – If yes, when is your court date? _____
Is this assessment due to a civil commitment?	☐ No ☐ Yes
Is this assessment for OWI or Zero Tolerance Offense?	☐ No ☐ Yes
If you received an alcohol-related charge, what was your Blood Alcohol Level at the time of arrest?	
Did you refuse the Breathalyzer test?	☐ No ☐ Yes
Do you currently have any legal issues related to alcohol or drug offenses pending? *If yes, please specify.*	☐ No ☐ Yes - _____
Do you have any past legal issues related to alcohol or drug offenses? *If yes, please specify.*	☐ No ☐ Yes - _____
Have you ever been incarcerated? If yes, please specify the reason for your last incarceration and the length.	☐ No ☐ Yes - _____
Are you presently awaiting charges, trial or sentence? *If yes, please explain.*	☐ No ☐ Yes - _____

OTHER

Do you identify with a particular cultural group? ☐ No ☐ Yes _____

Are you currently experiencing any concerns related to your gender or sexual orientation? ☐ No ☐ Yes:_____

_____

Do you identify with a particular religious group or spiritual practice? ☐ No ☐ Yes: _____

Do you have a valid driver's license? ☐ No ☐ Yes Do you have access to transportation? ☐ No ☐ Yes

Would you like copies of your assessment results sent to anyone? ☐ No ☐ Yes – If yes, who? _____

_____

GAMBLING SCREEN

During the past 12 months, have you become restless, irritable, or anxious when trying to stop/cut down on gambling?	☐ No ☐ Yes
During the past 12 months, have you tried to keep your family or friends from knowing how much you have gambled?	☐ No ☐ Yes
During the past 12 months, did you have financial troubles as a result of your gambling that you had to get help with living expenses from family, friends, or public assistance?	☐ No ☐ Yes

FEMALE PATIENTS ONLY

Do you use birth control? ☐ No ☐ Yes - If yes, what method do you currently use? _____

Are you pregnant? ☐ No ☐ Unsure ☐ Yes - If yes, have you had any complications? _____

FEMALE PATIENTS WITH CHILDREN ONLY

Does your family need assistance in any of the following areas?

☐ Family Counseling for Mental Illness ☐ Budgeting ☐ Continuing Education

☐ Public Benefits (food stamps, SSI, etc.) ☐ Housing

☐ Specialized Treatment Services ☐ Transportation

Does your family need assistance in securing any of the following services for children?

☐ Making and keeping pediatric and dental appointments

☐ Ensuring that children's immunizations are up to date

☐ Applying for Head Start or admission to school

☐ Obtaining WIC or other entitlements/supports

☐ Maintaining regular visitation with children not in custody

☐ Providing for children's daily needs (e.g. meals, laundry)

☐ Obtaining child care for times when you are at school or work

Do you need parenting information or assistance in any of the following areas?

☐ Knowledge of child development/realistic expectations

☐ Setting appropriate boundaries

☐ Bonding

☐ Communication

☐ Discipline / positive reinforcement

☐ Respite

☐ Other _____

Is child care assistance necessary for you to attend treatment? ☐ No ☐ Yes