## Adult Assessment Questionnaire

# PLEASE COMPLETE THIS FORM FIRST

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

| | | |
|---|---|---|
| Last Name: | MI: | First Name: |
| Preferred Name: | | Name if different from Legal Name: |
| Do you have a Legal Guardian: □ Yes □ No<br>If Yes, be prepared to provide legal documentation before being seen | | Name of legal guardian:<br>Phone Number: |
| Address: | | Land Line Home Phone: |
| Address (PO Box, Apt #): | | Cell Phone: |
| City: | | County: |
| State/Zip: | | Social Security: |
| Date of Birth: | | Gender:<br>○ Male<br>○ Female<br>○ Transgender<br>○ Other (Specify) _____<br>○ Refused<br>Preferred Pronouns: He/Him/His She/Her/Hers<br>They/Their/Theirs Other: |
| Ethnicity: □ NOT Spanish, Hispanic, Latino or Mexican<br>□ Puerto Rican □ Mexican □ Cuban<br>□ Central American □ Dominican □ South American<br>□ Other (Specify) _____ | | Race: □ Caucasian □ Black/African American<br>□ American Indian □ Asian □ Alaskan Native<br>□ Hawaiian or Pacific Islander □ Unknown |
| When possible, I prefer to be contacted via: □ Home Phone □ Cell Phone □ Email □ Text Message | | |
| Appointment reminders choice: □ Home Phone □ Cell Phone □ Email □ Text Message □ None | | |
| Email: | | |
| **Referral Source (circle all that apply):** Court Ordered *State Probation/Parole *Federal Probation/Parole<br>*DHS Employer Hospital Self- Referral OWI/Zero Tolerance Other:_____<br>*PO Worker Name _____ *DHS Worker Name _____ | | |
| **Reason for Seeking Assessment (circle all that apply):**<br>Mental Health Substance Use Gambling | | |
| **Have you been seen at Prairie Ridge under a different name (ex: Maiden name)?** | | |
| Communication Method: Communication Device Sign Language Verbal<br>Spoken & Written Language: English Spanish Other: _____<br>Last Grade Completed: _____ □ High School Diploma □ GED □ College | | |

**EMERGENCY CONTACT**

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

**Adult Assessment Questionnaire** Patient MRN: _____

**Welcome to Prairie Ridge! Thank you for taking the time to answer all following questions applicable to the assessment. 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 clinician so that alternative services can be provided.**

**Demographic Information** **Today's Date____/____/_____**

| | | |
|---|---|---|
| Last Name: | MI: | First Name: |
| Age: | | Do you have difficulty reading and/or writing? Y or N |
| Relationship Status: □ Single □ Married □ Cohabitating □ Separated □ Divorced □ Widowed | | |
| Pregnant: □ No □ Yes – Due Date: | | Valid Driver's License: □ No □ Yes DL#: |
| Sexual Orientation (heterosexual, gay, lesbian, bisexual, questioning, other): | | |

**Military Family and Deployment**

Have you served in the military or armed forces? (Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves) ☐ No ☐ Yes ☐ Prefer not to answer

If "yes", in which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.

| Branch of Service | Yes | No | Prefer not to answer |
|---|---|---|---|
| • Armed Forces | ◯ | ◯ | ◯ |
| • Reserves | ◯ | ◯ | ◯ |
| • National Guard | ◯ | ◯ | ◯ |

Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

☐ No ☐ Yes ☐ Prefer not to answer

If "yes", in which of the following are you currently serving? Please answer for each of the following. You may say yes to more than one.

| Branch of Service | Yes | No | Prefer not to answer |
|---|---|---|---|
| • Armed Forces | ◯ | ◯ | ◯ |
| • Reserves | ◯ | ◯ | ◯ |
| • National Guard | ◯ | ◯ | ◯ |

Have you ever been deployed to a combat zone? ☐ No ☐ Yes ☐ Prefer not to answer

If "yes", to which of the following combat zones have you been deployed? Please answer for each of the following. You may say yes to more than one.

| Combat Zones | Yes | No | Refused | Don't Know |
|---|---|---|---|---|
| Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn) | | | | |
| Persian Gulf (Operation Desert Shield or Desert Storm) | | | | |
| Vietnam/Southeast Asia | | | | |
| Korea | | | | |
| Deployed to combat zone not listed above (e.g., Somalia, Bosnia, Kosovo) | | | | |

Is anyone in your family or someone close to you currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard? ☐ No ☐ Yes ☐ Prefer not to answer

**Health Information**

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

Female Patients only, do you use birth control? ☐ No ☐ Yes - what method do you currently use? _____

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 any alternative medical practices (Example: Chiropractic care, yoga, acupuncture)? _____

How would you rate your overall health right now?

- Excellent
- Very good
- Good
- Fair
- Poor

I feel capable of managing my health care needs:

- On my own most of the time
- On my own some of the time and with support from others some of the time
- With support from others most of the time
- Rarely or never

**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: |
| Name of therapist: | Practice/ Facility Name and City: |

**Current Medications**

| Medication Name | Dose and Frequency | Reason | How long & Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Past Psychotropic/Mental Health Medications and Effectiveness:

_____

_____

**Infectious Disease (Diagnosed or Suspected) and STD Risk**

| Disease or Exposure | No or Not Applicable | Past | Current | Receiving/ed Treatment |
|---|---|---|---|---|
| Hepatitis Type: | | | | |
| HIV or AIDS *(optional)* | | | | |
| IV Drug Use | | | | |
| Tuberculosis (TB) | | | | |
| TB Exposure | | | | |
| Sexually Transmitted Disease (STD) | | | | |
| Sexual Contact without barrier protection | | | | |
| Blood transfusion | | | | |
| Yellow jaundice | | | | |
| Share needles/works | | | | |
| Exchanged sex for money or drugs | | | | |
| Been involved in a sexual assault | | | | |
| COVID-19 | | | | |

**Health measurements**

a. Systolic blood pressure _____ mmHg
b. Diastolic blood pressure _____ mmHg
c. Weight _____ kg/lbs
d. Height _____ cm/ft & inches

**Past Medical History**

History of surgeries: _____

History of head trauma: □ No □ Yes If yes, please explain:
_____

History of seizures: □ No □ Yes If yes, when was your last seizure: _____

Current medical conditions: _____

**Mental Health Information**

Current Mental Health Diagnosis: _____

Current Mental Health Symptoms: _____

_____

_____

Current or Past Mental Health Treatment: _____

_____

**Hospitalizations (Psychiatric, Detox, Committal)**

| Date | Reason |
|---|---|
| | |
| | |

Do you have a Durable Power of Attorney for Healthcare Decisions/Psychiatric Advance Directive?
□ No □ Yes

If you do not have a Durable Power of Attorney for Healthcare Decisions/Psychiatric Advance Directive, would you like more information about how to secure one?
□ No □ Yes

**Self/Family History**

Please place a check mark in box if these are or have ever been present in yourself or your biological relatives.

☐ Adopted

☐ Unknown

| | Self | Mother | Father | Brother | Sister | Maternal grandmother | Maternal grandfather | Paternal grandmother | Paternal grandfather |
|---|---|---|---|---|---|---|---|---|---|
| Heart disease | | | | | | | | | |
| High blood pressure | | | | | | | | | |
| Heart attack | | | | | | | | | |
| Asthma | | | | | | | | | |
| Sleep apnea | | | | | | | | | |
| Diabetes type 1 | | | | | | | | | |
| Diabetes type 2 | | | | | | | | | |
| Thyroid disorder | | | | | | | | | |
| High cholesterol | | | | | | | | | |
| ADHD | | | | | | | | | |
| Dementia | | | | | | | | | |
| Seizure | | | | | | | | | |
| Stroke | | | | | | | | | |
| Substance use | | | | | | | | | |
| Anxiety | | | | | | | | | |
| ADHD | | | | | | | | | |
| Autism | | | | | | | | | |
| Bipolar disorder | | | | | | | | | |
| Depression | | | | | | | | | |
| Learning disability | | | | | | | | | |
| Schizophrenia | | | | | | | | | |
| Suicide attempt | | | | | | | | | |
| Suicide completion | | | | | | | | | |
| Eating disorder | | | | | | | | | |
| Cancer (please specify) | | | | | | | | | |
| Other (please specify) | | | | | | | | | |

**Substance Use History**

| Substance of Use | Age of First Use & Last Date of Use | Pattern of Use within last 6 months (How much/How often) | Method of Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Past Substance Use Disorder Treatment: _____

_____

Family History of Substance Use:

_____

_____

**Tobacco Use**

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

Would you like assistance to quit? □ No □ Yes

Are you interested in information on Nicotine Replacement Therapy? □ No □ Yes

**Recovery Environment Information**

**Stability in Housing**

In the past 30 days, how many:

| | Number of Nights/Times | Don't Want to Answer | Don't Know |
|---|---|---|---|
| Nights have you been homeless? | | | |
| Nights have you spent in a hospital for mental health care? | | | |
| Nights have you spent in a facility for detox/inpatient or residential substance abuse treatment? | | | |
| Nights have you spent in a correctional facility including jail or prison? | | | |
| Times have you gone to an emergency room for a psychiatric or emotional problem? | | | |

In the past 30 days, where have you been living most of the time?

- Owned or rented house, apartment, trailer, room
- Someone else's house, apartment, trailer room
- Homeless (shelter, street/outdoors, park)
- Group home
- Adult foster care
- Transitional living facility
- Hospital (medical)
- Hospital (psychiatric)
- Detox/inpatient or residential substance abuse treatment facility
- Correctional facility (jail/prison)
- Nursing home
- VA hospital
- Veteran's home
- Military base
- Other housing (Specify) _____

**Current Household Members**

| Name | Relationship to You | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

In the last 4 weeks, how satisfied are you with the conditions of your living situation?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- Don't want to answer
- Don't know

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

Are there any living environment or family issues that you would like to have addressed in treatment? ☐ No ☐ Yes -

Please explain: _____ _____

**Living Situation**

- Independent
- With friend(s)/roomates
- College dorm
- With family
- 43 North Iowa
- Beje Clark or other correctional facility
- Other: _____

**Trauma/Abuse History**

| **Exposure** (Circle experienced or witnessed) | **No or Not Applicable** | **Past** | **Current** | **Receiving/ed Treatment** |
|---|---|---|---|---|
| Experience or witness physical abuse | | | | |
| Experience or witness emotional abuse | | | | |
| Experience or witness sexual abuse | | | | |
| Experience or witness domestic abuse | | | | |
| Traumatic experiences (could include childhood experiences, loss, car accident, violence, war, sexual assault, neglect, natural disaster or anything that was overwhelming to you) | | | | |

Did any of these experiences feel so frightening, horrible, or upsetting to you in the past and/or the present that you:

| | **Yes** | **No** | **Don't Want to Answer** | **Don't Know** |
|---|---|---|---|---|
| Have had nightmares about it or thought about it when you did not want to? | | | | |
| Tried hard not to think about it or went out of your way to avoid situations that remind you of it? | | | | |
| Were constantly on guard, watchful, or easily startled? | | | | |
| Felt numb and detached from others, activities, or your surroundings? | | | | |

In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- Never
- Once
- A few times
- More than a few times
- Don't want to answer
- Don't know

**Comment: _____**

_____

**Education**

| | |
|---|---|
| What is the last grade you completed? | ○ Less than 12th grade<br>○ 12th grade/high school diploma/equivalent (GED)<br>○ Vocational/Technical Diploma<br>○ Some college or university<br>○ Bachelor's degree<br>○ Graduate work/graduate degree |
| 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**

Are you currently employed:

- ○ Employed full time (35+ hours per week)
- ○ Employed part time
- ○ Unemployed, looking for work
- ○ Unemployed, disabled
- ○ Unemployed, volunteer work
- ○ Unemployed, retired
- ○ Unemployed, not looking for work
- ○ Other (Specify) _____
- ○ Don't want to answer

If you are employed, what is your employment status?

Are you paid at or above the minimum wage? ☐ No ☐ Yes ☐ Unknown

Are your wages paid directly by your employer? ☐ No ☐ Yes ☐ Unknown

Could anyone have applied for this job? ☐ No ☐ Yes ☐ Unknown

| Employer | Estimated Hire Date | Estimated End Date | Job Duties/Reason for Leaving/Comments |
|---|---|---|---|
| Current: | | | |
| Previous: | | | |

In the last 4 weeks, have you had enough money to meet your needs?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ Completely
- ○ Don't want to answer
- ○ Don't know

**Legal**

| | |
|---|---|
| In the past 30 days, how many times have you been arrested? | ○ _____ times<br>○ Don't want to answer<br>○ Don't know |
| Is this assessment court ordered?<br>Do you have a pending court date? | ☐ No ☐ Yes – If yes, what county?<br>☐ 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?<br>If yes, was an accident involved? | ☐ No ☐ Yes<br>☐ No ☐ Yes |
| If you received an alcohol-related charge, what was your Blood Alcohol Level at the time of arrest? | |
| 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 |
| Are you presently awaiting charges, trial or sentence? *If yes, please explain.* | ☐ No ☐ Yes |
| Are you required to be registered with the Iowa Sex Offender Registry? | ☐ No ☐ Yes |
| Are you on probation?<br>If yes, please check appropriate box. | ☐ No ☐ Yes<br>☐ State Probation ☐ Federal Probation |

**Social Connectedness**

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

| Statement | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Don't Want to Answer |
|---|---|---|---|---|---|---|
| I am happy with the friendships I have. | | | | | | |
| I have people with whom I can do enjoyable things. | | | | | | |
| I feel I belong to my community. | | | | | | |
| In a crisis, I would have the support I need from family and friends. | | | | | | |
| I have family or friends that are supportive of my recovery. | | | | | | |
| I generally accomplish what I set out to do. | | | | | | |

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

_____

Do you identify with a particular cultural group? □ No □ Yes- Please identify: _____

Are you currently experiencing any concerns or conflicts related to your cultural values? □ No □ Yes- Please identify:

_____

Do you identify with a particular religious/cultural group or spiritual practice? □ No □ Yes- Please identify:

_____

_____

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

_____

**Gambling Screen**

**PGSI**[15]

Below are a number of statements that describe the consequences of gambling. Please indicate how often you have experienced the following consequences in the past 12 months:

0 (Never) 1 (Sometimes) 2 (Most of the Time) 3 (Almost Always)

| | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| 1. Have you bet more than you could really afford to lose? | ☐ | ☐ | ☐ | ☐ |
| 2. Have you needed to gamble with larger amounts of money to get the same feeling of excitement? | ☐ | ☐ | ☐ | ☐ |
| 3. When you gambled, did you go back another day to try to win back the money you had lost? | ☐ | ☐ | ☐ | ☐ |
| 4. Have you borrowed money or sold anything to get money to gamble? | ☐ | ☐ | ☐ | ☐ |
| 5. Have you felt that you might have a problem with gambling? | ☐ | ☐ | ☐ | ☐ |
| 6. Has gambling ever caused you any health problems, including stress or anxiety? | ☐ | ☐ | ☐ | ☐ |
| 7. Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true? | ☐ | ☐ | ☐ | ☐ |
| 8. Has your gambling caused any financial problems for you or your household? | ☐ | ☐ | ☐ | ☐ |
| 9. Have you felt guilty about the way you gamble or what happens when you gamble? | ☐ | ☐ | ☐ | ☐ |

**Scoring:**

- 0 indicates no risk/non-problem gambler
- 1-2 indicates low risk
- 3-7 indicates moderate risk
- 8 or above indicates high risk ****Scores 3 and above should complete Gambling SBIRT

## *COMPLETE ONLY IF YOU ARE HERE FOR AN OWI ASSESSMENT:

# Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:   12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times a month | 2 - 3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 0 - 2 | 3 or 4 | 5 or 6 | 7 - 9 | 10 or more |
| 3. How often do you have five or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, in the last year |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, in the last year |
| | 0 | 1 | 2 | 3 | 4 |

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

| I | II | III | IV |
|---|---|---|---|
| 0-3 | 4-9 | 10-13 | 14+ |