

## PLEASE COMPLETE THIS FORM FIRST

### PATIENT INFORMATION

Today's Date \_\_\_/\_\_\_/\_\_\_

Last Name:	MI:	First Name:
Preferred Name:		Name if different from Legal Name:
Address:		Land Line Home Phone:
Address (PO Box, Apt #):		Cell Phone:
City:		County:
State/Zip:		Social Security:
Date of Birth:		Gender: <ul style="list-style-type: none"> <li><input type="radio"/> Male</li> <li><input type="radio"/> Female</li> <li><input type="radio"/> Transgender</li> <li><input type="radio"/> Other (Specify) _____</li> <li><input type="radio"/> Refused</li> </ul> Preferred Pronouns: He/Him/His She/Her/Hers They/Their/Theirs Other:
Ethnicity: <input type="checkbox"/> NOT Spanish, Hispanic, Latino or Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Central American <input type="checkbox"/> Dominican <input type="checkbox"/> South American <input type="checkbox"/> Other (Specify) _____		Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Unknown
When possible, I prefer to be contacted via: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text Message		
Appointment reminders choice: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> None		
Email:		
<b>Referral Source (circle all that apply):</b> Court Ordered *State Probation/Parole *Federal Probation/Parole *DHS Employer Hospital Self- Referral OWI/Zero Tolerance Other: _____ *PO Worker Name _____ *DHS Worker Name _____		
<b>Reason for Seeking Assessment (circle all that apply):</b> <div style="display: flex; justify-content: space-around; text-align: center;"> <span style="color: red;">Mental Health</span> <span style="color: blue;">Substance Use</span> <span style="color: green;">Gambling</span> </div>		
Have you been seen at Prairie Ridge under a different name (ex: Maiden name)?		
Communication Method: Communication Device Sign Language Verbal Spoken & Written Language: English Spanish Other: _____ Last Grade Completed: _____ <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> 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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes – Due Date:		Valid Driver's License: <input type="checkbox"/> No <input type="checkbox"/> 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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:

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### 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 ( <i>optional</i> )				
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)/roommates
- College dorm
- With family
- 43 North Iowa
- Beje Clark or other correctional facility
- Other: \_\_\_\_\_

**Trauma/Abuse History**

<b>Exposure</b> (Circle experienced or witnessed)	<b>No or Not Applicable</b>	<b>Past</b>	<b>Current</b>	<b>Receiving/ed Treatment</b>
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:

	<b>Yes</b>	<b>No</b>	<b>Don't Want to Answer</b>	<b>Don't Know</b>
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?	<input type="radio"/> Less than 12 <sup>th</sup> grade <input type="radio"/> 12 <sup>th</sup> grade/high school diploma/equivalent (GED) <input type="radio"/> Vocational/Technical Diploma <input type="radio"/> Some college or university <input type="radio"/> Bachelor's degree <input type="radio"/> Graduate work/graduate degree
Did you ever receive special education services?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Do you have difficulties reading and writing?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Do you have a history of developmental delay?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="radio"/> _____ times <input type="radio"/> Don't want to answer <input type="radio"/> Don't know
Is this assessment court ordered? Do you have a pending court date?	<input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what county? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, when is your court date?
Is this assessment due to a civil commitment?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this assessment for OWI or Zero Tolerance Offense? If yes, was an accident involved?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <i>If yes, please specify.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any past legal issues related to alcohol or drug offenses? <i>If yes, please specify.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you presently awaiting charges, trial or sentence? <i>If yes, please explain.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you required to be registered with the Iowa Sex Offender Registry?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you on probation? If yes, please check appropriate box.	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> State Probation <input type="checkbox"/> 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<sup>15</sup>

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)
1. Have you bet more than you could really afford to lose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you needed to gamble with larger amounts of money to get the same feeling of excitement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When you gambled, did you go back another day to try to win back the money you had lost?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you borrowed money or sold anything to get money to gamble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you felt that you might have a problem with gambling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has gambling ever caused you any health problems, including stress or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your gambling caused any financial problems for you or your household?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you felt guilty about the way you gamble or what happens when you gamble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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+