

Child & Adolescent Assessment Questionnaire

PLEASE COMPLETE THIS SHEET 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: 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"/> Other Hispanic or Latino <input type="checkbox"/> Unknown		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:		
Referral Source (circle all that apply): Court Ordered *State Probation/Parole *Federal Probation/Parole *DHS Employer Hospital Self-Referral OWI/Zero Tolerance Other: _____ *PO Worker Name _____ *DHS Worker Name _____		
Reason for Seeking Assessment (circle all that apply): <div style="display: flex; justify-content: space-around; text-align: center;"> Mental Health Substance Use Gambling </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:

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:		
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, questioning, etc.):		

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): _____

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 & 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 (<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				

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

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: _____

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

Current Household Members

Name	Relationship to You	Age

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

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: _____

Traumatic Exposure History

Exposure (Circle Experienced or Witnessed)	Past	Current	Receiving Treatment	Not Receiving Treatment	No or Not Applicable
Experience or witness physical abuse					
Experience or witness emotional abuse					
Experience or witness sexual abuse					
Experience or witness domestic abuse					
Other traumatic experiences (could include childhood experiences, loss, car accident, violence, war, sexual assault, neglect, or anything that was overwhelming to you)					

Comment: _____

Education

What is the last grade you completed?	Grade: <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> College
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

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

Previous:			
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Check (If Applicable): Currently Unemployed On SSI/Disability Unable to work due to physical/mental wellbeing

Legal

Is this assessment court ordered?	<input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what county?
Do you have a pending court date?	<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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, was an accident involved?	<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 currently experiencing any concerns related to your gender or sexual orientation? 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

PGSI¹⁵

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?	<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:

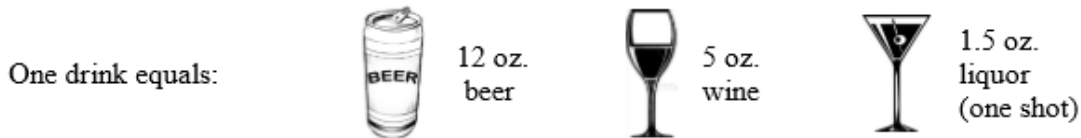
- 0 indicates no risk/non-problem gambler
- 1-2 indicates low risk

- 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 A ZERO TOLERANCE/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.



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+

PARENT QUESTIONNAIRE

(This document is front and back)

- 1) How would you describe your child? _____
- 2) How have things been going in the following areas (this can include things your child is doing, or things affecting him/her at home/school/with friends)?

Behavioral Concerns

Please select if there is past and/or present concern for any of the following behaviors. Comment box below can be used for further elaboration.

Child Behaviors

	Past concern	Present concern
Trouble Hearing		
Overly Sensitive to Sounds		
Visual Problems		
Tilts Head to Look at Items		
Daytime Toileting Accidents		
Nighttime Toileting Accidents		
Poor Eye Contact		
Does Not Play With Other Children		
Difficulty With Change in Routine		
Very Sensitive to Textures		
Stares Into Space, Seems in a Trance		
Easily Frustrated		
Frequent Tantrums		
Rarely Smiles, Laughs		
Eats Non-Food Items		
Aggressive Toward Others		
Cruel Toward Animals		
Runs Away From Home		
Shoplifting, Stealing		
Frequent Lying		
Rapid, Intense Mood Swings		
Frequent Outbursts		
Significant Weight Change		
Appetite Fluctuations		
Declining School Grades		
Refusal to Attend School		
Paranoid Thoughts		
Reoccurring Motor Movements		
Reoccurring Vocalizations		
Loss of Interest in Prior Activities, Hobbies		
Problematic Electronic Devices		

Additional Comments: _____

EDUCATION:

Select any events or services provided for the child in school

Education Details

	Yes	No
Attends School Regularly		
Grade Repeated		
Suspensions, Expulsions		
Special Education Services (IEP)		
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Counseling		

Select the most appropriate term for the child's performance in the following areas

School Performance

	Excellent	Above average	Average	Somewhat of a problem	Problematic
Reading					
Writing					
Mathematics					
Organizational Skills					
Assignment Completion					
Relationship With Peers					
Relationship With Teacher					

Additional Comments: _____

3)

Substance Use - Caregiver Reported Concerns

To the best of your knowledge, has the child ever:

Caregiver Reported Concerns

	Yes	No
Consumed Alcohol, Used Drugs		
Been Caught in Possession of Alcohol, Drugs, Paraphernalia		
Become Friends With Users of Alcohol, Drugs		
Misused or Taken More Than Prescribed Meds		
Taken Meds Prescribed for Someone Else		
Received Substance Use Counseling		

Additional Comments: _____

4) Did the child's mother use tobacco, alcohol, or other drugs while pregnant with the child (if yes, please explain)?
NO YES, _____

5) Were there any complications during pregnancy (if yes, please explain)? NO YES, _____

6) Does your child have problems with speech, hearing, or vision, not including contacts or glasses (if yes, please explain)? NO YES, _____

7) Are your child's immunizations current if under the age of 16? (Circle) NO YES

8)

Developmental History

Between the ages of 0-2 years old, was the child extremely sensitive to:

Infant Sensitivity

	Yes	No
Slight Changes in Touch		
Slight Changes in Sound Level		
Slight Changes in Lighting		

Between the ages of 0-2 years old, was your child

Infant Behaviors

	Yes	No
Unable to Develop Regular Sleep Pattern		
Very Difficult to Soothe When Upset		
Unable to Calm Self When Distressed		
Unable to Separate From Parent Without Distress		
Unable to Show Affection		

Developmental Milestones

	Early	On time	Late	Don't know
Walked Alone				
Said First Words				
Daytime Toileting				
Bladder Training				
Bowel Training				
Tied Shoelace				
Wrote Name				

Additional Comments: _____

9) Are there concerns with your child's mental health (if yes, please explain)? _____

10) What would you like to see happen as a result of this evaluation? _____

Is there anything else that is important for us to know? _____
