Child & Adolescent 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 If Yes, be prepared to provide legal documentation before being seen		Name of legal guardian: Phone Number:
Address:		Land Line Home Phone:
Address (PO Box, Apt #):		Cell Phone:
City:		County:
State/Zip:		Social Security:
Date of Birth:		Gender: ○ Male ○ Female ○ Transgender ○ Other (Specify) _____ ○ Refused Preferred Pronouns: He/Him/His She/Her/Hers They/Their/Theirs Other:
Ethnicity: □ NOT Spanish, Hispanic, Latino or Mexican □ Puerto Rican □ Mexican □ Cuban □ Central American □ Dominican □ South American □ Other (Specify) _____		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 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 *DHS Employer Hospital Self- Referral OWI/Zero Tolerance Other:_____ *PO Worker Name _____ *DHS Worker Name _____		
Reason for Seeking Assessment (circle all that apply): 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 Spoken & Written Language: English Spanish Other: _____ Last Grade Completed: _____ □ High School Diploma □ GED □ College		

EMERGENCY CONTACT

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

Child & Adolescent Assessment Questionnaire Patient ID: _____

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 indicate who is answering this form: □ Caretaker □ Child □ Both	Do you have difficulties reading and/or writing? Y or N
Pregnant: □ No □ Yes – Due Date:	Valid Driver's License: □ No □ Yes DL#:
Sexual Orientation (heterosexual, gay, lesbian, bisexual, questioning, other.):	

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)? _____

Is the child adopted or in foster care? **Yes/No** If yes, are they aware? **Yes/No**

Name of legal guardian(s):_____

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 Therapist/Counselor:	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_____

_____

Alprazolam (Xanax) Amitriptyline (Elavil) Amphetamine (Adderall) Aripiprazole (Ability) Asenapine (Saphris) Atomoxetine (Stratera) Bupropion (Wellbutrin) Buspirone (Buspar) Carbamazepine (Tegretol) Citalopram (Celexa) Clomipramine (Anafranil) Clonazepam (Klonopin) Clonidine (Kapvay) Clozapine (Clozaril) Desipramine (Norpramin) Desvenlafaxine (Pristiq) Dexmethylphenidate (Focalin) Amphetamine (Adderall)	Diazepam (Valium) Duloxetine (Cymbalta) Escitalopram (Lexapro) Fluoxetine (Prozac) Fluphenazine (Prolixin) Fluvoxamine (Luvox) Guanfacine (Intuniv) Haloperidol (Haldol) Hydroxyzine (Vistaril/Atarax) Iloperidone (Fanapt) Imipramine (Tofranil) Lamotrigine (Lamictal) Levomilnacipran (Fetzima) Lisdexamfetamine (Vyvase) Lithium Lorazepam (Ativan) Loxapine (Lovitane) Lurasidone (Latuda) Methylphenidate (Concerta, Daytrana, Ritalin)	Mirtazapine (Remeron) Nortriptyline (Pamelor) Olanzapine (Zyprexa) Oxycarbamazepine (Trileptal) Paliperidone (Invega) Paroxetine (Paxil) Prazosin (Minipress) Quetiapine (Seroquel) Risperidone (Risperdal) Sertraline (Zoloft) Topiramate (Topamax) Trazodone (Desyrel) Valproic Acid (Depakote) Venlafaxine (Effexor) Vilazodone (Vibryd) Vortioxetine (Trintellix) Ziprasidone (Geodon)

Has the patient made any **suicide attempts?**

How did they attempt suicide:	Age at attempt	Did they require medical attention?

Has the patient ever **threatened** to kill or harm themselves? **Yes/No** If so, explain:

Has the patient engaged in any self-harming behaviors (like cutting)? **Yes/No** if so explain:

Has the patient ever acted violently towards people, animals or property? **Yes/No** If so, explain:

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				

Health measurements

a. Systolic blood pressure _____ mmHg
b. Diastolic blood pressure _____ mmHg
c. Weight _____ kg
d. Height _____ cm

Mental Health Information

Current Mental Health Diagnosis: _____

Current Mental Health Symptoms: _____

_____

_____

Current or Past Mental Health Treatment: _____

_____

Hospitalizations (Psychiatric, Detox, Committal)

Date	Reason

In order to provide the best possible mental health and related services, we need to know what you think about how well you were able to deal with everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements:

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Don't Want to Answer
I am handling daily life.						
I get along with my family.						
I get along with friends and other people.						
I am doing well in school and/or work.						
I am able to cope when things go wrong.						
I am satisfied with my family life right now.						

The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

Question…. During the past 30 days, about how often did you feel…..	All the time	Most of the time	Some of the time	A little of the time	Don't know	Don't Want to Answer
Nervous						
Hopeless						
Restless or fidgety?						
So depressed that nothing could cheer you up						
That everything was an effort						
Worthless						

In the past 30 days:

How many times have you thought about killing yourself? _____

How many times did you attempt to kill yourself? _____

(For child's caregiver)
In the past 30 days:

Has your child expressed thoughts to you about killing himself/herself? ☐ No ☐ Yes

Did your child attempt to kill himself/herself? ☐ 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: _____

_____

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

Military Family and Deployment

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

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 juvenile detention, jail or prison?			
Times have you gone to an emergency room for a psychiatric or emotional problem?			

Recovery Environment Information

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

- Caregiver's owned or rented house, apartment, trailer, room
- Independent owned or rented house, apartment, trailer, or room
- Someone else's house, apartment, trailer room
- Homeless (shelter, street/outdoors, park)
- Group home
- Foster care (specialized therapeutic treatment)
- Transitional living facility
- Hospital (medical)
- Hospital (psychiatric)
- Detox/inpatient or residential substance abuse treatment facility
- Correctional facility (juvenile detention center/jail/prison)
- Other housing (Specify) _____

Current Household Members

Name	Relationship to You	Age

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

Family History of Mental Health Issues:

_____

_____

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

During the past 30 days of school, how many days were you absent for any reason?

- 0 days
- 1 day
- 2 days
- 3 to 5 days
- 6 to 10 days
- More than 10 days
- Don't want to answer
- Don't know
- Not applicable

If absent, how many days were unexcused absences?

- 0 days
- 1 day
- 2 days
- 3 to 5 days
- 6 to 10 days
- More than 10 days
- Don't want to answer
- Don't know
- Not applicable

What is the last grade you completed?	Grade:
Did you ever receive a 504 or IEP?	☐ 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 Hire Date	Estimated End Date	Job Duties/Reason for Leaving/Comments
Current:			
Previous:			

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

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?
In the past 30 days, how many times have you been arrested?	
Is this assessment due to a civil commitment?	☐ No ☐ Yes
Is this assessment for OWI or Zero Tolerance Offense? If yes, was an accident involved?	☐ No ☐ Yes ☐ 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

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 know people who will listen and understand me when I need to talk.						
I have people that I am comfortable talking with about my problems.						
In a crisis, I would have the support I need from family and friends.						
I have people with whom I can do enjoyable things.						

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_____

_____

Social History

School Name and Current Grade:_____

What type of school is this (circle one)? Public Private alternative vocational home schooled

Is there a 504 Plan or IEP? _____

Current average grades: _____

Any grades repeated? If so, what grade(s)? _____

List the patient's strongest subjects: _____

List the patient's weakest subjects: _____

Learning disabilities: _____

Is the patient being bullied at school? **Yes/No**

Guns or weapons in your home? **Yes/No** If yes, does the patient have access to them: **Yes/No**

Does the patient attend mainstream or special education classes? Explain:

Did the patient ever have any IQ or achievement testing? **Yes/No** (If yes, answer the next 2 questions)

Patient's age at testing: _____ Where was this done? _____

Behavioral problems at school? (Circle all that apply):

Bullying others Detentions Suspensions Expulsions Not paying attention Refusing to do school work Anger outbursts Defiance Trouble staying in seat Trouble with talking when it is not allowed Trouble relating to peers Physical aggression Skipping school or classes	Other:

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

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+

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? _____

_____

_____

_____