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: □ 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 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:

Adult 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 note, Federal Law prohibits us from serving any person who is currently serving as a <u>Confidential Informant.</u> 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:		
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, questioning, etc.):		
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		

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 *(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				

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

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: _____ _____

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)				

Comment: _____

_____

Education

What is the last grade you completed?	Grade: □ High School Diploma □ GED □ College
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 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 well-being

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? 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
Are you on probation? If yes, please check appropriate box.	☐ No ☐ Yes ☐ State Probation ☐ Federal Probation

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

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+

Informed Consent for Telehealth

Telehealth involves the use of electronic communications to enable health care provider(s) to provide services to a patient at a different location via live two-way audio/video transmission known as a telehealth virtual visit.

I, _____, the undersigned patient or parent / legal guardian for the minor patient, agree to receive medically necessary live, interactive video telehealth services from Prairie Ridge, from a provider who is located at a distant site location, for my (check all that apply):

□ Mental health treatment services (to include psychiatric services)

□ Substance use disorder treatment services

□ Problem gambling treatment services

The distant site(s) where my Prairie Ridge provider is located will be _____.

Patient Responsibilities

I understand that:

- I am responsible to safeguard the privacy of my telehealth service(s) from access by others in the environment the I am in at the time of the telehealth service(s).
- Electronic communication is not to be used for any emergency or urgent communications and to utilize the established emergency phone contact procedures if needed.
- To determine, in collaboration with my assigned Prairie Ridge provider, the appropriate use of telehealth services, and agree on the nature, volume and frequency which supports effective services.
- I retain the right to refuse telehealth services at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- Prairie Ridge reserves the right to cease the use of telehealth services at any time.
- I agree to safeguard the privacy of my telehealth service(s) from access by others in the environment I am in at the time of receiving telehealth services.
- All existing confidentiality protections shall apply to my telehealth services.
- I shall have access to all medical information resulting from the telehealth services, as provided by law.
- Information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent. However, information that discloses the potential for harm to the patient or to another person, including child or dependent adult maltreatment concerns, cannot be kept confidential.
- If I decline telehealth services, other alternative options are available to me, including in person services. I understand I may have to travel to see a licensed health care provider in person if I decline telehealth service(s). These options are in person:
    - ✓ Individual therapy

- ✓ Group therapy
- ✓ Medication Management

- I will discuss at the start of each session what my safety plan is should an urgent need arise.
- I may see an appropriately trained staff person or employee in-person immediately after the telehealth service(s) if an urgent need arises or I will be told ahead of time if there is no availability on the day of that telehealth virtual visit.
- I will be informed whether the telehealth consultation will be or will not be recorded.
- I will be informed of all people who will be present at all sites during my telehealth service and I retain the right to exclude anyone from either the originating or distant site.
- I understand that this consent is valid for one year for follow-up telehealth services with my Prairie Ridge provider(s).
- I am responsible for any copayments or coinsurances that apply to my telehealth virtual visit(s).
- There is always a risk that security protocols could fail or be breached, causing the privacy of my personal medical information to potentially be compromised. Knowing this possibility always exists, I still choose to obtain my services from Prairie Ridge by this electronic telehealth method.

Prairie Ridge Responsibilities

- Prairie Ridge has policies and practices in place to safeguard the privacy of all client information whether written or in electronic form.
- Prairie Ridge agrees to use electronic systems that incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures with the intent to safeguard the data and to protect its integrity against intentional or unintentional corruption or access.
- Prairie Ridge has the responsibility to thoroughly assess the security features and the risks of any third-party site utilized in treatment services before agreeing to the use of the site.
- Prairie Ridge telehealth providers will be educated on the use of the technology equipment and provide this education and support to clients receiving telehealth services.

I have read and fully understand the information provided above regarding telehealth, have discussed this service with my Prairie Ridge provider(s) or such assistants as may be designated, and all my questions have been answered to my complete satisfaction. Therefore, I hereby give my informed consent to receive telehealth service(s) in my treatment at Prairie Ridge.

Patient Signature: _____

Date: