

Ozark Guidance Adult Questionnaire

Date: _____
 Client Name: _____
 Client Address: _____
 Client Phone Number: Home: _____ Work: _____
 Client's Place of Employment: _____
 Client's Occupation: _____
 Legal Guardian: (Check all that apply): Self Mother Father Grandparents DHS
 Other (please explain): _____
 Name of person to contact in case of emergency: _____
 Relationship: _____ Phone: _____
 Address: _____
 Marital Status: (Please check): Married Single Divorced Separated Widowed
 Spouse/Partner Name: _____
 Spouse/Partner Address, if different: _____
 Spouse/Partner Phone Number, if different: _____

Living Arrangements (Please check):

Living alone Homeless Living with family Institutional Setting Living with friends
 Temporary Situation Other (Please specify): _____

Other occupants in the home:

Please specify for each occupant in the home:

<u>Name</u>	<u>Age</u>	<u>Employed</u>	<u>School</u>
_____	_____	Y N	_____
_____	_____	Y N	Y N
_____	_____	Y N	Y N
_____	_____	Y N	Y N
_____	_____	Y N	Y N

Have you had other psychiatric treatment? Yes No

If yes, when and where did you receive treatment? _____

Substance Abuse

Have you ever experimented with alcohol, marijuana, cocaine, pills, narcotics, PCP or hallucinogens?
 Yes No

If yes, please answer the following questions: (Please Circle)

1. Have you ever felt you should cut down on your substance abuse? Yes No
2. Have people ever annoyed you by criticizing your substance use? Yes No
3. Have you ever felt bad or guilty about your substance use? Yes No
4. Have you ever had to use a substance first thing in the morning to steady your nerves or get rid of a hangover or to get up and moving? Yes No
5. Is there a history of substance abuse in your family? Yes No
6. Have you ever received treatment for substance abuse? Yes No

If yes, where was treatment received? _____

Please indicate the amount you presently use of the following: (How many, daily, weekly, etc.)

Caffeinated Coffee _____ Tea _____ Soft Drinks with caffeine _____
 Nicotine _____ Alcohol _____ Sleeping Medications _____

Current Use of Community Resources

Please circle any of the following community resources you currently use:

Department of Human Services
Richardson Center
Housing Authority

Department of Health
Salvation Army
St. Francis House

Legal Aid
Schmeiding Center
Ozark Transit

Other: _____

Nutrition Screening

Have you had weight gain or loss that is unexplained within the last six months? ____ Yes ____ No

Do you have frequent nausea or vomiting? ____ Yes ____ No

What is your current weight? _____

Do you require a special diet? _____ If yes, please explain

Please circle any of the following with which you are currently having problems:

Loss of taste Food allergies Binging Purging Chronic diarrhea Other: _____

Pain Screening

Do you have physical pain for which you have not received care? ____ Yes ____ No

If yes, please explain _____

Physical Health Screening

Name of Primary Care Provider: _____

When was the last time you saw your primary care physician? _____

30 days 90 days 6 months 9 months 12 months Unable to recall

Date of last physical exam: _____

Please list currently and recently used medications:

Are you allergic or sensitive to any medications? ____ Yes ____ No If yes, please list:

Please list past and current diagnoses or problems:

Please list significant, known past treatment procedures:

Average hours of sleep per night: _____

Are you getting enough sleep at night? Yes No

How would you rate your overall health? Poor Fair Good Excellent

Please list which of the following conditions apply to yourself or to members of your family (parents, grandparents, aunts/uncles, brothers/sisters, children):

Self

List Family Members

Alcoholism _____

Allergies _____

Epilepsy _____

Depression _____

Headaches _____

Mental Illness _____

Short Attention Span _____

Hyperactivity _____

Impulsive Behavior _____

Head Injuries _____

Learning Disability _____

Other: _____

Did you experience speech development delays in childhood? Yes No

Did your mother experience complications with your pregnancy/delivery? Yes No

If yes, explain _____

Legal Screening

Do you have past or pending criminal charges? _____ Yes _____ No

Are you required to report to a probation or parole officer? _____ Yes _____ No

Probation Officer's name: _____

Parole Officer's name: _____

Do you have legal mandates involving mental health services? _____ Yes _____ No

Emotional and Behavioral

Please circle problems you have been experiencing:

Unstable mood	Coping with stress	
Extreme highs	Confusion	
Extreme lows	Reaction to traumatic events	
High levels of anxiety	Relationship problems	
Depression	Impulsive behavior	
Disordered thinking	Grief/bereavement	Other _____

How long have these problems been occurring?

One month Three months Six months Other _____

How often do these problems occur?

Daily Weekly Monthly Other _____

Using the scale below, rate your feelings toward the following areas of your life. Write NA if it is not applicable.

1	2	3	4	5
Terrible	Bad	Okay	Good	Terrific

Living arrangements _____ Employment _____ Social Life _____ Lifestyle _____

Personal habits _____ Life skills _____ Peer relationships _____

Spouse/Partner relationships _____ Family relationship _____

Have you ever been hurt or abused? _____ Yes _____ No If yes, circle all that apply

Physical Date Rape Intimidation Emotional Spousal
Neglect by parents Sexual Harsh discipline Neglect/indifference by spouse _____
Verbal

When did these events occur? _____

What was the most traumatic event(s) in your childhood?

What was the most traumatic event(s) in your adulthood?

Please circle your current source of emotional support

Spouse/Partner Children Parent(s)
Extended Family Members Friends Community Group
Other _____

Do you maintain stable relationships for long periods of time? ___ Yes ___ No

Are you currently in a stable relationship? ___ Yes ___ No

Are there sexual or relationship issues that you want considered in your treatment? ___ Yes ___ No

If yes, please explain:

Vocational/Educational Screening

Current Employer: _____

Usual Occupation: _____

Years of School Completed: _____

Problems in School or on the Job? ___ Yes ___ No If yes, explain

Special Classes: ___ Yes ___ No

Difficulty Reading ___ Yes ___ No

Desires further educational/vocational training? ___ Yes ___ No

Is receiving educational materials about issues related to your treatment important to you? ___ Yes ___ No

Please check all the following topics for which you would like additional information:

___ Treatment Plan ___ Safe and Effective Use of Medications

___ Basic Health and Safety Practices ___ Methods to be independent

___ Safe and Effective Use of Medication

___ Nutrition Interventions, diets, oral health

Learning Needs Assessment

Is there a history of learning disabilities? ___ Yes ___ No

Is an interpreter needed? ___ Yes ___ No

What is the preferred language? _____

Is there a learning preference? ___ Yes ___ No **Please circle:**

Visual (seeing); Auditory (hearing); Hands-on Tasks (doing); Unsure

Is receiving educational materials about issues related to your treatment important to you? ___ Yes ___ No

Cultural/Religious/Spiritual

Do you have cultural and/or spiritual concerns that you want considered in your treatment? ____ Yes ____ No
If yes, please explain:

Please circle your religious orientation.

Protestant Catholic Hindu Muslim Jehovah Witness Jewish
Latter Day Saints None Other: _____

Advanced Directive

An advanced directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decision if he or she should lose decision-making capability. Advance directives may include living wills, durable powers of attorney, or similar documents portraying the preference of the individual served.

Have you created an advanced directive? Yes No If Yes, where located? _____

Would you like additional information on the advance directive issues? Yes No

Miscellaneous

Please list your hobbies, recreational activities, and interests:

**Ozark Guidance Adult Questionnaire
Therapist Review of Screening Questions
Referral Criteria**

Instructions: This is the decision page for the adult questionnaire to be completed by the mental health professional as part of the assessment process. This page **MUST BE ATTACHED** to the completed questionnaire for imaging into the Electronic Medical Record (EMR).

PRIMARY THERAPIST'S SIGNATURE IS REQUIRED

Nutrition: If yes to either of the first two questions on the nutrition screen, refer to Primary Care Provider

Pain: If yes, refer to Primary Care Provider

Physical Health Screening: If date of last exam is longer than 18 months, refer to Primary Care Provider for physical examination

Emotional/Behavioral: Any items circled in left side list need to be given high consideration for referral for psychiatric and/or psychological testing.

Vocational /Educational Screening: Vocational/educational referral if difficulty reading or desire for further education/vocational training is marked yes.

Advanced Directive Information: Refer to admissions office at local hospital (or Receptionist)

Screening for Imminent Harm to Self or Others

Suicide Risk - Please check all that apply in the last three months:

Ideation Intent Plan Gesture Attempt NA

If checked, please explain: _____

Violence/Homicide Risk - Please check all that apply in the last three months:

Ideation Intent Plan Gesture Attempt NA

If checked, please explain: _____

Abuse/Violence - Please check all that apply in the last three months:

Domestic Child Sexual Other NA

If checked, please explain: _____

He or she is in such a mental condition as a result of mental illness, disease, or disorder that he or she poses a clear and present danger to himself or herself or others. Yes No

If yes, please explain: _____

This client **Requires Referral** **Does not Require a Referral**

If a referral is required, document to whom the referral was made and the date of referral

Reviewed by:

Primary Therapist's Signature

