CLIENT QUESTIONNAIRE

Welcome! Please take a few minutes to fill this out. The information will help us better understand your situation and needs. If there are questions you are uncomfortable answering, wait and discuss them with a staff member.

Today's Date	**Name: (First)**	**(Middle)**	**(Last)**	**(Last Name at Birth)**

Social Security Number	**Age**	**Date of Birth**	**Home Phone**	**Other Phone**

Address: (No. & Street)	**(Apt No.)**	**(City)**	**(State & Zip Code)**	**(County)**

Person Completing this Form: **Relationship to You:**

Sex: (check one)	**Current Marital Status:** (check one)	**Education:** High School Graduate: □ Yes □ No
□Male □ Female	□ Single □ Divorced	Last Grade Completed: _____
□Transgender-Male to Female	□ Separated □ Widowed	GED: □ Yes □ No Voc Ed: □ Yes □ No
□Transgender-Female to Male	□ Married - How Long? _____	Years of College completed: _____
		College Degree: □ Yes □ No Degree Type: _____

Race / Ethnicity: □ Alaskan □ American Indian □ Asian □ Black or African American (Not of Hispanic Origin)
□ Hispanic or Latino □ Native Hawaiian/ Other Pacific Islander □ Caucasian □ Other _____

Have You ever been in the military? □ Yes □ No – **If Yes, what are your dates of service?** _____
Are you currently seeing a therapist, counselor, psychologist or social worker? □ Yes □ No
Are you currently attending an addiction treatment program? □ Yes □ No – If Yes, where? _____
Are you currently involved with the Child Welfare system/foster care? □ Yes □ No
Are you current on parole/probation? □ Yes □ No – **If Yes, please complete the following information:**

_____

PO/ISO **Address** **Phone**

Who referred you to COMCARE?

Insurance / Coverage Provider:
Medicaid/Medikan/Medicare/Private: _____

Employment: □ Full-time □ Part-time	**Employer:** (If none, write none)
# of hours weekly _____	

EMERGENCY CONCTACT: Name: _____ Relationship to you: _____

Address: _____ Home Phone: _____ Work Phone: _____

Please list the reasons that bring you here today.
This may include concerns, problems, significant losses or changes that are causing you to seek treatment at this time.

_____

_____

_____

Over the last **2 weeks**, how often have you been bothered by any of the following problems? (Please circle your answer)

PHQ – 9 Questionnaire	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3

GAD – 7 Questionnaire	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: PHQ-9 and GAD-7 developed by Drs Robert L Spitzer, Janet BW Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc.

Additional Screening Questions	YES	NO	UNSURE
1. I see or hear things that others do not see or hear.	☐	☐	☐
2. I believe that someone may be watching me, planning to harm me, or may be about to harm me in the near future.	☐	☐	☐

AUDIT-C Questionnaire

1. How often do you have a drink containing alcohol?
   - ☐ A. Never
   - ☐ B. Monthly or less
   - ☐ C. 2-3 times a month
   - ☐ D. 2-3 times a week
   - ☐ E. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   - ☐ A. 1 or 2
   - ☐ B. 3 or 4
   - ☐ C. 5 or 6
   - ☐ D. 7 to 9
   - ☐ E. 10 or more

3. How often do you have six or more drinks on one occasion?
   - ☐ A. Never
   - ☐ B. Less than monthly
   - ☐ C. Monthly
   - ☐ D. Weekly
   - ☐ E. Daily or almost daily

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

	YES	NO
3. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
4. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
5. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
6. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Source: Brown RL, Leonard T, Saunders LA, Papasouliotis O. The prevalence and detection of substance use disorder among inpatients ages 18 to 49: an opportunity for prevention. Preventive Medicine. 1998;27:101-110.

Brief Bio-social Gambling Screen (BBGS)

During the <u>past 12 months</u>:	YES	NO
1. Have you become restless, irritable or anxious when trying to stop/cut down on gambling?	☐	☐
2. Have you tried to keep your family or friends from knowing how much you gambled?	☐	☐
3. Did you have such financial trouble that you had to get help from family or friends?	☐	☐

Source: Gebauer, L., LaBrie, R. A., & Shaffer, H. J. (2010). Optimizing DSM-IV classification accuracy: A brief bio-social screen for gambling disorders among the general household population. Canadian Journal of Psychiatry, 55(2), 82-90.

Medical History:

Primary Care Physician: _____ Address of Physician:_____

City of Physician _____ State of Physician_____ Zip _____
(If unknown please look up. Phone books available our waiting area.)

Please circle all that apply:

Smoke tobacco
Asthma
COPD
Active Tuberculosis
Diabetes
Epilepsy/Seizures
Hepatitis: A B C (circle all that apply)
HIV /AIDS
Arthritis

Heart problems
High Blood Pressure
Head injury/Loss of consciousness
Blackouts
Tremors
Weight loss
Weight gain
Other Chronic illness: _____
Serious injury: What?_____

Current health concerns:

For women:

Are you currently pregnant? □ No □ Yes (# of weeks pregnant: _____ due date: _____)

Number of pregnancies:_____ Number of births:_____

Current Prescribed Medications	**Dose**	**How Often**	**Prescribed by**

Are you allergic to any medications or drugs? □ No □ Yes (describe) _____

Spiritual and Religious History: Are there any religious or spiritual influences or practices that are important to you? Please list below:

Current Legal Status: Are you currently involved in any active cases (traffic, civil, criminal)? □ No □ Yes

Past Legal History: (Check all that apply)

Traffic Violations □ No □ Yes Other □ No □ Yes Incarcerated? □ No □ Yes

Leisure / Recreational Activities: Describe special areas of interest or hobbies (e.g. art, books, crafts, exercise, sports, outdoor activities, church activities, fishing, traveling, TV shows, etc.):
