

Interviewer: _____
 Company Name: _____
 Address: _____
 Phone Number: _____ Fax: _____
 Email: _____
 Date of Interview: _____

NATIVE AMERICAN ADULT QUESTIONNAIRE

Client's Name: First _____
 Middle _____
 Last _____

Social Security #: - -

Date of Birth: / /

Gender (M/F):

Client ID:

INSTRUCTIONS

1. Leave no blanks. Where appropriate code items:
 Y-Yes
 N-No
 X-Question not applicable
 Z-Question not answered
 Use only one character per item.
2. Space is provided after sections for additional comments.

SEVERITY RATINGS

The severity ratings are interview estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situations). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of the patient's treatment needs in a given area.

Orion Healthcare Technology is the U.S. leader in providing automated practice management solutions to the behavioral health and substance abuse fields. Our products include adult, adolescent, criminal justice and co-occurring assessments; treatment plans, patient placement, progress notes, discharge summaries, outcome research software, MIS, office scheduling and billing applications. If you would like information about the automated version of this questionnaire or others, please feel free to call our toll-free number 800-324-7966 or visit www.MyAccuCare.com. Orion allows the photocopying of this questionnaire for clinical use, but reserves the software rights for this product.

NATIVE AMERICAN ADULT QUESTIONNAIRE

GENERAL INFORMATION

G1. Client ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

G2. Social Security #:

					-			-						
--	--	--	--	--	---	--	--	---	--	--	--	--	--	--

G3. Provider #:

--	--	--	--	--	--	--	--

G4. Date of Admission:

		/			/		
--	--	---	--	--	---	--	--

G5. Date of Interview:

		/			/		
--	--	---	--	--	---	--	--

G6. Time Begun:

		:		
--	--	---	--	--

G51. Who referred you for an evaluation?

- 1-Attorney
- 2-Probation/Parole Officer
- 3-Presentence Investigator
- 4-Self
- 5-Judge or Court
- 6-Other

G52. Referral source's name _____

Address _____

Address _____

City, State, Zip _____

Phone #: (_____) _____ - _____

G53. By when do you need this assessment?

		/			/		
--	--	---	--	--	---	--	--

G54. Why are you receiving this assessment (1-6)?

- | | |
|------------------------|-------------------------|
| 1-OWI or DWI | 4-Other criminal arrest |
| 2-Court ordered | 5-Self interest |
| 3-Attorney recommended | 6-Other |

G55. BAC:

--	--	--	--

G56. By whom was it ordered (1-4)?

- | | |
|-------------|---------------|
| 1-Judge | 3-Presentence |
| 2-Probation | 4-Parole |

Specify other _____

G8. Class:

- 1-Intake
- 2-Follow-up

G9. Contact Code:

- 1-In person
- 2-Phone
- 3-Mail

G57. Interviewer's initials:

--	--	--	--

COMMENTS FOR GENERAL AREA: _____

MEDICAL STATUS

COMMENTS FOR MEDICAL AREA: _____

M1. How many times in your life have you been hospitalized for medical problems? (Include ODs, DTs, exclude detox)

M2. How long ago was your last hospitalization for a physical problem?
Years Months

M51. What was it for? _____

M3. Do you have any chronic medical problems which continue to interfere with your life (Y/N)?
Specify: _____

M4. Are you taking any prescribed medication on a regular basis for a physical problem (Y/N)?

M52. What is it? _____

M53. What is it for? _____

M5. Do you receive financial compensation (pension, disability, etc.) for a physical disability (Y/N)?
Specify: _____

M6. How many days have you experienced medical problems in the past 30 days?

M7. How troubled or bothered have you been by these medical problems in the past 30 days?
0-Not at all 3-Considerably
1-Slightly 4-Extremely
2-Moderately

M8. How important to you now is treatment for these medical problems?
0-Not at all 3-Considerably
1-Slightly 4-Extremely
2-Moderately

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medical treatment (0-9)?
0-None necessary to 9-Treatment needed to intervene in life-threatening situation

CONFIDENCE RATINGS

Is the Medical Status information significantly distorted by:

M10. Patient's misrepresentation (Y/N)?

M11. Patient's inability to understand (Y/N)?

EMPLOYMENT/SUPPORT STATUS

COMMENTS FOR EMPLOYMENT/SUPPORT STATUS: _____

E1. Education completed (GED = 12 years):

Years

Months

E2. Training or technical education completed

Months

E3. Do you have a profession, trade or skill (Y/N)?

Specify: _____

E4. Do you have a valid driver's license (Y/N)?

E5. Do you have an automobile available (Y/N)?

(Answer "no" if no valid driver's license)

E6. How long was your longest full-time job?

Years

Months

E7. Usual (or last) occupation:

- 1a. Higher Executives
- 1b. Large Proprietor (Value over \$180,000)
- 1c. Major Professionals
- 2a. Business Managers
- 2b. Proprietors of Medium-Sized Businesses
- 3a. Administrative Personnel
- 3b. Proprietors of Small Businesses (<\$55,000)
- 3c. Minor Professionals
- 3d. Farmers (Owners \$41,000-\$60,000)
- 4a. Clerical and Sales Workers
- 4b. Technicians
- 4c. Proprietors of Little Business (<\$10,000)
- 4d. Farmers (Owners \$21,000-\$40,000)
- 5a. Skilled Manual Employees and Small Farmers
- 5b. Small Farmers (Owners <\$20,000)
- 6a. Machine Operators and Semi-Skilled Employees
- 6b. Small Farm Tenants
- 7. Unskilled Employees

Specify: _____

E8. Does someone contribute to your support in any way? (Y/N)?

Specify: _____

E9. Does this constitute the majority of your support (Y/N)?

E10. Employment status:

- 1-Full-time (35+ hrs/wk)
- 2-Part-time (reg. hrs.)
- 3-Part-time (irreg., daywork)
- 4-Student
- 5-Service
- 6-Retired/Disability
- 7-Unemployed
- 8-In controlled environment

E11. How many days were you paid for working in the last 30?

How much money did you receive from the following sources in the past 30 days?

E12. Employment (net income):

E13. Unemployment compensation:

E14. Welfare:

E15. Pension, benefits or social security:

E16. Mate, family or friends:

E17. Illegal

E51. What was your gross income last year? \$

E18. How many people depend on you for the majority of their food, shelter, etc.?

E19. How many days have you experienced employment problems in the past 30?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 3-CONSIDERABLY
1-SLIGHTLY 4-EXTREMELY
2-MODERATELY

E20. How troubled or bothered have you been by these employment problems in the past 30 days?

E21. How important to you now is counseling for these employment problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

E22. How would you rate the patient's need for employment counseling (0-9)?

0-None necessary to 9-Treatment needed to intervene in life-threatening situation

CONFIDENCE RATINGS

Is the Employment/Support Status information significantly distorted by:

E23. Patient's misrepresentation (Y/N)?

E24. Patient's inability to understand (Y/N)?

COMMENTS FOR EMPLOYMENT/SUPPORT STATUS: _____

Horizontal lines for writing comments.

DRUG/ALCOHOL USE

D51. What age did you first try alcohol or drugs?

D52. What was it? _____

	# Days		Route of Admin
	Past 30	Lifetime	
D1. Alcohol (any use at all)	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D2. Alcohol (to intoxication)	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D3. Heroin	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D4. Methadone	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D5. Other opiates/analgesics	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D6. Barbiturates	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D7. Other sedatives/hypnotics/ tranquilizers	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D8. Cocaine	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D9. Amphetamines	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D10. Cannabis	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D11. Hallucinogens	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D12. Inhalants	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>
D13. More than 1 substance per day (including alcohol)	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>

Route of Administration

- 1-Oral
- 2-Nasal
- 3-Smoking
- 4-Non-IV injection
- 5-IV injection

D53. Have you ever used a needle to administer any of these drugs (Y/N)?

D54. Are you an I.V. drug user (Y/N)?

D14. According to the interviewer, which substance(s) are the major problem (00-16)?

When not clear, ask patient.

- 00-No problem
- 01-Alcohol
- 02-Alcohol to intoxic.
- 03-Heroin
- 04-Methadone
- 05-Opiates/analgesics
- 06-Barbiturates
- 07-Other sed/hyp/tranq
- 08-Cocaine
- 09-Amphetamines
- 10-Cannabis
- 11-Hallucinogens
- 12-Inhalants
- 15-Alcohol & one or more drugs
- 16-More than one drug

COMMENTS FOR DRUG/ALCOHOL AREA: _____

D15. How long was your last period of voluntary abstinence from this major substance (substance identified in D-17)? (00=never abstinent) Months

D16. How many months ago did this abstinence end? (00=never abstinent)

How many times have you:

D17. Had alcohol DTs?

D18. Overdosed on drugs?

How many times in your life have you been treated for:

D19. Alcohol abuse?

D20. Drug abuse?

How many of these were for detox only:

D21. Alcohol?

D22. Drug?

D55. How long ago were you last in treatment? Years

Months

D56. Name of Center _____

D57. Address _____

D58. Type of treatment:

- 1-Inpatient
2-Outpatient

D59. How long did it last? Days

D60. Did you complete it successfully (Y/N)?

D61. Have you been evaluated for alcohol or drugs before today (Y/N)?

D62. Where: _____

When: / /

How much money would you say you spent during the past 30 days on:

D23. Alcohol? \$

D24. Drugs? \$

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (include NA & AA)?

How many days in the past 30 days have you experienced:

D26. Alcohol problems

D27. Drug problems?

COMMENTS FOR DRUG/ALCOHOL AREA _____

Multiple horizontal lines for entering comments.

How troubled or bothered have you been in the past 30 days by these:

0-Not at all
1-Slightly
2-Moderately

3-Considerably
4-Extremely

D28. Alcohol problems?

D29. Drug problems?

How important to you now is treatment for these:

0-Not at all
1-Slightly
2-Moderately

3-Considerably
4-Extremely

D30. Alcohol problems?

D31. Drug problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

How would you rate the patient's need for treatment for (0-9):

0-None necessary to 9-Treatment needed to intervene in life-threatening situation

D32. Alcohol Problems?

D33. Drug Problems?

CONFIDENCE RATINGS

Is the DRUG/ALCOHOL STATUS information significantly distorted by:

D34. Patient's misrepresentation (Y/N)?

D35. Patient's inability to understand (Y/N)?

COMMENTS FOR DRUG/ALCOHOL AREA: _____

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.) (Y/N)?

L2. Are you on probation or parole?

- 0-Neither
- 1-Probation
- 2-Parole

How many times in your life have you been arrested and charged with the following?

Under the influence at the time (Y/N)?

L3. Shoplifting/vandalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L4. Parole/probation violations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L5. Drug charges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L6. Forgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L7. Weapons offense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L8. Burglary/larceny/B & E?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L9. Robbery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L10. Assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L11. Arson?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L12. Rape/sex related crimes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L13. Homicide/manslaughter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L14. Prostitution?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L15. Contempt of court?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L16. Other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L17. How many of these charges resulted in convictions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many times in your life have you been charged with the following:

L18. Disorderly conduct?	<input type="checkbox"/>	<input type="checkbox"/>
Vagrancy?	<input type="checkbox"/>	<input type="checkbox"/>
Public intoxication?	<input type="checkbox"/>	<input type="checkbox"/>
L19. Driving while intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>
L20. Major driving violations?	<input type="checkbox"/>	<input type="checkbox"/>
L51. MIP (minor in possession)?	<input type="checkbox"/>	<input type="checkbox"/>
L21. How many month(s) were you incarcerated in your life?	<input type="checkbox"/>	<input type="checkbox"/>
L22. How long was your last incarceration?	Months	<input type="checkbox"/>
L23. What was it for?	<input type="checkbox"/>	<input type="checkbox"/>

- | | |
|--------------------------------|---------------------------------|
| 03-Shoplifting/vandalism/theft | 12-Rape/sex related crimes |
| 04-Parole/probation violation | 13-Homicide/manslaughter |
| 05-Drug charges | 14-Prostitution |
| 06-Forgery | 15-Contempt of court |
| 07-Weapons offense | 16-Other |
| 08-Burglary/larceny/B & E | 18-Disorderly conduct, vagrancy |
| 09-Robbery | 19-Driving while intoxicated |
| 10-Assault | 20-Major driving violations |
| 11-Arson | |

COMMENTS FOR LEGAL AREA: _____

L24. Are you presently awaiting charges, trial or sentencing (Y/N)?

L25. For what? _____

L26. How many days in the past 30 were you detained or incarcerated?

L27. How many days in the past 30 have you engaged in illegal activities for profit?

L28. How serious do you feel your present legal problems are? (exclude civil problems)

- 0-Not at all
 - 1-Slightly
 - 2-Moderately
- 3-Considerably
 - 4-Extremely

L29. How important to you now is counseling or referral for these legal problems?

- 0-Not at all
 - 1-Slightly
 - 2-Moderately
- 3-Considerably
 - 4-Extremely

THE QUESTIONS BELOW ARE BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient's need for legal services or counseling (0-9)?

0-None necessary to 9-Treatment to intervene in life-threatening situation.

CONFIDENCE RATINGS

Is the LEGAL STATUS information significantly distorted by:

L31. Patient's misrepresentation (Y/N)?

L32. Patient's inability to understand (Y/N)?

COMMENTS FOR LEGAL AREA: _____

FAMILY HISTORY

Have any of your relatives had what you would call a significant drinking, drug use or psychological problem – one that did or should have led to treatment?

Y-Yes N-No X-Not applicable Z-Not answered

Mother's Side

Alcohol Drug Psychological

H1. Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2. Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H3. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H4. Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H5. Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Father's Side

Alcohol Drugs Psychological

H6. Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H7. Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H8. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H9. Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H10. Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many siblings do you have?

H53. Brothers:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

H54. Sisters:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Have any of your siblings had what you would call a significant drinking, drug use or psychological problem - one that did or should have led to treatment?

Y-Yes N-No X-Not applicable Z-Not answered

Alcohol Drug Psychological

H11. Brother #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H51. Brother #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H12. Sister #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H52. Sister #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS FOR FAMILY HISTORY AREA: _____

FAMILY/SOCIAL RELATIONSHIPS

COMMENTS FOR FAMILY/SOCIAL RELATIONSHIPS AREA: _____

F1. Marital Status: :

- 1-Married
- 3-Widowed
- 5-Divorced

- 2-Remarried
- 4-Separated
- 6-Never married

F2. How long have you been in this marital status (If never married, then since age 18)?

Years Months

F3. Are you satisfied with this situation (0-2)?

- 0-No
- 1-Indifferent
- 2-Yes

F51. How many children do you have?

F4. Usual living arrangements for the past three years:

- 1-With sexual partner and children
- 2-With sexual partner alone
- 3-With children alone
- 4-With parents
- 5-With family
- 6-With friends
- 7-Alone
- 8-Controlled environment
- 9-No stable arrangements

F5. How long have you lived in these arrangements (If with family or parents, since age 18)?

Years Months

F6. Are you satisfied with these arrangements?

- 0-No
- 1-Indifferent
- 2-Yes

Do you live with anyone who:

F7. Has a current alcohol problem (Y/N)?

F8. Uses non-prescribed drugs (Y/N)?

F51. What do you consider to be your first language? _____

F52. Do you speak and understand your native language (Y/N)?

Understand:

Speak:

F53. What languages are spoken at home? _____

F54. Have you been given your Indian name?

Specify: _____

F55. Why were you given this name? _____

F56. Who gave you your name? _____

F57. Were you raised on the reservation (Y/N)?

F58. Has this been a positive experience for you (Y/N)?

Explain why? _____

F59. Did you or a family member attend a boarding school (Y/N)?

F60. Was this a positive experience for you (Y/N)?

Explain why? _____

F9. With whom do you spend most of your free time?

- 1-Family
- 2-Friends
- 3-Alone

F10. Are you satisfied spending your free time this way?

- 0-No
- 1-Indifferent
- 3-Yes

F11. How many close friends do you have?

Would you say you have had close, reciprocal relationships with any of the following people in your life?

- Y-Yes N-No X-Not applicable Z-Not answered*

F12. Mother

F13. Father

F14. Brothers/Sisters

F15. Sexual partner/Spouse

F16. Children

F17. Friends

Have you had significant periods in which you have experienced serious problems getting along with:

- Y-Yes N-No X-Not applicable Z-Not answered*

Past 30 Days In Your Life Affected by Alcohol or Drugs

F18. Mother

F19. Father

F20. Brothers/Sisters

F21. Sexual partner/Spouse

F22. Children

F23. *Other significant family

F24. Close friends

F25. Neighbors

F26. Co-workers

F23. *Specify other relative: _____

COMMENTS FOR FAMILY/SOCIAL RELATIONSHIPS AREA: _____

Did any of these people abuse you:

- 00-None
- 18-Mother
- 19-Father
- 20-Brother/Sister
- 21-Sexual partner
- 22-Children
- 23-Other family
- 24-Close friends
- 25-Neighbors
- 26-Co-Workers
- 27-Yes, but does not know or chooses not to identify the person

Past 30 Days In Your Life

- F27. Emotionally (make you feel bad through harsh words)?
- F28. Physically (cause you physical harm)?
- F29. Sexually (force sexual advances or sexual acts)?

How many days in the past 30 have you had serious conflicts:

- F30. With your family?
- F31. With other people (excluding family)?

How troubled or bothered have you been in the past 30 days by these:

- 0-Not at all
- 1-Slightly
- 2-Moderately
- 3-Considerably
- 4-Extremely

- F32. Family problems?
- F33. Social problems?

How important to you now is treatment or counseling for these:

- 0-Not at all
- 1-Slightly
- 2-Moderately
- 3-Considerably
- 4-Extremely

- F34. Family problems?
- F35. Social problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

- F36. How would you rate the patient's need for family and/or social counseling (0-9)?
- 0-None necessary to 9-Treatment needed to intervene in life-threatening situation

CONFIDENCE RATINGS

Is the FAMILY/SOCIAL RELATIONSHIPS information significantly distorted by:

- F37. Patient's misrepresentation (Y/N)?
- F38. Patient's inability to understand (Y/N)?

COMMENTS FOR FAMILY/SOCIAL RELATIONSHIPS AREA: _____

PSYCHIATRIC STATUS

COMMENTS FOR PSYCHIATRIC STATUS _____

P1. How many times have you been treated for any psychological or emotional problems:

In a hospital or inpatient setting?

--	--

As an outpatient or private patient?

--	--

P2. Do you receive financial compensation for a psychiatric or emotional disability (include pension, SSI, SSDI, etc.) (Y/N)?

Have you had a significant period (that was not a direct result of drug or alcohol use) in which you have:

Y-Yes N-No X-Not applicable Z-Not answered Past 30 Days Lifetime

P3. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily functioning?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P4. Experienced serious anxiety/ tension - uptight, unreasonably worried, inability to feel relaxed?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P5. Experienced hallucinations - saw things or heard voices that others did not see or hear?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P6. Experienced trouble understanding, concentrating or remembering?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P7. Experienced trouble controlling violent behavior including episodes of rage or violence?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P8. Experienced serious thoughts of suicide?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P9. Attempted suicide?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

P10. Been prescribed medication for any psychological/emotional problems?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

NOTE: For questions 7-9, include incidents that occurred when the person was under the influence of substances.

P11. How many days in the past 30 have you experienced these psychological or emotional problems?

--	--

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 3-CONSIDERABLY
1-SLIGHTLY 4-EXTREMELY
2-MODERATELY

P12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

P13. How important to you now is treatment for these psychological or emotional problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

At the time of the interview, is the patient (Y/N)?

P14. Obviously depressed/withdrawn?

P15. Obviously hostile?

P16. Obviously anxious/nervous?

P17. Having trouble with reality testing, thought disorders, paranoid thinking?

P18. Having trouble comprehending, concentrating, remembering?

SPIRITUALITY

S1. Do you believe in the Creator (Y/N)?

S2. What is your relationship with your Creator now? _____

S3. Have you been given any spiritual teachings (Y/N)?

Specify: _____

S4. How have these influenced your life in the past and today?

S5. Do you attend:
 Church (Y/N)?

Traditional ceremonies (Y/N)?

S6. When was the last time you attended? _____

S7. Do you participate in any of the following:

Sweatlodge Ceremony (Y/N)?

Pipe Ceremony (Y/N)?

Talking Circle (Y/N)?

Mentoring (Y/N)?

Other (Y/N)?

Specify: _____

S8. Why are they important to you? _____

S9. Whom do you seek out for help?
 Medicine People (Y/N)?

Traditional Practitioners (Y/N)?

S10. Are you comfortable with your spirituality and beliefs (Y/N)?

S11. How has the use of alcohol and/or drugs affected any of these important life areas? _____

Time begun: ____:____

Time ended: ____:____

COMMENTS FOR SPIRITUALITY AREA: _____
