Human Service Center
Client Assessment Questionnaire/ Mental Health Issues Self-report (CAQ)
8/22/16

Today's Date:_____

[assessor to update address and phone numbers.]
Please **Print** so we can make sure we enter your information correctly. Thank-you!

Date of Birth: _____

****Important**** Print your **Legal Name** below

First Name:_____ **Last Name**:_____

Address:_____

City:_____ **Zip**_____ **County** _____

Home phone:_____ **Cell Phone:**_____

Work phone: _____ **Email:** _____

Demographic Information

Check off or fill in the information on this form. Please **Print** so we can make sure we enter your information correctly. Thank-you!

Ethnicity (choose all that apply): ***[assessor to enter on I.A.]***

☐	White
☐	African American
☐	Hispanic
☐	Asian
☐	Pacific Islander/Hawaiian
☐	Native American
☐	Other

What type of insurance do you have? ***[Hamilton staff to enter.]***

☐	None	☐	Medicaid	☐	Medicare	Name of Insurance:	

What is your marital status? ***[assessor to enter on I.A.]***

☐	Single/Never Married	☐	Married	☐	Widowed
☐	Divorced	☐	Separated	☐	Civil Union

What is your current living situation?

☐	House or apartment	☐	Shelter	☐	Homeless
☐	Jail	☐	Nursing Home		
☐	Other, please describe:				

Are you in the military?

☐	Yes
☐	No

Are you a veteran?

☐	Yes
☐	No

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Who you live with?

☐ I live alone ☐ I live with people I'm **not** related to

☐ I live with 1 or more relatives (Please list their relationships to you and approximate age)

_____
_____
_____
_____

Number of children 25 & under by birth or adoption.

How many children age 25 & under do you have?		# that parental rights were lost?	
How many of these children live with you?		# who live elsewhere due to court order?	

If you were to start attending services, would you need to arrange childcare or care for anyone in your household?

☐	Yes, **describe your needs:**
☐	No

Is the place you live safe and supportive?

☐	Yes
☐	No

Do you ever feel like you or your family is in danger?

☐	Yes, please describe:
☐	No

Does anyone you live with use alcohol or drugs?

☐	Yes
☐	No

Who are the people in your life you spend the most time with?

_____
_____

Contacts

Do you have a legal guardian? *[if "Yes", add to Contacts list]*

☐	Yes, Name/relationship:_____ Phone:_____ Address: City Zip:
☐	No

Please list a person to be contacted in case of an emergency. *[add to Contacts list]*

Name:
Phone:
Relationship:

Do you have a payee? *[if "Yes", add to Contacts list]*

☐	Yes, Name/relationship: Phone:
☐	No

Financial

What is your employment status?

☐ Employed: ☐ full time? or ☐ part time?		Hours you work:	
Employed by:			For how long?
☐ Homemaker	☐ Retired	☐ Disabled- Are you on SSI? ☐ Yes ☐ No	
☐ Unemployed since (date):		☐ looking for work	☐ not looking for work

Do you have the financial resources to meet your daily needs?

☐	Yes
☐	No

Education

Are you a Student? ☐ Yes ☐ No

☐ full time? or ☐ part time?	Hours of classes:

What is the highest level of education you have completed (# of years)?

Please list/describe any specialized or vocational training.

Do you have any barriers to learning? (for example: difficulty reading or understanding)

☐	Yes	If "Yes", describe:
☐	No	

Substance Use

Have you ever been treated for substance use? (*IA Q 11-12) ***[assessor to enter on I.A.]***

☐	Yes
☐	No

Have you ever taken a prescribed medication for alcohol or drug problems (for example: methadone, suboxone, buprenorphine or naltrexone? *[if "yes", add to Medication list]*

☐	Yes, **describe:**
☐	No

Do you smoke cigarettes or use other forms of tobacco (such as chewing tobacco)? ***[assessor to enter on I.A.]***

☐	Yes, and I would like to cut down or quit
☐	Yes, and I am not interested in quitting
☐	No

Family History

Has anyone in your family (blood relative, such as parent, grandparent, sibling or child) had the following?

	Yes	**No**
Mental health problems	☐	☐
Problems with alcohol	☐	☐
Problems with drugs	☐	☐
Problems with addictive behaviors (for example, gambling)	☐	☐

Physical Health

Height:_____ **Weight**:_____

How would you rate your overall health?

☐	Excellent
☐	Very Good
☐	Good
☐	Fair
☐	Poor

Do you have a primary care doctor?

☐	Yes **Doctor's name/practice:**
	Phone: **Date of last visit:**
☐	No

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Please mark the "Yes" box for any medical condition you have. Describe any treatment you are receiving or have received.

[For each Medical Condition checked, add to Medical Problems list]

Medical Condition	**Please mark if yes**	**Describe treatment, if any.**
Pregnancy (women only)	☐	Due Date:
Post-Partum (women only)	☐	Date delivered:
Hepatitis, yellow jaundice or cirrhosis of the liver	☐	
Tuberculosis (TB)	☐	
Dental Problems	☐	
Difficulty swallowing	☐	
Seizures/Migraines/Nervous system problems	☐	
Physical injuries/Unhealed wounds	☐	
Heart, blood or circulatory problems	☐	
Asthma, shortness of breath or respiratory problems	☐	
Tumors, cancer or unusual lumps	☐	
Diabetes or thyroid problems	☐	
Shaky hands, delirium tremens (DTs), seizures when stopping substances	☐	
Stomach or digestive problems	☐	
Sexual/Fertility problems	☐	
Bone, muscle or foot problems	☐	
Skin problems	☐	
Chronic pain	☐	
Allergies	☐	
Physical disability	☐	
Wears Dentures	☐	
Other medical condition, please describe	☐	

Will any of your medical conditions interfere with your participation in treatment or require accommodations? Please describe.

_____

_____

_____

Legal (*IA Q 30, 31)

Are you currently involved with the legal system or DCFS?

☐	If "Yes", **describe your legal and/or DCFS involvement:**
☐	No

Have you ever been arrested?

☐	Yes	If "Yes' answer the question below (# arrests, convictions & times in jail/prison)
☐	No	

Total # of arrests:	**# of times arrested in past 30 days:**	
# of convictions:	**# of times in jail:**	**# of times in prison**

SIGNATURES

Assessment reviewed by_____ Date:_____
Signature of Assessor

Assessment data entered by: _____ Date: _____
Signature of Data-entry Staff

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First Name:_____ **Last Name**:_____ **DOB: _____**

Today's Date: _____

Suicide

	Yes	**No**
1. In the past **30 days,** have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
2. In the past **30 days**, have you had thoughts about killing yourself?	☐	☐
3. In the past **30 days**, have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐	☐

Aggression

	Yes	**No**
1. In the past **12 months,** have you felt like you wanted to hurt someone else?	☐	☐
2. During the past **12 months**, have you threatened to hurt someone else?	☐	☐

Mental Health 1

Have you ever…	**Yes**	**No**
1. Have you **ever** in your life talked to a psychiatrist, therapist, social worker, or counselor about an emotional problem?	☐	☐
2. Have you **ever** in your life been seen in a psychiatric emergency room or been hospitalized for a psychiatric reason?	☐	☐
3. Have you **ever** in your life been told by teachers, guidance counselors, or others that you have a special learning problem?	☐	☐
4. Have you **ever** in your life experienced any traumatic event(s) (e.g., assault, abuse, neglect, exploitation, natural disaster, war or combat) that continues to impact your day to day life?	☐	☐

Mental Health 2

In the past 12 months…	**Yes**	**No**
5. In the past **12 months**, have you felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	☐	☐
6. In the past **12 months**, have you been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problems?	☐	☐
7. In the past **12 months**, do you hear voices that no one else could hear or see objects which others could not see?	☐	☐
8. In the past **12 months**, have you been depressed for **weeks** at a time, lost interest or pleasure in most activities?	☐	☐

In the past 12 months… (continued)	**Yes**	**No**
9. In the past **12 months**, have you felt like people had something against you, without them necessarily saying so, or that someone or some group is trying to influence your thoughts or behavior?	☐	☐
10. In the past **12 months**, have you had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and you believed you could do almost anything?	☐	☐
11. In the past **12 months**, have you had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?	☐	☐

Comments:

SIGNATURES

Assessment reviewed by_____ Date:_____
Signature of Assessor

Assessment data entered by: _____ Date: _____
Signature of Data-entry Staff

Instructions to staff who enters this information into the CAQ

If **Data-entry staff** enters the information:

1) When finished, add the assessor as a "co-signature" then do a "**Save**".
2) When the Assessor is notified they need to sign the "**CAQ**", they will add an "L" and/or their Supervisor (if required) as a "Co-signature" and do the "**Final Save**"

If the **Assessor** enters the information:

1) When finished, add your Supervisor (if required) as a "co-signature" then do the "**Final Save**".

Medication List Worksheet

Please list any medications (including psychotropic medications and over the counter medications) you are currently taking: (*IA Q 23)

Medication	Dosage	Reason	Prescribing Doctor

Please list any medications (including psychotropic medications and over the counter medication) you have stopped using within the last 3 months: (*IA Q 23)

_____
_____
_____
_____
_____