# COMPREHENSIVE ASSESSMENT QUESTIONNAIRE

**Thank you for the opportunity to provide you with a comprehensive assessment.**

The goal of the comprehensive assessment is to provide new ideas that will help improve quality of life and functioning. To make this process as useful as possible, please follow these steps:

1. If possible, type your answers and use email for transmission. This is not required, but it is very helpful.

2. Please do the best you can and be as direct as possible while answering the referral questions. Your answers are very important because we want to make the most of the face to face time and we do not want to waste time gathering information that you could send us ahead of time. Also, we need to know as much as possible about the symptoms of concern before the assessment so we don't have to spend a lot of time talking about them during the assessment. A final reason we ask you to answer the questions as best you can is that some of you may be frustrated or even a little angry with the person. It is very important for us to know this, but it is much better not to put the person through a recital of this during the assessment meeting.

3. Please write in any team members' speculations, ideas or impressions. The majority of the actual assessment meeting will be spent visiting with the person, and the preliminary written materials are essential in helping us get the whole team's input.

4. Send the completed questionnaire requested materials to myersandmyers@yahoo.com or to The Community Circle, 3000 County Road 42 West, Suite 210, Burnsville, Minnesota 55337.

5. If you have any questions please call us at (952) 898 – 7578. fax (952) 898 - 7592

6. One of the most important components the assessment is for us to be able to bond and communicate with the supported person. It is very helpful if you arrange for the assessment to take place in a location which is comfortable for the individual. Unless there are reasons not to, the best place is the person's home. It is best if the person does not experience a penalty for participating in the assessment (such as missing a favorite activity). It is also preferred if favorite team members/family members and others who know the person well accompany the person, per his or her preference.
7. Please invite people like the therapists, treating physicians, and others who have tried hard to be helpful, unless there are some compelling reasons not to do so.

8. Anyone who has been abusive to the individual should not be included in the consultation process/meeting.

9. We prefer to be addressed by our **first names** and to avoid using titles such as "Doctor". Thank you again for having us in.

Ruth M. Myers, MD Stephen P. Myers, Ph.D., bcba-d

*Please answer these questions the best you can. Every word is important and your efforts are greatly appreciated. Try to avoid answering questions by saying "see attached" often the information gets forgotten and is never attached. Also it will save us a great deal of time. Thanks for this extra effort.*

***Please keep a copy of the completed packet in case the original is lost.***

**Date Packet Completed:**

**NAME:** **Date of Birth**

**Preferred Nickname**:

**Home Phone:**

**Address**:

**Your Name (person completing questionnaire):**

**Your relationship with the Person to be served:**

**Person making referral/Phone number:**

**Legal Status:**

**If the person has a Guardian**

**Name**

**Telephone number**:

**Case Manager/service coordinator**

**Name**

**Telephone number:**

**Fax number**:

**Where should the Comprehensive Assessment Report be sent?**

**(Fax number or address**):

1. **Please describe the person's best liked qualities:**

2. **Please describe the symptoms of concern:**

3. **Please list any questions you want the assessment team to address**

4. **Please describe the person's living situation**:

- type of dwelling
- housemates if any
- support arrangements
- other important information)

5. **Please describe the person's daytime activities and daily schedule:**

- job or school
- recreation
- number of colleagues and support persons
- other important information)

6. **Please describe the person's most important relationships:** (family, friends, romantic friends, mentors, therapists, teachers, doctors, any others)

7. **Please describe the person's dreams/hopes/goals:** (if a personal futures plan or other dream process has been initiated, please attach)

8. **Please describe the ways the person is integrated into community:**

9. **Please list all medications, including over the counter medications, vitamins, and supplements: *Please do not refer to an attached listing of medication*. List each medication and provide the following information: 1. The name of the medication. 2. Total daily dose in milligrams. 3. Describe how the medication is given. See example below. Thank you for your time in this effort.**

| | | |
|---|---|---|
| Name of Medication | 2400 mg | 900mg at 8am - 600mg at 4pm , and 900mg at 8pm |

| Medication | Total Daily Dose | How Given |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |

10. **Have there been any noted side effects?**

11. **Are there any known medical problems?**

12. **Is there a known developmental syndrome?**

13. **When did the symptoms of concern start?**

14. **How do the symptoms relate to each other?**

15. **Do they occur all at once, or is there a sequence?**

16. **What interventions have been tried**

17. **How did these interventions work out?**

18. **Are the symptoms worse or better when the person is with some people? If YES, who?**

19. **Are the symptoms worse or better in some environments? If YES where?**

**20. Is there a belief that the symptoms of concern:**

- **Gets the person attention? If yes explain**

- **Gets the person something s/he wants? If yes explain**

- **Gets the person out of doing something s/he doesn't want to do. If yes explain**

- **Occurs because the person is bored? If yes explain**

- **Occurs because the person is in pain or doesn't feel well? If yes explain**

**21. Is the team trying to teach the person positive and health promoting activities that s/he can do instead of the symptoms of concern? (These alternative activities are often called "replacement behaviors")**

**22. What are some of the coping strategies the person has created on their own?**

***23.*** **Please describe system of tracking psychiatric criteria related to psychotropic medication use**.

24. **Does this individual have seizures?** Please describe.

25. **Please describe the individual's sleep pattern:**

- Time s/he goes to bed?
- Time s/he wakes up?
- Does the person snore?
- Does the person have nightmares?
- Is the person awakened on purpose?
- Where does the person sleep?
- With whom does the person sleep?

26. **Please describe the person's appetite.**

27. **List any food preferences.**

28. **Has the person's weight changed? If yes, describe.**

29. **What is the person's height?**

30. **What is the person's weight?**

31. **List any unusual food preferences**

32. **Describe any unusual food rituals**

33. **Have there been any changes in bladder or bowel function**

34. **Have there been any changes in personal hygiene?**

35. **Is there any suspicion of hallucinations?** (seeing, hearing, smelling, tasting, or being touched by things not there)

36. **Is there any suspicion of delusions?** (false beliefs)

37. **Are there any rituals or compulsive acts?**

38. **What sort of energy level does the person have**

39. **Are there any unusual physical movements?** (like tics, writhing movements, unusual walking style…)

40. **Are there any changes in the person's skin or hair?**

41. **Is there any suspicion that the person is in pain?**

42. **Does this person have anxiety or panic attacks?**

43. **Does this person have any dental problems?**

44. **Does this individual use alcohol, tobacco, or street drugs?**

45. **How is this person's memory?** Any lapses?

46. **How does this person respond to stress?**

47. **How does this person respond to enjoyable stimulation?**

48. **What is this person's sexual expression?**

49. **Have there been any changes in cognitive function?**

50. **What is the person's attention span?**

51. **What is this individual's general mood?**

52. **Please describe this person's hygiene**

53. **Please describe the person's self-esteem**

54. **Has there been or is there any suicidality or homicidally?**

55. **Is there any history of abuse or other trauma?**

56. **Have there been any recent stresses?**

57. **Please list placements and other program history.**

58. **What is the person's best previous level of functioning?**

59. **How well is the person able to participate in preferred activities?**

60. **What are the most preferred activities?**

61. **Please list any *family history* of medical problems** such as seizures, developmental disabilities, substance misuse issues, arthritis, mental health problems/treatment, diabetes, migraine, cancers, blood problems, or other medical problems…

62. **Has there been any family or personal involvement in the legal system?**

**Please complete this packet by adding the items on the checklist.**

***Thanks so much for your time and effort***

***Records to attach to the referral packet: (Place a check-mark in the space provided if the record is provided. Write "none" if this record does not exist. Write NA if record exists, but is non assessable.)***

_ Medical records, most recent notes/summaries from primary care physician, traditional healer, homeopath, psychotherapist, psychiatrist, neurologist, and any other involved health care professionals

_ For persons receiving antipsychotic medications any tardive dyskinesia screening.

_ For persons receiving antipsychotic medications any blood levels

_ For persons receiving antipsychotic medications any other side effects monitoring information.

_ Behavior support plan or any written instruction concerning what to do when Particular behavior occurs.

_ Graphs of Symptoms of Concern

_ Report of most recent physical examination

_ Social history

_ Psychology reports and evaluations

_ Copies of x-ray reports

_ Copies of laboratory reports

_ Copies of blood tests

_ Copies of other medical assessments

_ Individual service plan (IEP, ISP, whatever is indigenous to the agency)

_ Case manager contact notes

_ Incident reports from past 12 months.

_ Direct care staff notes, suspicions, and/or observations

_ Recent photograph

_ Current video (standard VHS), if possible.

_ Samples of artwork or writings, if possible

_ physician's referral

_ release of information

_ photography permission (COMPLETELY OPTIONAL)

_ Anything else that seems important.

## *Thanks Again.*