Kolpia Counseling Services, a program of Options for Southern Oregon
611 Siskiyou Blvd. Ste 8 Ashland, OR 97520 P: (541)482-1718 F: (541)482-0964
836 E Main St. Ste 6 Medford, OR 97504 P: (541)500-8023 F: (541)500-8065

Pre-Assessment Questionnaire Client ID:_____

Name: _____ DOB: _____ Today's Date: _____

Medical Profile

Height: _____ft. _____in. Weight: _____lbs. Calculated BMI: _____ (office use only)

Blood Pressure: _____ Have you been diagnosed with diabetes? ☐ Yes ☐ No

Are you feeling mouth or dental pain? ☐ Yes ☐ No When was the last time you saw a dentist? _____

In the last 30 days, other than the activities you did for work, on average, how many days/week did you engage in moderate exercise (e.g. walking, running, jogging, dancing, swimming, biking, or other similar activities)?
_____times per week

On average, how many minutes did you spend exercising at this level on one of those days? _____minutes

Client Profile: Personal Demographics

Nicotine Use:
How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Alcohol Use: (wording in this question follows federal requirements)

Men: How many times in the past year have you had 5 or more drinks in a day?_____
Women: How many times in the past year have you had 4 of more drinks in a day?_____
Adults over 65: How many times in the past year have you had 4 or more drinks in a day?_____

Recreational Drug Use:
How many times in the past year have you used prescription drugs for non-medical reasons?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily
How many times in the past year have you used illegal drugs?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Mental Health

Stress means a situation in which a person feels tense, restless, nervous, anxious, or is unable to sleep at night because their mind is troubled all the time. Do you feel this kind of stress?
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Disabilities:

Are you currently enrolled or eligible for Developmental Disability Services? ☐ Yes ☐ No ☐ Don't Know

PHQ-2: Over the last 2 weeks, how often have you been bothered by any of the following?
(Circle a number below)

	Not at all	Several Days	More than Half the days	Nearly Every Day
1. Little interest in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

(Office Use Only) Total: _____

Please give a general statement of the problem for which you are seeking help today:

_____

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Other Demographics

Gambling:

Do you gamble? (examples: bingo, lottery, sports, online, video poker) ☐ Yes ☐ No
Have you ever had to lie to people important to you about how much you gambled? ☐ Yes ☐ No
Have you ever felt the need to bet more and more money? ☐ Yes ☐ No

Financial: How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
☐ Very Hard ☐ Somewhat Hard ☐ Not hard at all

Living Situation

Are you currently houseless? ☐ Yes ☐ No

Do you have problems with any of the following at the place you live? (choose all that apply)
☐ Pests (bugs, ants, mice) ☐ Mold ☐ Lead Paint/Pipes ☐ Lack of Heat ☐ Oven or Stove not working
☐ Smoke detectors missing/not working ☐ Water Leaks ☐ None of the above

Utilities: Within the past 12 months, has the electric, gas, oil, or water company threatened to shut off service in your home? ☐ Yes ☐ No ☐ Already shut off

Food

Within the past 12 months, have you been worried that your food would run out before you got money to buy more? ☐ Often True ☐ Sometimes True ☐ Never True

Within the past 12 months, has the food you bought not lasted, and you didn't have money to get more?
☐ Often True ☐ Sometimes True ☐ Never True

Transportation

Within the past 12 months, has the lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for your daily living? ☐ Yes ☐ No

*****QUESTIONS BELOW THIS POINT ARE FOR THOSE 18 YEARS AND OLDER ONLY*****

Extended Demographics: 18 YEARS & OLDER ONLY

Safety (circle a number below for each question)

	Never	Rarely	Sometimes	Fairly Often	Frequently
How often does anyone, including family and friends, physically hurt you?	1	2	3	4	5
How often does anyone, including family and friends insult or talk down to you?	1	2	3	4	5
How often does anyone, including family and friends, threaten you with harm?	1	2	3	4	5
How often does anyone, including family and friends, scream or curse at you?	1	2	3	4	5
(Office Use Only) Total: _____					

Family & Community Support

If you need help with daily activities (e.g. bathing, cooking, shopping, etc.) do you get the help you need?
☐ I don't need any help ☐ I get all the help I need ☐ I could use a little more help ☐ I need a lot more help

How often do you feel lonely or isolated from those around you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

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	Disabilities Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ☐ Yes ☐ No Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping? ☐ Yes ☐ No