**INLAND COUNTIES EMERGENCY MEDICAL AGENCY**
***Serving San Bernardino, Inyo and Mono Counties***
**515 N ARROWHEAD AVENUE**
**SAN BERNARDINO, CA 92415-0060**
**909-388-5823 FAX: 909-388-5825**

# MEDICAL / PSYCHIATRIC ASSESSMENT QUESTIONNAIRE

**Please complete this questionnaire and bring it with you to your initial appointment.**

Date: _____

**A. Please tell us about yourself.**

_____
Name

_____
Home Address: Street City State Zip Code
☐ Check Box if home is preferred mailing address

_____
Work Address: Street City State Zip Code
☐ Check Box if work is preferred mailing address

_____
Other Address: Street City State Zip Code
☐ Check Box if other is preferred mailing address

_____
Telephone Cell Phone Email

_____
Age Gender Marital Status

_____
EMT/AEMT License # Date Issued

_____
Ethnic Origin (i.e., White, Hispanic, Black, Asian) [Optional]

_____
Current Living Situation (i.e., Rent/Own, house, apartment, members of your household)

**B.** **Presenting Problem:** (A summary of the circumstances which resulted in you being ordered to undergo this medical/psychiatric evaluation)

**C.** **Please describe any prior participation in an assessment or treatment for problems with drugs and/alcohol.**

# I. Mental Health

**A. Please tell us about your mental health history, if applicable (depression, anxiety, chemical dependency, bipolar disorder, schizophrenia, suicide attempts, etc.)**

1. _____
Problem/Diagnosis Dates

_____
Type of Program/Treatment Medication

_____
Was it helpful?

2. _____
Problem/Diagnosis Dates

_____
Type of Program/Treatment Medication

_____
Was it helpful?

3. _____
Problem/Diagnosis Dates

_____
Type of Program/Treatment Medication

_____
Was it helpful?

**B. Please tell us if you have ever experienced any of the following and indicate dates and duration, e.g., last 6 months, 5 years ago:**

| **Conditions/Symptoms** | **Dates/Duration** |
|---|---|
| ☐ Depression | _____ |
| ☐ Anxiety, excessive worries | _____ |
| ☐ Suicidal ideation/behavior | _____ |
| ☐ Homicidal ideation/behavior | _____ |
| ☐ Abuse of any kind | _____ |
| ☐ Difficulty concentrating | _____ |
| ☐ Fights | _____ |
| ☐ Compulsive Behavior | _____ (eating, sex, work, substances) |

☐ Shopping sprees _____

☐ Phobia _____

☐ Mania _____

☐ Feelings of worthlessness _____

☐ Hallucinations _____

☐ Feelings of intense shame or guilt _____

**C. Please tell us if you have experienced problems in any of the following areas. Please note the approximate date and give a brief description.**

- Gambling

_____
_____
_____
_____

- Sexual compulsion/Addiction

_____
_____
_____
_____

- Eating Disorders

_____
_____
_____
_____

- Relationships

_____
_____
_____
_____

- Internet Addiction

_____
_____
_____
_____

Other

**D. Please describe any negative consequences you have experienced as a result of adverse mental health in any of the following areas:**

- Relationships
- Career
- Financial
- Health (include emotional health)
- Legal

- Personal

- Sexual

## II. Substance Use

**A. Please tell us about your history with substance use, if applicable.**

1. _____
Substance Used Method of Use (e.g. oral, inject, etc.) Date of First Use

_____
Last Use Frequency Reason for Stopping

2. _____
Substance Used Method of Use (e.g. oral, inject, etc.) Date of First Use

_____
Last Use Frequency Reason for Stopping

3. _____
Substance Used Method of Use (e.g. oral, inject, etc.) Date of First Use

_____
Last Use Frequency Reason for Stopping

4. _____
Substance Used Method of Use (e.g. oral, inject, etc.) Date of First Use

_____
Last Use Frequency Reason for Stopping

5. _____
Substance Used Method of Use (e.g. oral, inject, etc.) Date of First Use

_____
Last Use Frequency Reason for Stopping

**B. Have you ever experienced any of the following?**

☐ Shakes

☐ Blackouts

☐ Hallucinations

☐ Convulsions/Seizures

**C. In general terms, please describe the way(s) you used substances, i.e., alone, with friends, social settings.**

**D. Please describe any negative consequences you have experienced as a result of substance abuse in the following areas:**

- Relationships

- Career

- Financial (please include an estimate of the annual cost of substance abuse)

- Health (include emotional health)

- Legal

- Personal

- Sexual

**E. Please describe any treatment you have undertaken for substance abuse.**

1. _____
Problem/Diagnosis Dates

_____
Type of Program/Treatment Medication

_____
Was it helpful?

2. _____
Problem/Diagnosis Dates

_____
Type of Program/Treatment Medication

_____
Was it helpful?

3. _____

Problem/Diagnosis Dates

_____

Type of Program/Treatment Medication

_____

Was it helpful?

4. _____

Problem/Diagnosis Dates

_____

Type of Program/Treatment Medication

_____

Was it helpful?

**F. Please describe any significant periods of sobriety/abstinence in the past 5 years and the means you used to achieve it.**

**G. Please list the date at which you began to think you had a problem wit alcohol or drugs. What were the surrounding circumstances?**

**H. Please describe your involvement with "12 Step" or other abstinence-based self-help groups. Include dates.**

## III. Physical Health

**A. Please tell us about your physical health.**

- Please describe all serious illnesses, hospitalizations and surgeries. Include treatment and response to treatment.

- Please describe any current medical concerns.

- Please describe your level of exercise, past and present.

Please describe your past and present use of tobacco and caffeine.

- Who is your primary care physician (PCP) and when was your last contact? Does your PCP know about your current Substance Abuse/Mental Health condition?

**B. What medications are you taking currently? Include any OTC medications, herbal remedies, health food preps, supplements, vitamins, etc.**

1. _____

Medication | Source (e.g. Physician) | Date Last Filled

_____

Reason for taking it | Side Effects | Is it helpful?

2. _____

Medication | Source (e.g. Physician) | Date Last Filled

_____

Reason for taking it | Side Effects | Is it helpful?

3. _____

Medication | Source (e.g. Physician) | Date Last Filled

_____

Reason for taking it | Side Effects | Is it helpful?

4. _____

Medication | Source (e.g. Physician) | Date Last Filled

_____

Reason for taking it | Side Effects | Is it helpful?

**C. Describe any additional issues involving your physical health.**

## IV. Employment History

**A. Please tell us about your current EMS employment.**

Ambulance Company_____Public safety agency (police/fire) _____

Paid/Volunteer_____

Job Status (suspended, will be fired, medical leave, etc.)_____

Number of hours worked per week: minimum_____maximum_____

Co-worker knowledge of problems_____

Length of time in current job_____

**B. Please tell us about your license status (past/present license in other states, enforcement actions against you, restrictions, etc.).**

**C. Please tell us about your future/retirement plans.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**D. Employment History:**

1. _____
Employer Dates

_____
Duties

_____
Reason for Leaving Position Held

2. _____
Employer Dates

_____
Duties

_____
Reason for Leaving Position Held

3. _____
Employer Dates

_____
Duties

_____
Reason for Leaving Position Held

4. _____
Employer Dates

_____
Duties

_____
Reason for Leaving Position Held

# V. Family & Relationships

**A. Please tell us about your family of origin.**

- Please describe your parents. Include marital status, substance abuse/mental health history (if any), personalities, values, deaths, chronic illnesses, past and present quality of relationship, etc.

- What were the discipline patterns and parenting styles in your family?

- Please describe your siblings, if any. Include number, gender, birth order, substance abuse/mental health history (if any), personalities, deaths, past & present quality of relationship.

- Did you experience physical abuse, sexual abuse, or neglect in your family of origin?

- Which family members know of your substance abuse/mental health history and what is their opinion?

- Who is supportive of you and who is not?

**B. Please tell us about your relationship history.**

- Please describe your current relationship status, (i.e., married, single, widowed, divorced, separated, dating, living together).

- How would you describe the quality of your current relationship? (i.e., good, troubled, distant, supportive, violent, conflictual)

- Please indicate the number of times you have been married, and if divorced, the length of marriage(s) and the reason for the marriage(s) ending.

- If substance abuse was involved in a relationship (i.e., your partner used), please describe the relationship and the effect of substance abuse on it.

**C. Please tell us about your immediate family history.**

- Do you have children?_____Living at home?_____Not at home?_____?

Names and ages:

- Please describe significant friendships and indicate if substance abuse is involved.

- Do you have any pets? Please describe.

- College/University Attended/Dates.

**D. Please tell us about your legal history.**

- Please describe any arrests as a juvenile or adult, including charges, dates and disposition.

- Please describe any impending legal concerns, including present status on probation, if applicable.

**VI. What are your expectations of this assessment and the current action in process on your EMT/AEMT license?**

**VII. Do you have any additional issues, concerns or questions regarding your physical or emotional health?**