

## TAA-R

Consumer's Name: \_\_\_\_\_

Consumer's CRN Number: 

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Tool Completion Date: \_\_\_\_\_

I am now going to ask you about different types of stressful or difficult life events. These kinds of events can be frightening or upsetting to almost everyone. During your life, have any of the following things ever happened to you?

Please say "YES" OR "NO" in response to each question about the following types of events.

	Yes	No
1. Have you ever been in the military in a war zone, or had a military combat experience?	—	—
2. Have you ever been in a really bad accident (car, at work, or somewhere else) and thought you might be killed or injured?	—	—
3. Have you ever been in a natural disaster (tornado, hurricane, flood, or major earthquake) and thought you might be killed or injured?	—	—
4. Have you had a serious illness, such as cancer, leukemia, AIDS, multiple sclerosis, etc.?	—	—

The next three questions are about unwanted sexual experiences you may have had during your life. You may not have reported these experiences to the police or ever told family or friends. Also, the person who did these things might not have been a stranger, but may have been a friend, a date, or even a family member. These kinds of sexual experiences can happen at anytime in a person's life, even as a child. Regardless of how long ago it happened, or who did these things, have any of the following events ever happened to you...

	Yes	No
5. Did you ever have sexual contact with anyone who was at least 5 years older than you before you reached the age of 13?	—	—
(Sexual contact can mean between someone else and your sexual organs—(penis or genital area for men; vagina, genital area, or breasts for women), -or between you and someone else's sexual organs (a male or female's genital area, or a woman's breasts)		

6. Before you were age 18, has anyone ever used pressure or threats to have sexual contact with you?	—	—
7. At any time in your life, whether you were an adult or a child, has anyone used physical force or threat of force to make you have some type of unwanted sexual contact?	—	—

	Yes	No
8. At any time in your life has anyone (including family members or friends) ever attacked you with a gun, knife, or some other weapon, regardless of whether you ever reported it?	—	—
9. At any time in your life has anyone (including family members or friends) ever attacked you <u>without a weapon</u> , but <u>with the intent to kill or seriously injure you</u> ?	—	—
10. While growing up, were you physically hit and/or punished by someone older in a way that resulted in bruises, burns, cuts or broken bones?	—	—
11. Have you ever witnessed someone seriously injured or killed? If yes, what happened? _____	—	—
12. Have you experienced any other situation that was not already asked about which was extremely stressful? If yes, what was it? _____	—	—
13. Has a close friend or family member ever been intentionally killed or murdered by another person or killed by a drunk driver? A. Murdered/killed? B. Killed by a drunk driver? Relationship of the victim(s) to you? _____	—	—

Total Number of "Yes" Answers:

# Health Survey

Consumer's Name: \_\_\_\_\_

Consumer's CRN Number: 

2	0										
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Today's Date: \_\_\_\_\_

**Instructions:** I'm now going to ask you some questions about your health and well-being.

1. What is your **Height**? \_\_\_\_\_ What is your **Weight**? \_\_\_\_\_
  
2. Have you ever been told by your doctor or health professional that you have \_\_\_\_\_? (tell me about all that apply)  

<input type="checkbox"/> Angina or coronary heart disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart attack or myocardial infarction	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Blood cholesterol is high	
  
3. Do you smoke cigarettes? (pick one)  
 Everyday  
 Some Days  
 Does not smoke
  
4. Would you say that your general health is: (pick one)  
 Excellent  
 Very Good  
 Good  
 Fair  
 Poor
  
5. Now thinking about your **physical health**, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?  
\_\_\_\_\_ Number of Days
  
6. Now thinking about your **mental health**, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?  
\_\_\_\_\_ Number of Days
  
7. During the past 30 days, about how many days did poor **physical or mental health** keep you from doing usual activities, such as self-care, school, or recreation?  
\_\_\_\_\_ Number of Days

## Demographics

## Health Survey

8. What is your race or ethnicity? (check all that apply)

- Alaska Native (322)*
- American Indian (400)*
- Black or African American (11)*
- White or Caucasian (10)*
- Portuguese (323)*

### ASIAN

- Asian Indian (410)*
- Chinese (318)*
- Filipino (325)*
- Japanese (320)*
- Korean (319)*
- Vietnamese (321)*
- Other Asian (407)*

### NATIVE HAWAIIAN AND PACIFIC ISLANDER

- American Samoan (16)*
- Chamorro/CNMI (500)*       *Chamorro/Guam (501)*
- Chuukese (502)*
- CNMI/Carolinian (503)*
- Hawaiian (404)*
- Kosraean (505)*
- Marshallese (506)*
- Palauan (507)*
- Pohnpeian (508)*
- Yapese (509)*
- Other Pacific Islander (317)*

### HISPANIC OR LATINO\*\*

- Cuban (402)*
- Mexican (405)*
- Puerto Rican (324)*
- Other Hispanic or Latino (408)*

\*\* If Hispanic or Latino, also select a race  
(these are in the bold italics)

### OTHER

- Other (14)*
- Adopted--don't know (410)*
- Unknown (411)*
- Prefer not to answer (99)*

9. With which race or ethnicity group do you PRIMARILY identify?

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## Health Survey

10. Is English the language that you are most comfortable speaking?  Yes  No

If no, then what language do you prefer? \_\_\_\_\_

11. What is your sex?  Male  Female

Other (please describe) \_\_\_\_\_

12. What is your date of birth? \_\_\_\_\_(MM/DD/YY)

13. What is the highest level of education that you have completed?

- |  |   |
|--|---|
| <input type="checkbox"/> Less than Grade 8                   | <input type="checkbox"/> Professional School  |
| <input type="checkbox"/> Grade 8                             | <input type="checkbox"/> Some College         |
| <input type="checkbox"/> Grade 9                             | <input type="checkbox"/> Associate Degree     |
| <input type="checkbox"/> Grade 10                            | <input type="checkbox"/> Bachelor's           |
| <input type="checkbox"/> Grade 11                            | <input type="checkbox"/> Masters              |
| <input type="checkbox"/> Grade 12 or GED                     | <input type="checkbox"/> Doctorate            |
| <input type="checkbox"/> Vocational, Business or Tech School | <input type="checkbox"/> Prefer not to answer |

14. Have you ever served in the US military?  Yes  No

15. What is your current living situation?

- |   |   |
|---|---|
| <input type="checkbox"/> Independent<br>(On your own or with family/others or semi-independent) | <input type="checkbox"/> Nursing Home                         |
| <input type="checkbox"/> HUD Rental Subsidy (Section 8, Shelter Plus Care)                      | <input type="checkbox"/> Hospital                             |
| <input type="checkbox"/> Supported Housing/Bridge Subsidy Program                               | <input type="checkbox"/> Licensed Crisis Residential Services |
| <input type="checkbox"/> 8-16 hour group home   | <input type="checkbox"/> Hospice                              |
| <input type="checkbox"/> 24-hour group home   | <input type="checkbox"/> Homeless Shelter                     |
| <input type="checkbox"/> Licensed Specialized Residential Services                              | <input type="checkbox"/> Homeless Unsheltered                 |
| <input type="checkbox"/> Care home  | <input type="checkbox"/> Jail                                 |

16. What is your current marital status?

- |                     |                          |
|---------------------|--------------------------|
| Living with partner | <input type="checkbox"/> |
| Divorced            | <input type="checkbox"/> |
| Married             | <input type="checkbox"/> |
| Single              | <input type="checkbox"/> |
| Other               | <input type="checkbox"/> |
| Widowed             | <input type="checkbox"/> |
| Separated           | <input type="checkbox"/> |

**CAGEAID**  
Substance Use Screening

Consumer's Name: \_\_\_\_\_

Consumer's CRN Number:

2	0										
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Tool Completion Date: \_\_\_\_\_

**Instructions: Ask the consumer the following four questions:**

1. Have you ever felt you should CT down on your drinking or drug using (excluding prescribed medication, drugs given to you by your doctor)? Yes  No
  
2. Have you ever felt ANNOYED (i.e., irritated/aggravated) by a friend, significant other, or an individual in your family criticizing your drinking or drug use (e.g., anyone telling you to cut down or stop drinking and/or using drugs, or anyone telling you that you might have a problem with drinking and/or drug use)?  
Yes  No
  
3. Have you ever felt bad or GUILTY about how much you drink and/or use drugs? Yes  No
  
4. Have you ever had a drink or used drugs first thing in the morning (EYE-OPENER) to get rid of a hangover or to get the day started? Yes  No

**Clinician Over-ride: The interviewer should answer (not ask) the following question:**

5. There is compelling evidence (history of DUI's, presence of paraphernalia, observed intoxication, etc.) that the consumer has a history of substance-related problems or issues: Yes  No

Final Instructions after screening is completed.

Please answer the following questions:

1. How confident are you that the consumer's answers to the questions in these screening and assessment tools accurately reflect his or her actual feelings and experiences?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Not at all  
Confident

Moderately  
Confident

Very  
Confident

2. How confident are you that the consumer will benefit from a treatment designed to help him or her deal with personal trauma and PTSD related problems?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Not at all  
Confident

Moderately  
Confident

Very  
Confident

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Tool Completion Date: \_\_\_\_\_

## PCL-C

INSTRUCTIONS: I am going to read to you a list of problems and complaints that people sometimes have in response to stressful life experiences. Please listen carefully and then let me know, using the numbers on this card, how much you have been bothered by that problem in the **past month**. I will mark your answer on this sheet.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing <i>memories, thoughts, or images</i> of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing <i>dreams</i> of the stressful experience?	1	2	3	4	5
3. Suddenly <i>acting or feeling</i> as if the stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling <i>very upset</i> when something reminded you of the stressful experience?	1	2	3	4	5
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding <i>thinking about or talking about</i> the stressful experience or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
7. Avoiding <i>activities or situations</i> because they reminded you of the stressful experience?	1	2	3	4	5
8. Trouble <i>remembering important parts</i> of the stressful experience?	1	2	3	4	5
9. <i>Loss of interest</i> in activities that you used to enjoy?	1	2	3	4	5
10. Feeling <i>distant or cut off</i> from other people?	1	2	3	4	5
11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your <i>future</i> somehow will be <i>cut short</i> ? Other ways to ask this may be: "Feeling like something bad is going to happen, or Feeling a sense of doom?"	1	2	3	4	5
13. Trouble <i>falling or staying asleep</i> ?	1	2	3	4	5
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	1	2	3	4	5

15. Having <i>difficulty concentrating</i> ?	1	2	3	4	5
16. Being " <i>super alert</i> " or watchful or on guard?	1	2	3	4	5
17. Feeling <i>jumpy</i> or easily startled?	1	2	3	4	5

**Diagnosis Update following PCL-C**

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Upon completion of the TAA and PCL-C, consumers who score 3's or higher on more than 3 PCL items should have their tools reviewed by a QMHP to determine if the person meets criteria for PTSD. Upon review and/or assessment, if the individual meets criteria for PTSD, notification should be made to AMHD Utilization Management for a diagnosis update. Following the steps below can accomplish this.

Upon determination that the criteria for PTSD are met, the QMHP shall:

1. Complete this form
2. Fax the two forms to AMHD Utilization Management. Fax # 808) 453-6966

<b>Diagnosis Update Attestation</b>	
As a Qualified Mental Health Professional, I attest that I have reviewed the attached material and determined that this individual meets the criteria for a diagnosis of:	
309.81 Posttraumatic Stress Disorder	QMHP initials:
Optional Specifiers;	
	Acute: Onset and duration of symptoms are less than 3 months
	Chronic: Symptoms last 3 months or longer
	With Delayed Onset: At least 6 months have passed between the traumatic event and the onset of symptoms
Signature w/credentials of QMHP	Date
Phone or email information:	