



INTAKE & DIAGNOSTIC ASSESSMENT

PLEASE PRINT

Date of Evaluation Patient ID Number

Name Home Phone ( )

Address Work Phone ( )

City State ZIP Code Date of Birth Month Day Year

Drivers License or ID# State Age

Social Security Number Height Weight Gender M F

Personal Physician Name Address City Phone ( )

Preferred Hospital Name Address City

Emergency Contact Name Relationship City Phone ( )

Preferred Contact Name Relationship City Phone ( )

Ever been a patient here before? Yes No If Yes, when?

How did you learn about us? (check the one that influenced your decision the most)

- Attorney / Court / Probation School Yellow Pages
Chemical Dependency Agency / Detox Mental Health Counselor Family Member
Physician or Hospital Native American Tribe Friend
Insurance Company / Managed Care Other From a Former Patient / Alumni
Employer / EAP / Union Re-Admit / Relapse

If you checked a box in the first two columns, please write the name:

What is the problem or reason that brought you here?

What special needs or concerns should the staff be aware of for your visit today?

Continue on next page

What is the impact of the problem on your life? \_\_\_\_\_

\_\_\_\_\_

Why does this problem continue in your life? \_\_\_\_\_

\_\_\_\_\_

What have you tried to address the problem? \_\_\_\_\_

\_\_\_\_\_

Ideally, what would you like to happen? \_\_\_\_\_

\_\_\_\_\_

What do you think might bring about this preferred solution? \_\_\_\_\_

\_\_\_\_\_

What do you think supports or inhibits this solution? \_\_\_\_\_

\_\_\_\_\_

What are you willing to do to find a solution? \_\_\_\_\_

\_\_\_\_\_

What do you want from us? \_\_\_\_\_

\_\_\_\_\_

What are the next steps we need to take? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**EDUCATION**

Years of Education (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 or more

Level Completed  None  GED  HS Diploma  Vocational  Associate  BA/BS  Masters  Doctorate

How do you rate your English reading / writing skills?  Good  Fair  Poor

Have you ever had a learning disability or been placed in a special education class?  Yes  No If yes, explain \_\_\_\_\_

**FINANCIAL**

Financial Status  Good  Fair  Poor

Housing  Rent  Own  Other \_\_\_\_\_

Monthly Payment \$ \_\_\_\_\_

Combined Family Monthly Income \$ \_\_\_\_\_

Healthcare Reimbursement Information

Insurance Insurance Company Name \_\_\_\_\_

Private Pay Phone \_\_\_\_\_

Medicare Group Number \_\_\_\_\_

CHAMPUS Subscriber Number \_\_\_\_\_

Title XIX Subscriber Name \_\_\_\_\_

Agency Funded

Other

**FAMILY**

Marital Status Since Number of Times

Single (Never Married)

Married \_\_\_\_\_

Separated \_\_\_\_\_

Divorced \_\_\_\_\_

Widowed \_\_\_\_\_

Who are you currently living with? \_\_\_\_\_  
Name and Relationship

Does the person you are now living with:

Drink or Use?  Yes  No

Drink or Use to Excess?  Yes  No

Drink or Use in the Residence?  Yes  No

Number of Brothers \_\_\_\_\_ Your Birth Order? \_\_\_\_\_  
1st, 2nd, etc.

Number of Sisters \_\_\_\_\_

Children

Gender	Age	Person Living With
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birthplace \_\_\_\_\_

Placed raised \_\_\_\_\_

Years in this state \_\_\_\_\_

Write additional children on the back of this page

Check the one that is closest to your race/ethnicity:

- White/European American
- Black/African American
- Native American
- Eskimo/Alaskan Native
- Aleut
- Chinese
- Filipino
- Hawaiian
- Korean
- Vietnamese
- Japanese
- Samoan
- Asian Indian
- Guamanian
- Cambodian
- Laotian
- Thai
- Other Asian/Pacific Islander
- Other race
- Refused to answer

• If Native American/Eskimo/Alaska Native/Aleut, please provide tribal information:

Tribe or corporation \_\_\_\_\_

Tribal recognition  Federal  Non-Federal  Canadian

Eligible for enrollment?  Yes  No

Enrollment number \_\_\_\_\_

Blood degree  Less than 1/4  1/4 or more

Check the one that is closest to your Spanish/Hispanic origin:  Not Spanish/Hispanic  Mexican  Other Spanish/Hispanic  Puerto Rican  Cuban  Refused to answer

Continue on next page

**VETERAN STATUS**

Yes No

Military Service?   Branch \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Highest Rate/Rank \_\_\_\_\_

Honorable Discharge?   Drink/Use In Service  Yes  No Demotions  Yes  No

Combat Service?   Combat Location \_\_\_\_\_

PTSD Diagnosed?   If YES, where and when diagnosed \_\_\_\_\_

Prior PTSD treatment?   If YES, where and when treated \_\_\_\_\_

Eligible for VA Benefits?

**LEGAL**

Current Legal Problem \_\_\_\_\_ Date of Offense \_\_\_\_\_ BAL \_\_\_\_\_

Court \_\_\_\_\_ Judge \_\_\_\_\_ Case # \_\_\_\_\_

Court \_\_\_\_\_ Judge \_\_\_\_\_ Case # \_\_\_\_\_

Next Court Date \_\_\_\_\_ Case Status \_\_\_\_\_

Attorney Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

Probation Officer \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Do you have your Driving Record available today?  Yes  No  Not Applicable

Outstanding Warrants?  Yes  No What & When \_\_\_\_\_

Past Arrests or Convictions

Charge	Date	Court	Final Outcome	BAL

**EMPLOYMENT**

Employed Full-Time      Employer \_\_\_\_\_ Location \_\_\_\_\_

Employed Part-Time      Length In Current

Self-Employed      Employment \_\_\_\_\_ Monthly Income \$ \_\_\_\_\_

Military

Student      Position & Type of Work \_\_\_\_\_

Homemaker

Retired      Number of Employers      Longest Time

Disabled      In Past Five Years \_\_\_\_\_ With One Employer \_\_\_\_\_

Welfare      If Unemployed, What Is

Unemployed (Seeking work)      Your Source of Income \_\_\_\_\_

Unemployed (NOT seeking work)      Do You Enjoy Your Job?  Yes  No      Is your job seasonal?  Yes  No

Continue on next page 

**MEDICAL**

How is your overall health now?  Excellent  Good  Fair  Poor Are you pregnant?  Yes  No

What physical problems do you now have? \_\_\_\_\_

Are you currently under a doctor's care?  Yes  No Why? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

What medications are you now taking? \_\_\_\_\_

What medications have you taken in the last 6 months? \_\_\_\_\_

What over-the-counter products (aspirin, cough medicine, etc.) are you now using? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

Have you or anyone in your family ever had or been diagnosed as having any of the following?  
(Check NONE for questions that do not apply)

You	Family	None		You	Family	None	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning nausea, vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in fingers or toes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DT's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatty Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shaking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant weight loss or gain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache or Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Antabuse or Trexan
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or gastritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of prescription drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis				

How many times in the past five years have you been hospitalized? \_\_\_\_\_ When? \_\_\_\_\_

Reason? \_\_\_\_\_

How many times in the past five years have you used Emergency Room services? \_\_\_\_\_ When? \_\_\_\_\_

Reason? \_\_\_\_\_

How many days in the past five years have you used sick leave (all employers)? \_\_\_\_\_ When? \_\_\_\_\_

Reason? \_\_\_\_\_

	Yes	No
Have you ever: Had any fractures or dislocations to your bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Been injured in a traffic accident?	<input type="checkbox"/>	<input type="checkbox"/>
Injured your head?	<input type="checkbox"/>	<input type="checkbox"/>
Been injured in an assault or fight (not sports injuries)?	<input type="checkbox"/>	<input type="checkbox"/>
Been injured while drinking?	<input type="checkbox"/>	<input type="checkbox"/>

Continue on next page 

**MENTAL HEALTH**

Are you currently receiving services at a mental health center or seeing a private practitioner?  Yes  No

If yes, where and when \_\_\_\_\_

Have you ever received mental health counseling or psychiatric treatment?  Yes  No

If yes, where and when \_\_\_\_\_

Are you currently using medications for mental health reasons?  Yes  No

If yes, what \_\_\_\_\_

Is there a family history of mental illness?  Yes  No

If yes, explain \_\_\_\_\_

Have you had a significant period (not the direct result of alcohol/drug use) where you experienced any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Anxiousness                | <input type="checkbox"/> Serious depression        |
| <input type="checkbox"/> Sleep Disturbances         | <input type="checkbox"/> Hostility/violence        |
| <input type="checkbox"/> Phobias/paranoia/delusions | <input type="checkbox"/> Referral to mental health |
| <input type="checkbox"/> Anorexia                   | <input type="checkbox"/> Grief and loss issues     |
| <input type="checkbox"/> Bulimia                    | <input type="checkbox"/> Inability to comprehend   |
| <input type="checkbox"/> Hallucinations             | <input type="checkbox"/> Loss of appetite          |

Have you ever attempted suicide?  Yes  No

Do you have suicidal thoughts?  Yes  No

If yes, when and where \_\_\_\_\_

If yes, most recent thoughts \_\_\_\_\_

Is there a family history of suicide?  Yes  No

Do you have a plan to harm yourself?  Yes  No

If yes, explain \_\_\_\_\_

If yes, describe \_\_\_\_\_

Are you experiencing any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hopelessness                     | <input type="checkbox"/> Moodiness                | <input type="checkbox"/> Feeling withdrawn         |
| <input type="checkbox"/> Decreased energy                 | <input type="checkbox"/> Preoccupation with death | <input type="checkbox"/> Self-destructive thoughts |
| <input type="checkbox"/> Giving away valuable possessions | <input type="checkbox"/> Sleeplessness            | <input type="checkbox"/> Taking unnecessary risks  |

Is there any kind of physical, emotional or sexual abuse where you live?  Yes  No

Are you at risk of being abused?  Yes  No

Have you ever been abused physically, emotionally or sexually?  Yes  No

Do you have a history of violence toward others?  Yes  No

If yes to any of the above, explain \_\_\_\_\_

\_\_\_\_\_

Continue on next page 

## ALCOHOL & OTHER DRUG USE HISTORY

At what time in your life did you drink the most? From age \_\_\_\_\_ to age \_\_\_\_\_

At what time in your life did you use other drugs the most? From age \_\_\_\_\_ to age \_\_\_\_\_

In a 12 month period, have you:

Yes    No

- Needed noticeably increased amounts of alcohol or other drugs to achieve intoxication or desired effect?
- Experienced withdrawal, such as: sweats, shakes, insomnia, nausea or vomiting, hallucinations or illusions, anxiety or seizures?
- Taken alcohol or other drugs in larger amounts or over a longer period than you intended?
- Had a persistent desire or unsuccessful efforts to cut down or control alcohol/substance use?
- Spent a great deal of time obtaining or using alcohol or other drugs or recovering from the effects?
- Given up important social, work or recreational activities because of substance use?
- Had a persistent physical or psychological condition and knew continued use of alcohol or other drugs would make those conditions worse?

Please complete the table below. List all substances (including alcohol and prescription medication you have used).

Drugs Used	Additional Drug Information <small>(Valium, crack, meth, etc.)</small>	Age at First Use	Age When Regular Use Began	Average Number of Times Used Each Week	Average Amount Used Each Time	Usual Way Used <small>(Oral, Smoked, Snorted, IM or IV)</small>	Date of Last Use
Beer							
Wine							
Liquor							
Nicotine							
Marijuana							
Cocaine							
Caffeine							
Amphetamines							
Tranquilizers							
Opiates							
Barbiturates							
Inhalants							
Hallucinogens							
Other Drug							

Were any of the above drugs you used prescribed by a doctor or dentist?  Yes  No

Continue on next page



**ALCOHOL & OTHER DRUG USE HISTORY**

Has anyone in your immediate family had any problems with alcohol or other drugs? (children, parents, brothers and sisters, grandparents, uncles and aunts, cousins)  Yes  No

Who? \_\_\_\_\_

Have you ever received education or treatment for alcoholism or drug addiction?  Yes  No

If you have, when and where, and did you complete? \_\_\_\_\_

Have you ever attended a meeting of Alcoholics Anonymous or Narcotics Anonymous?  Yes  No

If you have, when? \_\_\_\_\_

What is the longest period of time you have gone without drinking or drugging? \_\_\_\_\_

When? \_\_\_\_\_ Why? \_\_\_\_\_

When did you return to drinking or using? \_\_\_\_\_

Why? \_\_\_\_\_

Do you think you have a problem with alcohol or other drugs?  Yes  No Why? / Why Not? \_\_\_\_\_

What are your typical daily activities? \_\_\_\_\_

Describe your childhood religious or spiritual upbringing, traditions or experiences \_\_\_\_\_

Describe the religious preferences or spiritual practices and beliefs you have now \_\_\_\_\_



Please return this questionnaire to a staff member as directed

**STAFF USE ONLY**

**DSM DIAGNOSIS**

- AXIS I**     Assessment does not support a diagnosis of substance abuse or dependency at this time.  
 Assessment supports a diagnosis of substance abuse or dependency as indicated below:

Diagnoses Supported					Substance	Route of Administration							
Primary / Secondary / Tertiary	Current Dependence	DSM	Current Abuse	DSM		Previous Use History	Severity	Physiological Dependence	Oral	Smoking	Injection	Intra Nasal	Other
		303.9		305.0									
		304.4		305.7									
		304.3		305.2									
		304.2		305.6									
		304.5		305.3									
		304.6		305.9									
		304.0		305.5									
		305.1											
		304.0		305.5									
		304.9		305.9									
		304.8											
		304.1		305.4									
		304.9		305.9									

1 = Primary  
2 = Secondary  
3 = Tertiary

1 = Mild  
2 = Moderate  
3 = Severe

Y = Yes  
N = No

Assessment Tool(s) Used:

Assessment Tool Summary:

Other Axis I Diagnoses

\_\_\_\_\_

\_\_\_\_\_

**AXIS II** (Personality Disorders/Mental Retardation)

\_\_\_\_\_

\_\_\_\_\_

**AXIS III** (General Medical Condition)

\_\_\_\_\_

\_\_\_\_\_

**AXIS IV** (Psychosocial & Environmental Problems)      Description (If Checked)

- Primary support group \_\_\_\_\_
- Social environment \_\_\_\_\_
- Educational \_\_\_\_\_
- Occupational \_\_\_\_\_
- Housing \_\_\_\_\_
- Economic \_\_\_\_\_
- Access to healthcare services \_\_\_\_\_
- Legal/crime \_\_\_\_\_
- Other psychosocial environment \_\_\_\_\_

**AXIS V** (Global Assessment of Functioning)    Past 12 Months \_\_\_\_\_    Present Assessment \_\_\_\_\_



Complete an assessment of all of the following elements when assessment is conducted on a youth and patient is in need of treatment. Information should be obtained from parents and legal guardians and prior medical and psychological evaluations with proper consent.

Parental and sibling use of drugs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Developmental history, such as developmental age factors, motor development and functioning \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of psychological and emotional stability \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Childhood or adolescent development problems associated with the use of chemicals \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Language functioning, including reading, writing, speech and hearing \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Visual functioning \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Complete an assessment of all of the following elements when assessment is conducted on a youth and patient is in need of treatment. Information should be obtained from parents and legal guardians and prior medical and psychological evaluations with proper consent.

Intellectual functioning \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Interaction with peers \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Learning ability, including disabilities and special education \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Culture/ethnicity \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treatment history

Provider	City and State	Dates	Outcomes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

School history

School	City and State	Dates	Assessment and Referrals
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Complete an assessment of all of the following elements when assessment is conducted on a youth and patient is in need of treatment. Information should be obtained from parents and legal guardians and prior medical and psychological evaluations with proper consent.

Determination of immunization status: \_\_\_\_\_

Environmental surroundings, including historical and current parental or custodial status \_\_\_\_\_

---

---

---

---

---

History of running away, out-of-home placements and institutional care or custody \_\_\_\_\_

---

---

---

---

Prenatal exposure to alcohol, tobacco or other drugs \_\_\_\_\_

---

---

---

Support from significant adults and extended family \_\_\_\_\_

---

---

---

Ability of parents/guardian to participate in treatment \_\_\_\_\_

---

---

---

Counselor's interpretation of history of alcohol, tobacco or other drugs \_\_\_\_\_

---

---

---

---

---

Other \_\_\_\_\_

---

---

---

---



STAFF USE ONLY

**DIMENSION 1 - ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL**

Signs and Symptoms of Withdrawal/Intoxication (use CIWA scale and attach if appropriate)

- None     Nausea & Vomiting     Auditory Disturbances     Agitation
- Tremor     Visual Disturbances     Headache
- Sweats     Anxiety     Orientation
- Tactile Disturbances

History of withdrawal problems (include dates)  None \_\_\_\_\_

Modality of previous withdrawal \_\_\_\_\_

Date/Time of last chemical use \_\_\_\_\_

Chemical used the most in past three months \_\_\_\_\_

**Indicated Level of Service for DIMENSION 1**     None     .5     I     II     III     IV

**DIMENSION 2 - BIOMEDICAL CONDITIONS & COMPLICATIONS**

Place and Date of Last Physical Exam \_\_\_\_\_ Physician \_\_\_\_\_

Current physical conditions other than withdrawal that need to be addressed or which complicate treatment (include pregnancy)     None

Chronic conditions that affect treatment     None \_\_\_\_\_

**Indicated Level of Service for DIMENSION 2**     None     .5     I     II     III     IV

**DIMENSION 3 - EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS**

Current psychiatric illness or psychological, behavioral, emotional or cognitive problems that need to be addressed or which complicate treatment?     None

Chronic conditions that affect treatment?     None \_\_\_\_\_

Do any emotional, behavioral or cognitive problems appear to be an expected part of addiction illness?

No     Yes (describe) \_\_\_\_\_

Suicide Risk? 1=low 5=high    1    2    3    4    5    due to: \_\_\_\_\_

If problems are connected to addiction, are they severe enough to warrant specific mental health treatment?

No     Yes (describe) \_\_\_\_\_

**Indicated Level of Service for DIMENSION 3**     None     .5     I     II     III     IV



**DIMENSION 4 - READINESS TO CHANGE**

Patient's perception of the problem \_\_\_\_\_

Results of assessment of personal risk (assessment tool used) and patient's response \_\_\_\_\_

Patient's motivations for change \_\_\_\_\_

Patient's self-motivation for change at this time  High  Medium  Low

Patient's awareness of self-responsibility to change at this time  High  Medium  Low

Patient's awareness of discrepancy between present behavior and important goals  High  Medium  Low

Specific areas of patient resistance to change \_\_\_\_\_

Advice and/or treatment alternatives offered by counselor and patient's response \_\_\_\_\_

Involvement of significant other(s) to change \_\_\_\_\_

Other factors affecting readiness to change

- Age  Illiteracy or learning disability  Gender  Coexisting Disorder  
 Language Spoken  Ethnic Group  Sexual Orientation

- Patient's stage of change at this time  Precontemplation (not considering change)  
 Contemplation (aware that a problem exists)  
 Preparation (planning for change)  
 Action (pursuing change)  
 Maintenance (sustaining change)

Indicated Level of Service for DIMENSION 4  None  .5  I  II  III

STAFF USE ONLY

**DIMENSION 5 - RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL**

Relapse history (include agency, modality, dates, lengths of service) \_\_\_\_\_

Impulse control ability \_\_\_\_\_

Preoccupation or craving symptoms \_\_\_\_\_

Ability to refuse use of chemicals \_\_\_\_\_

Consequences of relapse \_\_\_\_\_

Risk of relapse  High  Moderate  Low - due to: \_\_\_\_\_

Indicated Level of Service for DIMENSION 5  None  .5  I  II  III

**DIMENSION 6 - RECOVERY/LIVING ENVIRONMENT**

Social activities and relationships that support chemical use \_\_\_\_\_

Social activities and relationships that support recovery \_\_\_\_\_

Social support as verbalized by patient \_\_\_\_\_

Other environment issues that are likely to impact recovery (check box and describe, if present)

- Employment/financial impact on recovery
- Rural, suburban or urban background
- Domestic violence
- Sexual abuse
- Living situation (Including homelessness)
- Childcare responsibilities
- Availability of medical care, including CD treatment
- Cultural issues

Describe \_\_\_\_\_

Indicated Level of Service for DIMENSION 6  None  .5  I  II  III

Was any of the following a factor in making any placement decision?  Yes  No

- Legal
- Failure to progress at any given level of care
- Laws/regulations/court order requiring use of different criteria

Describe, if a factor \_\_\_\_\_

**DIAGNOSTIC SUMMARY**

Patient's perception of his/her needs, strengths, limitations and problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Assessment of patient strengths and needs: (check NA for those dimensions not applicable at this time)

DIM 1 \_\_\_\_\_  
 NA

DIM 2 \_\_\_\_\_  
 NA

DIM 3 \_\_\_\_\_  
 NA

DIM 4 \_\_\_\_\_  
 NA

DIM 5 \_\_\_\_\_  
 NA

DIM 6 \_\_\_\_\_  
 NA

Ability to attain and maintain abstinence is  Good  Fair  Poor because: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Recommended treatment (include level of service and anticipated length): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Recommended treatment goals: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



STAFF USE ONLY

DUI ASSESSMENT SUMMARY

☐ This Section Not Applicable

Evaluation of BAL and other drug levels at time of arrest, if available \_\_\_\_\_

Assessment of self-reported and abstract of legal driving record \_\_\_\_\_

CONSENTS AND REFERRAL OPTIONS

HIV/AIDS Brief Risk Intervention provided and referrals made (if required) ☐ Yes ☐ No (document reason)

Patient initial before each item to indicate:

\_\_\_ I have received HIV/AIDS information, and referrals, if required.

\_\_\_ I have read, understood and received a copy of the Patient Rights.

\_\_\_ I have received tuberculosis information and referrals, if required.

\_\_\_ I have been fully informed and received a copy of the Counselor Disclosure Statement.

\_\_\_ I have read, understood and received a copy of information regarding this agency's outcome policy and agree to be contacted for a confidential follow-up interview.

\_\_\_ I have read, understood and received a copy of the Patient Rules.

\_\_\_ I have been informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2.

\_\_\_\_\_  
Staff witness

Referral options provided \_\_\_\_\_

I have received the results of this assessment and I have also been advised of my right to be referred to another approved alcohol or drug treatment facility consistent with those results.

I have chosen to receive services from \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

If the patient was not notified of the results of this assessment and advised of referral options, document reason(s)

CONSENT TO TREATMENT

I hereby voluntarily consent to treatment at Eastside Addiction Professionals and will comply with the terms of the treatment plan and conditions recommended by Eastside Addiction Professionals. I understand that Eastside Addiction Professionals will report my compliance to the court, probation or Department of Licensing, as applicable. I understand that my failure to follow the rules and regulations or treatment plan may result in my immediate dismissal from Eastside Addiction Professionals and / or my case being referred back to the referring court or agency.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if required) Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

Assessment completed by:

\_\_\_\_\_  
Chemical Dependency Professional

\_\_\_\_\_  
Date

