

Stillwater Counseling

Client Name _____

Counselor Recommendations and Diagnosis

Assessment: _____

Diagnosis:

	Mild	Moderate/Severe
Alcohol	305.00 (F10.10)	303.90 (F10.20)
Marijuana	305.20 (F12.10)	304.30 (F12.20)
Opiates	305.50 (F11.10)	304.00 (F11.20)
Methamphetamine	305.70 (F15.10)	304.40 (F15.20)
Cocaine	305.60 (F14.10)	304.20 (F14.20)
Other	_____	_____

Mild 2-3 symptoms Moderate 4-5 Symptoms Severe 6 or more symptoms

Diagnostic Criteria from DSMV American Psychiatric Assoc (copyright 2013)

Counselor's Signatures and Certifications

_____ Date _____

Stillwater Counseling

929 Grand Avenue-Glenwood Springs, CO 81601

Phone (970) 230-9347

INTAKE AND ASSESSMENT DWI AND SUBSTANCE USE DISORDER PROGRAM

CLIENT NAME _____ TODAY'S DATE _____

TYPE: DWI LII ED DWI LII TX DWI EOP OTHER _____

CLIENT INFORMATION	CASE RELATED INFORMATION
Birth Date: _____ Age: _____	Have you been sentenced: Yes No
Social Security #: _____	Supervised Probation: Yes No
Home/Cell: _____	Probation Officer: _____
E-Mail: _____	Case Number: _____
OK to leave a message?	County Charged In: _____
Mailing Address: _____	Year Arrested: _____
City: _____ Zip: _____	BAC at time of Arrest: _____
County: _____	Education Hours Required: _____
Employer: _____	Therapy Track/Hours Required _____
Names and Ages of Children	Have you previously attended our agency?:
Name: _____ Age: _____	Yes No
Name: _____ Age: _____	When: _____
Name: _____ Age: _____	Why: _____
If client is under Age 18	Have you attended another agency? :
Parent's Name: _____	Yes No
Home Phone: _____	Name of Agency: _____
Work Phone: _____	Education Hours: _____
For Information on Holidays or increment weather	Therapy Hours: _____
Please call 970 230-9347	Emergency Contact: _____
	Relationship to contact: _____
	Contact Number: _____

Stillwater Counseling
929 Grand Avenue- Glenwood Springs, CO 81601
Phone: 970 230-9347

STILLWATER STAFF AND CREDENTIALS

Stillwater Counseling is a substance use treatment agency licensed by the Office of Behavioral Health (OBH), Colorado Department of Human Services. The counseling staff and their qualifications are as follows:

1. Wendy Caldwell MA, CAC II, ATP Wendy has a Masters Degree in Education from the University of Northern Colorado and is a Certified Addiction Specialist# ACC 0997858. Wendy is certified in Driving with Care DWI Program, Prime for life National Substance Use program, The Matrix Model, and is proficient in the 12 steps of recovery. Wendy has been a teacher in the Roaring Fork Valley for over 20 years and has provided counseling services for over 10 years.
2. Kenneth Hamburg, CAC II Glenwood Springs, Colorado
Mr. Hamburg studied at Metro University. Mr. Hamburg has been a Certified Addiction Counselor since 1996. Mr. Hamburg has worked within the Garfield County and Eagle County Courts for over 20 years. Mr. Hamburg has been employed with Addiction Counseling agencies within the valley and has worked with Youth Zone and is currently the guidance counselor for Yampah High School here in GWS. Kenny is licensed through the State of Colorado Division of Behavioral Health.
3. Peter C Hille, CAC III Glenwood Springs, Colorado
Peter has been a CAC III since 1989. Mr. Hille has worked for Valley View Hospitals Youth Recovery Center, White River Counseling, Alpine Springs Counseling, ABC Counseling and previously owned his own agency. Mr. Hille also worked as a therapist and educator at the Rifle Correctional Center. Mr. Hille is trained in the Driving with Care program, Criminal and Substance abuse treatment, Strategies in Self Improvement and Change and the Matrix Model. Mr. Hille completed 3 years of college in New Jersey. Peter is licensed through the State of Colorado Division of Behavioral Health.
4. Susan Kempton is our Administrative Director and will probably be the first person you will have contact with. Susan has lived in the valley for over 30 years and has worked with Substance Abuse agencies for over 22 years. Susan has worked with agencies such as The Right Door, Colorado West and ABC Counseling. She is proficient in the TMS system as well as the PROST billing and voucher system. She is in the process of completing her CAC licensing and looks forward to continuing her education in the Substance Abuse field.
5. Linda S. Potter is a Certified Addiction Specialist. Linda is certified in the Driving with Care Program, the Prime for Life National Substance Abuse Program, Criminal and Substance Abuse treatment, Strategies in Self Improvement and Change and Anger Management. Linda has worked at Garfield County Community Corrections as a counselor and educator, at Roaring Fork Counseling and at Alpine Counseling. Linda has attended 2 years of college in Colorado, and continues to attend to earn her Bachelors of Science degree in Addictions Studies. She has provided counseling services for over 15 years. Linda is licensed through the State of Colorado Division of Behavioral Health.

Client Signature _____ Date _____

Staff Signature _____ Date _____

STILLWATER COUNSELING DISCLOSURE STATEMENT

1. The practice of registered, certified or licensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints regarding addiction counselors may be addressed to: Board of Addiction Counselor Examiners, 1560 Broadway, Suite 1350, Denver CO 80202. Phone (303) 866-7400.

The regulatory requirements applicable to mental health professionals are as follows:

- Registered psychotherapist is a psychotherapist listed in the States database and is authorized by law to practice in Colorado, but is not licensed or certified by the State and is not required to satisfy any standardized educational or testing requirements.
 - Certified Addiction Counselors I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1000 hours of clinically supervised work experience.
 - Certified Addiction Counselors II (CAC II) must meet the CAC I requirements, complete additional hours above the CAC I, and 2000 hours of clinically supervised work experience.
 - Certified Addiction Counselor III (CAC III) must have a bachelors degree in the behavioral health sciences field: complete additional training above the CAC II, and 2000 hours of clinically supervised work experience.
 - Licensed addiction counselor must have a clinical masters degree, meet the CAC III requirements and pass a national examination in addiction treatment.
 - Licensed Social Worker must hold a masters degree in social work.
 - Psychologist candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
 - Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a Masters degree in their profession and have 2 years of post-masters supervision.
 - Licensed Psychologist must hold a doctorate degree in psychology and have one year of post -doctoral supervision.
2. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Board that registers, certifies or licenses the registrant, certificate holder or license.
 3. Generally speaking, the information provided by and to the client during therapy sessions is legally, confidential and cannot be released without the clients consent. There are exceptions to this confidentiality, some of which are listed in Section 12-43-218 of the Colorado Revised Statutes as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception to confidentiality arises during therapy, if feasible, you will be informed accordingly.
 4. I understand that my alcohol and/or drug treatment records are protected under the Federal Confidentiality Regulation 42 S.F.R. Part 2. Governing Confidentiality of Alcohol and Drug Abuse Patients Records. Confidential information cannot be disclosed without my written permission unless otherwise provided for by the regulations.
 5. Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of the last seven years commencing either upon the last day of treatment or when the child reaches eighteen years if age, whichever comes later, but in no event shall records be kept for more than twelve years.

I have read the preceding information and I understand my rights s a client or as the clients responsible party.

Client Name _____ Client Signature _____ Date _____

STILLWATER COUNSELING, LLC

Stillwater Counseling
929 Grand Avenue
Glenwood Springs, CO 81601
970 230-9347

FEES & POLICIES

Stillwater Counseling believes in client center care focused on alleviating the shame and stigma associated with addiction and depression. Our mission is to guide each individual; through personal choice, to achieve healthy and positive life outcomes. Change comes with awareness and knowledge creates power in our lives. Both allow for new perspectives and understanding of where we have been to shape and create the outcomes we desire. Challenges and struggle allow us to become stronger, more resilient and bring a sense of gratitude for the strengthening of our character and resolve.

FEES

Individual Therapy

60 minute session \$100.00

Evaluations \$250.00

Group Therapy

DUI Intake fee \$65.00

DUI Level I \$350.00 (12 hours)

DUI Level II \$420.00 (24 hours) \$35 per group

TRACK A-D DUI LEVEL II CLASSES \$35.00 per class

Relapse Prevention SSIC Group \$40 per class 2 X per week

EOP (Extended Outpatient) \$40.00 per class 2 X per week

Family and Friends Support Group \$40.00 per group

Women's Recovery Group \$35.00 per group

Mindfulness in Recovery \$35.00 per group

Positive Life Outcomes \$35.00 per group

Zoom classes are currently available for DUI ED and TX \$35.00 per group

Sliding Scale Fees are available to eligible clients based on family income and number of dependents. Information from clients will be used to determine eligibility.

Client Signature Date Therapist Signature Date

STILLWATER COUNSELING
929 GRAND AVE-GLENWOOD SPRINGS, CO 81601
PHONE (970) 230-9347

ATTENDANCE AND FEE PAYMENT: Clients are expected to pay for services at time of service.

1. If you are having difficulty paying for treatment please contact our Administrative Director by calling our agency phone number to make payment arrangements. We want to work with you.
2. Fees are provided in this Intake form. Additional fees may include:
 - \$20 for a check or credit/debit card chargeback.
 - \$20 for additional or duplicate paperwork.
 - Completing another intake assessment if discharged prior to completion of treatment.
3. Client cannot complete the program without paying their balance in full and will not receive credit for unpaid sessions. Clients will be suspended from class attendance if balance outstanding balance is \$90 or above.
4. If a balance is unpaid for over six months and it becomes necessary to assign the account for collection, or that any costs are incurred by SWC for collection of the past due account the client will be responsible for all costs of collection, including court costs and reasonable attorney fees.
5. SWC has a sliding scale for clients who qualify and are verified as indigent status. Clients can access probation to receive vouchers for treatment sessions.

ATTENDANCE AND ADDITIONAL AGREEMENTS:

- I agree to be punctual, attend each week and stay the entire session.
- If I arrive late, I may not be allowed to attend.
- If I am going to miss a session, I will let the counselor or the office know in a timely manner. Failure to attend regularly will result in discharge from treatment.
- I agree that all cell phones will be turned off during group sessions.
- I agree to participate sober and not under the influence of controlled substances.
- I agree that it is my responsibility to discuss and participate in sessions.

CONFIDENTIALITY AGREEMENT: You have the right to confidentiality and privacy by the group leaders and other group members. Confidentiality within the group setting is a shared responsibility of all members and leaders. While group leaders may not discuss any client communications or information except as provided by law, group members communications are not protected. As such, confidentiality within the group setting is often based on mutual trust and respect. As a member of this group, **I agree not to disclose to anyone outside the group any information that may help identify another group member.** This includes but is not limited to names, physical descriptions, biological information, and specifics to the content of interactions with other group members.

Client Name

Date

Client Signature

Date

STILLWATER COUNSELING CLIENTS RIGHTS AND RESPONSIBILITIES AND GRIEVANCE POLICY

CLIENT'S RIGHTS AND RESPONSIBILITIES: SWS accepts clients without regard to race, color, religion or national origin. Services are provided for fees. Clients are expected to pay for services either at the time of service or as arranged with the office. Clients have a right to professional counseling services that meet the standard of care of the profession, and to receive a written statement from the counselor regarding such standards and the counselor's credentials. Clients have a right to the least restrictive treatment possible given their clinical status. Clients wishing to view their own records have the right to do so. Former clients have the right to receive copies of their records; however, whenever possible records are released to another treatment provider so that such matters as the format of clinical notes can be discussed with the client by the provider. There may be a fee for copying records. Clients are responsible for being active participants in their own treatment, for coming to appointments on time without having used chemical substances, for working towards goals to improve their lives, for maintaining a cooperative relationship with the counselor and other group members, for payment posted fees as agreed to, for keeping information about other clients confidential, and for providing necessary forms that allow SWS to carry through on its responsibilities.

CONSENT TO TREAT: Client consents that assessment and treatment is provided by the professional staff of SWC. Clients acknowledge that no guarantees have been made as to the results of treatment and evaluation, and that he/she will pay the fees that have been explained verbally or in writing. Client authorizes SWC to contact them for the purposes of follow up studies and agree that their chart may be randomly selected for review purposes of quality assurance.

THE TERMS OF PARTICIPATION: Client agrees to make every effort to attend each session and to be on time. If you are late you will not be admitted to the group. It is strongly advised that clients attend every session so that they can complete the program in a timely manner. Failure to attend at least once a month will result in termination from the program as non-compliant. No one whom the Counselor determines has used alcohol or drugs will be allowed to attend the session. If a counselor believes a client has used such substance and the client denies it, the counselor may request a breathalyzer test or other form of drug testing as appropriate. Client agrees to complete all assignments and participate in group discussions. Agreement with the Counselor or other group members is not mandatory. Honest concerning client's opinions and what is going on in his/her life is essential. Confidentiality will be respected. SWC is a private agency that does not give the court information about client's statements, opinions or values. Each client agrees to maintain the same level of guarding confidentiality about others in the group and does not tell other people the names, identifying information, or other data about other group members.

GRIEVANCE PROCESS: Occasionally questions or disagreements between therapists and clients come up. You may question why your therapist made a particular statement, or made a specific recommendation. If this happens, the first thing to do is ask your therapist the reason for the action or statement. You won't be punished or given inferior care for voicing your opinion, but you are likely to feel resentful and get less out of your treatment experience if you do not bring up concerns you have. Most differences can be resolved through open discussion. The administration shall insure that all complaints are handled promptly and professionally. Complaints that cannot be satisfactorily resolved by agency treatment staff shall be referred to the Director and/or Clinical Supervisor and resolved at a maximum of fifteen (15) business days from receipt of complaint. If necessary and with your written consent, we will bring in a mediator to help resolve the problem. Grievances will be maintained separately from the clients clinical chart and will be reported annually to OBH. If after participating in the grievance process clients think they are not getting treatment, counseling, or care needed clients can see another therapist or attend another agency. Clients also have the right to file a complaint with the State of Colorado at:

STATE DEPARTMENT OF REGULATORY AGENCIES

Colorado Mental Health Section
1560 Broadway, Suite 880
Denver, CO 80202
Phone: 303 894-2559

Colorado State
Division of Behavioral Health
3824 W Princeton Circle
Denver, CO 80236
Phone: 303 866-7400

CLIENT NAME (Please Print)

CLIENT SIGNATURE

DATE

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COLORADO
 Department of Corrections
 Division of Adult Parole

Revised February 2016

Interstate Compact Unit
 940 N Broadway
 Denver, CO 80203
 P 303.763.2441 F 303.861.1548
rebecca.frazier@state.co.us | DOC_interstatetreatment.state.co.us

**OUT-OF-STATE OFFENDER
 CLIENT QUESTIONNAIRE**

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in a denial to attend the treatment program and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

- 1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or DMV? Yes No
- 2) Do you have any pending cases in another state? Yes No if yes

to 1 or 2, please answer the following questions:

- 3) What state are you completing treatment for? _____
- 4) Who are you to report the treatment to? _____
 (Example: Court, Judge, Probation Parole, etc.)
- 5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado? Yes No
- 6) For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring you driving privileges as the result of an alcohol or drug related driving Offense in another state, but are not under court order to do so? Yes No

Your Name: _____ Date of Birth: _____ Social Security Number: _____
 Place of Birth: _____
 Signature: _____ Today's Date: _____

If you answered "Yes" to 1 or 2 above, please provide the following:

Name, address and phone number of your Probation officer, parole officer, judge Or diversion officer. _____

A copy of your probation, parole, court or diversion order, including treatment requirements must be included

John W. Hickenlooper, Governor | Rick Raemisch, Executive Director

Form C



STILLWATER COUNSELING
929 GRAND AVENUE-GLENWOOD SPRINGS CO 81601
PHONE: (970) 230-9347

SMART GOALS AND SERVICE PLAN

INTAKE DATE: _____ REVIEW (6 MONTHS): _____

UPDATE (AS NEEDED): _____ DISCHARGE DATE: _____

PROBLEM STATEMENT (WHAT THE CLIENT SEES AS A PROBLEM)

1. _____
2. _____

GOALS: SPECIFIC, MEASURABLE, ATTAINABLE, REVELANT, TIME

1. _____
2. _____

SMART OBJECTIVES-ACTION STEPS FOR GOAL 1

1. _____
2. _____

SMART OBJECTIVES-ACTION STEPS FOR GOAL 2

1. _____
2. _____

INTERVENTIONS (DWI GROUP, AA, INDIVIDUAL THERAPY)

1. _____
2. _____

STRENGTHS TO MEET YOUR GOALS:

1. _____
2. _____

RESOURCES:

I HAVE BEEN OFFERED A COPY OF THIS SERVICE PLAN. Client Initials _____

CLIENT SIGNATURE _____ DATE _____

STAFF SIGNATURE _____ DATE _____

INFECTIOUS DISEASE BEHAVIORAL SCREEN SCORING

Transfer responses from the Infectious Disease Behavioral Screen onto this form and total the corresponding numeric values.

- | | | | | |
|-----|------------|----------------|-----------------|-----------------|
| 1. | Yes (5) | No (0) | | |
| 2. | Yes (10) | No (0) | | |
| 3. | Never (20) | Sometimes (15) | Always (10) | No anal sex (0) |
| 4. | Yes (15) | No (0) | | |
| 5. | Yes (10) | No (0) | | |
| 6. | Yes (20) | No (0) | | |
| 7. | Yes (30) | No (0) | | |
| 8. | Yes (30) | No (0) | Don't know (15) | |
| 9. | Yes (30) | No (0) | Don't know (15) | |
| 10. | Yes (30) | No (0) | Don't know (15) | |

My Score: _____

SCORE OVER 120 = HIGH RISK

A score over 120 indicates you are at high risk for acquiring/transmitting HIV and/or Hepatitis. See your counselor right away for referral to your local county health department or the Colorado Department of Public Health and Environment for further evaluation and follow-up.

SCORE BETWEEN 30-119 = MEDIUM RISK

A score of 30-119 indicates that you are at medium risk for acquiring/transmitting HIV and/or Hepatitis. See your counselor for more information about ways that you can reduce your risk and other programs that can help you.

SCORE BELOW 29 = LOW RISK

A score of 0-29 indicates that you are at low risk for acquiring HIV and/or Hepatitis. Low risk doesn't necessarily mean no risk. See your counselor if you have questions or concerns about behaviors that may place a person at risk.

YOUR COUNSELOR IS REFERRING YOU TO THE FOLLOWING AGENCY / PROGRAM FOR FOLLOW-UP:

Public Health – Glenwood Springs
 2014 Blake Avenue
 Glenwood Springs, CO 81601
 970-645-6614 phone

Public Health – Rifle
 195 West 14th Street
 Rifle, CO 81650
 970-625-5200 phone

Community Health Services (Pitkin County)
 0405 Castle Creek Road, Suite 6
 Aspen, CO 81611
 970-920-5420 phone

Clear Creek County Public Health
 1531 Colorado Blvd. (Comm. Res. Center)
 Idaho Springs, CO 80452
 303-567-3147 phone

Eagle County Public Health Office
 100 W. Beaver Creek Blvd.
 Avon, CO 81620
 970-949-7026 phone

Eagle County
 20 Eagle County Road, Suite E
 El Jebel, CO 81623
 970-704-2760 phone

Lake County Public Health Agency
 112 W. 5th Street
 Leadville, CO 80461
 719-486-2413 phone

Summit County Public Health
 360 Peak One Drive, Suite 100
 Frisco, CO 80443
 970-668-5230 phone

CRISIS LINES:

AIDS hotline.....1-800-342-2437
 Suicide hotlines.....1-800-784-2433, 1-800-SUICIDE, 1-800-273-8255

SUPPORT GROUPS:

Alcoholics Anonymous.....(970) 928-0499
 Al-anon/Alateen.....1-888-966-4662
 Narcotics Anonymous.....1-800-912-4597

DECLINE

CLIENT NAME (PRINT)

SIGNATURE

DATE

(13)

INFECTIOUS DISEASE MEDICAL AND BEHAVIORAL SCREENING

In response to increasing rates of hepatitis B and C, sexually transmitted diseases, TB and HIV, all clients/patients receiving services from substance abuse treatment providers licensed by the Alcohol and Drug Abuse Division (ADAD) shall be screened for past and present risk factors, including those associated with substance abuse, for disease acquisition and transmission. In a joint effort, ADAD, the Colorado Department of Public Health and Environment, substance abuse treatment providers and HIV and hepatitis advocacy groups and coalitions have developed two Screens for determining client/patient risk. In introducing the Screens to clients/patients the following points should be made (not in preferential order):

- Administering a screen is required by state regulation;
- Privacy of responses to screen questions is protected by federal regulation and state law;
- The screen provides important information to clients/patients about their levels of risk;
- In order to get the best information, honest, accurate responses to questions are vital.

INFECTIOUS DISEASE MEDICAL SCREEN

The Infectious Disease Medical Screen is intended to be self-administered at time of intake or shortly thereafter. A counselor or other person knowledgeable about the Screen should be available to assist with any client/patient questions or concerns. Questions 1 through 8 screens for risk of hepatitis B and/or C exposure. Questions 9 through 14 screens for risk of tuberculosis exposure/infection.

Appropriate Clinical Responses Guide

A "Yes" response to any of questions 1 through 7 and no record of being tested for hepatitis B and C should prompt a referral for testing and appropriate follow-up.

A "Yes" response to question 8 should prompt making information available about the possible (though low-level) risks involved.

If any of the categories in question 9 are marked, a TB skin test should be encouraged.

A "Yes" response to any of questions 10 through 14 indicates a high risk for active TB or TB infection and a referral to a healthcare practitioner or health department for testing/treatment should be made immediately.

INFECTIOUS DISEASE BEHAVIORAL SCREEN

The Infectious Disease Behavioral Screen can be self-administered or used in a face-to-face interview. The questions identify behaviors that may place clients/patients at risk for HIV and hepatitis B and C exposure. A scoring instrument for the screen tallies numeric values of client/patient responses and indicates appropriate clinical responses.

Because of the sensitive nature of the information being collected and the possibility of clients/patients perceptions of personal intrusion, it is recommended that the Screen be administered after some rapport and trust has been established, preferably following HIV and hepatitis education. If self-administered, a counselor or other person knowledgeable about the Screen should be available to assist with any client/patient questions or concerns.

INFECTIOUS DISEASE BEHAVIORAL SCREEN

Name _____ Date _____

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

I have read and understand the above. Signature: _____

PLEASE MARK THE ONE MOST ACCURATE RESPONSE TO EACH QUESTION.

1. Have you had 2 or more sexual partners in the past 10 years?:
 Yes No
2. Have you had anal sex (penis in anus) with any of your sexual partners during the past 10 years?:
 Yes No
3. How often have you used a condom when having anal sex in the past 10 years?
 Never Sometimes Always Have not had anal sex
4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?:
 Yes No
5. In the last 10 years, have you ever given money or drugs to anyone to have sex with you?:
 Yes No
6. Have you ever had sex with someone so that they would give you money or drugs?:
 Yes No
7. Have you ever injected street drugs, steroids, or vitamins with a needle?:
 Yes No
8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?:
 Yes No Don't know
9. Have any of your sexual partners in the past 10 years been men who have had sex with other men?
 Yes No Don't know
10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease such as gonorrhea, syphilis, Chlamydia, genital warts (HPV), genital herpes, or hepatitis?:
 Yes No Don't know

INFECTIOUS DISEASE MEDICAL SCREEN

Name: _____ Date _____

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

I have read and understand the above. Signature: _____

1. Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)?: Yes No
2. Have you ever been or are you now on long-term hemodialysis (blood cleansing)?: Yes No
3. Are you a recipient of clotting factor made prior to 1987?: Yes No
4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C-infected blood?: Yes No
5. Were you born to a mother who had hepatitis?: Yes No
6. Have you ever had symptoms of liver disease or abnormal liver function/enzyme tests?: Yes No
7. Have any of your sexual partners been infected with hepatitis B or C?: Yes No
8. Have you been the recipient of tattooing or piercing in unsanitary conditions (unsterile needles)?: Yes No
9. Mark all of the following that currently apply to you or that applied to you in the past.
 - Close contact with active TB
 - Medical condition that increases risk of TB disease (HIV, immune disorders, diabetes, silicosis, black lung or coal miners disease, bleeding/clotting disorders, specific malignancies, kidney failure, etc.)
 - Abnormal chest x-ray showing fibrotic lesions
 - Resident or employee of a high risk group setting (e.g., correctional facilities, nursing homes, mental institutions, homeless shelters, residential treatment, etc.)
 - Health care worker or volunteer who serves high-risk clients
 - Foreign-born person who has arrived within the last five years from countries that have a high TB incidence or prevalence (e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia)
 - Person from a medically underserved, low-income population
 - Member of a high-risk racial, ethnic, or other minority population with an increased prevalence of TB (Asian and Pacific Islanders, Hispanics, African-Americans, Native Americans, migrants, homeless)
 - History of inadequately treated TB
10. Have you had a cough for more than three weeks?: Yes No
11. Have you coughed up blood/colored mucous?: Yes No
12. Do you have swollen, non-tender lymph nodes?: Yes No
13. Have you had a prolonged loss of appetite or unexplained weight loss of ten pounds or more?: Yes No
14. Have you had recurrent fevers or heavy night sweats for more than three weeks?: Yes No

Response Guide:

- * If you answered "yes" to any question # 1-7, please see your counselor for a referral to be screened for hepatitis B and C.
- * If you answered "yes" to question # 8, please see your counselor for a referral for infectious disease screening and testing.
- * If you answered "yes" to any of the categories in question # 9, please see your counselor for a referral to be screened for TB.
- * If you answered "yes" to any question # 10-14, please see your counselor immediately for a referral TB screen and treatment

Please Complete This State Required Questionnaire (DACODS)

Gender: Male Female, Are you pregnant? No Yes, please complete page 4 Questionnaire

Sexual orientation:

- Heterosexual (having attraction to opposite sex, straight) Other (pansexual, attraction to all genders; or asexual, uns
 Homosexual (having attraction to same sex) Declined (choose not to answer)
 Bisexual (having attraction to either sex)

Previous Detox episodes: Number of times _____ (example: 0, 1, 5, 8)

Previous counseling for substance abuse: Number of times _____ (example: 0, 1, 5, 8)

Primary Race:

- White
 Black
 Native Alaskan/American
 Asian
 Hawaiian
 Declined

Hispanic Ethnicity:

- Hispanic/Mexican
 Hispanic/Puerto Rican
 Hispanic/Cuban
 Other Hispanic
 Not Hispanic
 Declined

Marital Status: Never Married Married Widowed Separated Divorced

Monthly Income: _____ Number of persons living on your income: _____

Number of children legally dependent on you _____ Are you a military veteran? Yes No

Living Situation:

- Correctional facility/Jail Foster home (Youth)
 ATU, Adults only Residential Treatment/Group (Youth)
 Inpatient Boarding home (Adult)
 Group home (Adult) Nursing home
 Residential facility (MH Adult) Residential facility (other)
 Sober living Homeless
 Supported housing Assisted living
 Independent living Halfway house

Highest education level: _____ (CLIENT UNDER 18: Have you attended school in the last 3 months?: Yes No)
(GED=12, AA=14, BA=16, MA=18, etc.)

Disability:

- None Cerebral Palsy
 Mental retardation Seizure disorder/Epilepsy
 Non-ambulatory Autism
 Brain Injury Other neurological
 Psychiatric Development delay
 Downs Syndrome Significant hearing impairment/Deaf
 Attention Deficit Disorder Significant speech impairment/Non-Verbal
 Other Significant vision impairment/Blind

Current employment:

- Employed full time (35+ hours per week) Student Homemaker
 Employed part time (less than 35 hours per week) Retired Military
 Unemployed Disabled Volunteer
 Supported employment (help getting back into workforce) Inmate

Primary Source of income/support:

- Wages Retirement/Pension Other
 Public Assistance Disability None

Primary Source of Payment:

- Active duty military/Dept Gov. Health Plan Blue Cross/Blue Shield Colorado ATR
 Medicaid Medicare MSO Funds
 Other Self Pay Worker's Compensation
 Other Health Insurance Other Gov. payments

Health Insurance (regardless of payment source): I AM insured I am NOT insured
If insured, does insurance cover substance abuse treatment? Yes No

Females Only IF You Are Currently Pregnant

Are You Currently Pregnant?: Yes No Do Not Fill Out This Page

Your age today:

- 34 to 45
- 21 to 33
- 15 to 20

Age of first use:

- 34 to 45
- 21 to 33
- 15 to 20 Under 15 years

Pregnancy Status:

- First trimester
- Second trimester
- Third trimester

Prenatal Care Status:

- Already receiving prenatal care routinely
- Already receiving prenatal care, but not consistently
- Not receiving prenatal care, but willing to access
- Not receiving prenatal care

Put a 1 for Primary Drug of Choice, a 2 for Secondary, and 3 for Tertiary Drug of Choice (when you were using):

<input type="checkbox"/> Nicotine	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Marijuana/Cannabis	<input type="checkbox"/> Cocaine
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Heroin	<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Ketamine
<input type="checkbox"/> Amphetamine	<input type="checkbox"/> LSD	<input type="checkbox"/> Clonazepam	<input type="checkbox"/> Pain Pills
<input type="checkbox"/> Barbiturate	<input type="checkbox"/> Opiates	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Inhalants
<input type="checkbox"/> Sedatives	<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Flunitrazepam	<input type="checkbox"/> Gamma-Hydroxybutyrate
<input type="checkbox"/> PCP	<input type="checkbox"/> Other stimulant	<input type="checkbox"/> Anabolic steroids	<input type="checkbox"/> Over the counter drug

Frequency of use:

- Monthly
- Weekly, three to five times
- Daily
- Three or more times a day

Do you have access to other drug treatment?:

- Have access to other drug treatment
- Have limited or no access to other drug treatment

Family support:

- Strong
- Moderate
- Minimal or none

Family history:

- No family history of substance abuse
- Recovering family member(s)
- Family history of substance use or current use

Drug using partner:

- No
- Yes, partner interested or enrolled in treatment
- Yes, partner not interested in treatment

HIV risk:

- No history of high risk behaviors
- Occupational exposure to HIV risk
- Blood transfusion prior to 1985
- Sex with IV drug user/multiple partners/prostitution

Home environment:

- Stable, drug free home with support
- Lives alone/with children in stable housing
- No stable residence for past year
- Homeless or living with drug user

Legal status:

- Not on parole or probation
- Charges pending
- Currently on parole or probation

Personal safety:

- No incidents of emotional, verbal, or physical abuse between the beginning of the pregnancy and now
- One to two incidents of emotional, verbal, or physical abuse between the beginning of the pregnancy & now
- Multiple incidents of emotional, verbal, or physical abuse between the beginning of the pregnancy & now

Employment/Education:

- Secure employment: homemaker with income, student or job training program.
- Employed, but moderate disruptions; unemployed but income.
- Unemployed due to disruptions/employed but major disruptions/virtually unemployed now

Prior criminal record:

- No prior felony or misdemeanor conviction
- One felony or misdemeanor conviction
- Two or more felony or misdemeanor convictions

Prior alcohol/drug education or treatment:

- No prior alcohol/drug education or treatment
- One education or treatment experience
- Two or more treatment experiences

Emotional stability:

- No symptoms, no apparent impairment
- Some symptoms with mild/moderate impairment
- Symptoms with severe impairment

Family status:

- First pregnancy, no other children
- One child living at home under age six
- Two or more children living at home under age six
- Children living outside of home
- Three or more children living at home

Attitude:

- Highly motivated; receptive to assistance
- Moderate motivation to change
- Not motivated

Hopefulness:

- Ability to envision a positive future
- Ability to believe there is hope for the future for self and infant
- Not able to envision a future or vision is negative

Self-esteem:

- High
- Moderate
- None or low

Any additional mental health problems? Yes _____ No _____

Have you (now or ever) experienced or witnessed a traumatic event? Yes _____ No _____

Referral or Transfer Source:

- Alcohol /Drug Abuse Care Provider
- Drug Court
- Employer
- Involuntary Commit
- Other healthcare provider (medical, mental)
- Social/Human Services
- Non DUI Criminal Justice (Probation, Parole, SB94, Community Corrections)
- Crisis System
- DUI/DWAI/DWI Criminal Justice
- Individual (self, family, friend)
- Other Community Referral
- School (educational)
- STIRRT Residential Continuing Care

Family Issues and Problems:

- None (issues are temporary and relationships are generally positive)
- Slight (some issues present, occasional friction or discord)
- Moderate (frequent disruptions or turbulence in family functioning)
- Severe (extensive disruption of family functioning)

Socialization Problems:

- None (able to form good relationships with others)
- Slight (difficulty developing or maintaining relationships)
- Moderate (inadequate social skills resulting in tenuous and strained relationships)
- Severe (unable to form relationships)

Education/Employment Problems

- None (comfortable and competent in school or work)
- Slight (occasional or mild disruption of performance at school or work)
- Moderate (occasional major or frequent minor disruptions)
- Severe (serious incapacity; absent motivation and ineffective functioning)

Medical/Physical Problems

- None (no physical problems or well-controlled chronic conditions)
- Slight (occasional or mild problems that interfere with daily living)
- Moderate (frequent or chronic health problems)
- Severe (incapacitated due to medical/physical problems)

	Primary Drug	Secondary	Tertiary
Drug of choice	_____	_____	_____
Age of 1 st Use	_____	_____	_____
Use in 30 days	_____	_____	_____
How it was used	_____	_____	_____
Clinicians Dx Impression	_____	_____	_____
(Use, abuse, dependence or unknown)			

In the six (6) months prior to admission how many times did you:

Visit an emergency room? _____ Admitted to a hospital _____ Psychiatric ER _____ Psychiatric hosp _____

Number of DUI arrests in the last 30 days _____ Number of all other arrests in last 30 days _____

Have you attended any self help meeting in the last 30 days? _____ If yes how many _____

Do you currently use a tobacco product?

Former smoker/tobacco user _____ Current smoker (daily) _____ periodically _____ Never _____

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Addiction Severity Index (ASI) - Self-Report Format

What are you seeking help for? _____

How long has this been a problem for you? _____

How has it affected you most? _____

Strengths and Resources

What strengths do you bring to assist with solving this problem? _____

List your strengths and resources: _____

History of Mental Illness/Treatment (Do not include substance abuse, employment or family counseling)

How many times have you been treated for any psychological or emotional problems:

In a Hospital or inpatient setting? _____ When? _____ Where? _____

With Whom? _____ What for? _____

In an Outpatient setting? _____ When? _____ Where? _____

With Whom? _____ What for? _____

Do you receive a pension for a psychiatric disability? Yes No

Have you had a significant period of time (not a direct result of alcohol/drug use) during which you have:

	<u>In the past 30 days?</u>	<u>In your lifetime?</u>
Experienced serious depression, sadness, hopelessness, loss of interest, or difficulty with daily functioning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Experienced serious anxiety/tension/uptightness, unreasonable worry, or inability to feel relaxed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--

Experienced hallucinations-saw things or heard voices that were not there?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--

	<u>In the past 30 days?</u>	<u>In your lifetime?</u>
Experienced trouble understanding, concentrating, or remembering?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Experienced trouble controlling violent behavior, or episodes of rage or violence, including when you have been under the influence of alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--

Experienced serious thoughts of suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--

Attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------	--	--

Been prescribed medication for any psychological or emotional problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	--

How many days in the past 30 have you experienced these psychological or emotional problems? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?	0	1	2	3	4

How important to you now is treatment for these psychological or emotional problems?	0	1	2	3	4
--	---	---	---	---	---

Health Related Issues/Medical Information (use additional pages if necessary)

How many times in your life have you been hospitalized for medical problems? _____

Hospitalizations and dates _____

Surgeries and dates _____

How long ago was your last hospitalization for a physical problem? _____

Do you have any chronic medical problems which continue to interfere with your life? Yes No

If yes, please describe _____

What treatment, if any, have you received for this problem? _____

Do you have any current medical problems? Yes No

If yes, please describe _____

What treatment, if any, have you received for this problem? _____

Are you taking any prescribed medication on a regular basis for a physical problem? Yes No

Please list all medications you are taking, the doses, and what you take them for: _____

Please list all allergies or adverse drug reactions you have: _____

Do you receive a pension for a physical disability? Yes No

How many days have you experienced medical problems in the past 30 days? _____

When was your last physical exam (including pap smear if you are female)? _____

What were the results/recommendations? _____

Please indicate if you have had any of the following symptoms:

<u>Symptoms</u>	Never had	Have now	Had in Past	<u>Symptoms</u>	Never had	Have now	Had in Past
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	See or hear things that weren't there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling as though your heart were racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems, glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight loss or gain (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent/painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/bowel disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough/lung disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in memory or concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male or female reproductive problems (i.e. change in menstrual pattern, prostate trouble)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Jaundice/liver disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Arthritis/gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Constant irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

*List any other diseases or conditions you have had or have now that are not listed above a separate piece of paper.

**If you have ever had any of the symptoms listed above, please provide as much of the following information as possible on a separate piece of paper: date of occurrence, duration of illness, symptoms, whether or not treatment was sought, treatment received, results of treatment, and physician's name. If you did not seek treatment, what was the outcome?

	Not at all	Slightly	Moderately	Considerably	Extremely
How troubled or bothered have you been by medical problems in the past 30 days?	0	1	2	3	4
How important to you now is treatment for medical problems?	0	1	2	3	4

Please indicate your family's medical history:

Names	Ages	Mental Health Diagnosis	Alcohol/Drug Use	Medical Problems	Cause & Year of Death (if applicable)
Name of your Biological Father:					
Name of your Biological Mother:					
Names of your Brothers and Sisters:					

This Section for Females Only

Have you ever had any of the following health problems? (Check those that apply)

Hepatitis Chlamydia Syphilis
 Tuberculosis Genital Herpes Venereal Warts
 Gonorrhea
 Pelvic Inflammatory Disease

How many times have you been pregnant? _____

How many times have you actually given birth? _____

How old were you when your first baby was born? _____

Are you currently pregnant? Yes No If yes, how far along are you? _____

Have you ever experienced medical complications in childbirth? Yes No

If yes, please describe: _____

Psychosocial History (use a separate page if necessary)

Family/Social Relationships:

When were you born? _____ Where? _____

Were you raised by both parents? Yes No If not, who did you live with? _____

Please describe your childhood: _____

Please describe how you were disciplined as a child: _____

What is your current marital status? Married Remarried Widowed Separated
 Never Married Common-law marriage Divorced

How long have you been in this marital status? _____ How many times have you been married? _____

Are you satisfied with this situation? Yes No Indifferent

Please give your ages and the names of the individuals you have been married to:

From what age to what age?	Partner's name

Please provide the following information on your biological children:

Child's Name	Age	Where living?	Name of other parent

Please list any other children who are living with you:

Child's Name	Age	Names of biological parents

What have been your usual living arrangements over the past three years?
 With sexual partner and children With sexual partner alone With children alone
 With parents With family With friends
 Alone Controlled environment (jail, etc.) No stable arrangement

How long have you lived in these arrangements? _____

Are you satisfied with these arrangements? Yes No Indifferent

Do you live with anyone who: has a current alcohol problem? Yes No
uses non-prescribed drugs? Yes No

With whom do you spend most of your free time? Family Friends Alone

Are you satisfied with spending your free time this way? Yes No Indifferent

About how many close friends do you have? _____

Would you say you have had a close reciprocal (back and forth) relationship with any of the following people?
Your mother Yes No Uncertain Sexual partner/Spouse Yes No Uncertain
Your father Yes No Uncertain Children Yes No Uncertain
Siblings Yes No Uncertain Friends Yes No Uncertain

Psychosocial History (use a separate page if necessary)

Family/Social Relationships:

When were you born? _____ Where? _____

Were you raised by both parents? Yes No If not, who did you live with? _____

Please describe your childhood: _____

Please describe how you were disciplined as a child: _____

What is your current marital status? Married Remarried Widowed Separated
 Never Married Common-law marriage Divorced

How long have you been in this marital status? _____ How many times have you been married? _____

Are you satisfied with this situation? Yes No Indifferent

Please give your ages and the names of the individuals you have been married to:

From what age to what age?	Partner's name

Please provide the following information on your **biological** children:

Child's Name	Age	Where living?	Name of other parent

Please list any other children who are living with you:

Child's Name	Age	Names of biological parents

What have been your usual living arrangements over the past three years?

- With sexual partner and children
- With sexual partner alone
- With children alone
- With parents
- With family
- With friends
- Alone
- Controlled environment (jail, etc.)
- No stable arrangement

How long have you lived in these arrangements? _____

Are you satisfied with these arrangements? Yes No Indifferent

Do you live with anyone who: has a current alcohol problem? Yes No
uses non-prescribed drugs? Yes No

With whom do you spend most of your free time? Family Friends Alone

Are you satisfied with spending your free time this way? Yes No Indifferent

About how many close friends do you have? _____

Would you say you have had a close reciprocal (back and forth) relationship with any of the following people?

- Your mother Yes No Uncertain
- Your father Yes No Uncertain
- Siblings Yes No Uncertain
- Sexual partner/Spouse Yes No Uncertain
- Children Yes No Uncertain
- Friends Yes No Uncertain

Have you had significant periods in which you have experienced serious problems getting along with:

	<u>In the past 30 days</u>	<u>In your lifetime</u>		<u>In the past 30 days</u>	<u>In your lifetime</u>
Your mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual partner/Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your father	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other family members		
Siblings	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	(specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neighbors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Close friends	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Co-workers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been abused physically? emotionally? sexually?

How many days in the last 30 have you had serious conflicts: with your family _____
with other people (excluding your family) _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How troubled or bothered have you been in the past 30 days by family problems?	0	1	2	3	4
by social problems?	0	1	2	3	4
How important to you now is treatment or counseling for family problems?	0	1	2	3	4
for social problems?	0	1	2	3	4

Employment:

How many years of education have you completed? _____ (GED = 12 years)

How many years of job training or technical education have you received? _____

Do you have a profession, trade or skill? Yes No, If so, please specify _____

How long was your longest full-time job? _____

What is your usual, or last occupation? Professional/ large business owner Manager/small business owner
 Clerical/sales/direct service (Technician, Bookkeeper, etc.) Semi-skilled (Hospital Aide, Waiter, etc.)
 Skilled manual(Construction, Electrician, etc.) Student, disabled or no occupation
 Unskilled or unemployed (Janitor, attendant, etc.) Homemaker Other (Please specify _____)

Does someone contribute to your support in any way? Yes No

If so, does this constitute the majority of your support? Yes No

What has been your usual employment pattern the past three years?

- Full time (35 + hours)
- Student
- Military Service
- Unemployed
- Part time (regular hours)
- Part time (irregular hours)
- Retired/disability
- In controlled environment

How many days were you paid for working in the past 30 days? _____

How much money did you receive from the following sources in the past 30 days?

Employment \$ _____
 Unemployment compensation \$ _____
 Welfare, disability benefits \$ _____
 Pensions, Social Security \$ _____
 Mate, family or friends \$ _____
 Illegal sources \$ _____

How many people depend on you for the majority of their food, shelter, etc.? _____

How many days have you experienced employment problems in the past 30 days? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How troubled or bothered have you been by employment problems in the past 30 days?	0	1	2	3	4
How important is counseling for employment problems?	0	1	2	3	4

Do you have a valid driver's license? Yes No

Do you have an automobile available? Yes No

Please indicate your history of drug and alcohol use.

Substance	How old were you when you first used it?	When was your last use?	Over the last year, how often have you used the substance? (i.e. every day, once a week, etc.)	Over the last year, what is the normal amount you use in a 24 hr. period of time?	What is the most you have ever used in a 24 hr. period of time?	How have you used it?
NICOTINE Cigarettes, Cigars, Chew						<input type="checkbox"/> Smoke <input type="checkbox"/> Oral
ALCOHOL Beer, Wine						<input type="checkbox"/> Oral
ALCOHOL Hard liquor						<input type="checkbox"/> Oral
CANNABIS Marijuana, Hash, Oils						<input type="checkbox"/> Smoke <input type="checkbox"/> Oral
COCAINE Rock, Crack, Powder						<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Snort
METHAMPHETAMINE Crystal Meth, Crank, Ice						<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Snort
AMPHETAMINE Speed, Diet pills, White crosses						<input type="checkbox"/> Oral
HALLUCINOGENS LSD, Acid, Mushrooms, Peyote						<input type="checkbox"/> Eye Drops <input type="checkbox"/> Oral <input type="checkbox"/> Smoke
OPiates Morphine, Heroin, Opium, Methadone						<input type="checkbox"/> Inject <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
PAIN PILLS Demerol, Darvon, Percocet, Percodan, Tylenol with Codein						<input type="checkbox"/> Inject <input type="checkbox"/> Oral
SEDATIVES Downers, Reds, Yellows, Quaaludes, 7						<input type="checkbox"/> Oral
TRANQUILIZERS Valium, Xanax, Ativan						<input type="checkbox"/> Inject <input type="checkbox"/> Oral
INHALANTS Gas, Glue, Solvent, Paint, Poppers, Rite						<input type="checkbox"/> Inhale
PCP Angel Dust						
OTHER (please list)						
OTHER (please list)						
OTHER (please list)						

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Which substance do you see as the major problem for you? _____
 How long was your last period of voluntary abstinence from this major substance? _____
 How many months ago did this abstinence end? _____
 Have you ever experienced withdrawal symptoms several hours to several days after stopping or reducing your drug or alcohol use? Yes No

If yes, please indicate the symptoms you have experienced:

- Tremors, shakiness
- Nausea, vomiting or diarrhea
- Increased heart rate or blood pressure
- Little or no energy
- Significant weight loss or weight gain
- Sleep problems (too much or too little)
- Anxiety, depression or irritability
- Sweating
- Significant increase or decrease in appetite
- Seeing or feeling things that aren't there
- Achy joints or muscles
- Poor concentration
- Runny nose or eyes
- Headaches
- High Fever

Have you ever "blacked out" or lost periods of time when you were using drugs and/or alcohol? Yes No
 Have you noticed that throughout your use history you have needed to use more and more drugs and/or alcohol to get drunk or high? Yes No
 Have you ever received complaints from your family, friends, employer or others around you concerning your drug and/or alcohol use, or concerning your behavior while using? Yes No

How many times in your life have you been treated for Alcohol abuse? _____ Drug abuse? _____
 How many of these were Detox only? _____ Alcohol abuse? _____ Drug abuse? _____

How much money would you say you spent during the last 30 days on Alcohol? _____ Drugs? _____
 How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? _____
 How many days have you been treated as an inpatient for alcohol or drugs in the past 30 days? _____
 How many days in the past 30 have you experienced Alcohol problems? _____ Drug problems? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How troubled or bothered have you been in the past 30 days by Alcohol Problems?	0	1	2	3	4
Drug Problems?	0	1	2	3	4
How important to you now is treatment for Alcohol Problems?	0	1	2	3	4
Drug Problems?	0	1	2	3	4

Legal:

How many times in your life have you been arrested and charged with the following:

Shoplifting/vandalism _____	Burglary/larceny/ breaking and entering _____	Rape _____
Parole/probation violation _____	Robbery _____	Homicide/manslaughter _____
Drug charges _____	Assault _____	Prostitution _____
Forgery _____	Arson _____	Contempt of court _____
Weapons offense _____		Other (please specify) _____

How many of these charges resulted in convictions? _____
 How many times in your life have you been charged with the following?
 Disorderly conduct, vagrancy or public intoxication _____ Major driving violations _____ Driving while intoxicated _____

What has been your highest measured Blood Alcohol Level? _____
 How many months were you incarcerated in your life? _____
 (check here if not applicable)
 How long was your last incarceration? _____ What was it for? _____
 How many days in the past 30 were you detained or incarcerated? _____
 How many days in the past 30 have you engaged in illegal activities for profit? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How serious do you feel your present legal problems are?	0	1	2	3	4
How important to you now is counseling or referral for these legal problems?	0	1	2	3	4

Client STOP! Counselor Use Only

Adult ASAM Admission Criteria INSTRUCTIONS for Counselors: Review each Criteria Dimension and check the box of the Level of Service descriptor which most accurately represents the current status of the person being evaluated. Indicate the recommended level of care on the back of this document according to the level with the most boxes checked. If ASAM recommended level of care is different from actual level of care, provide clinical assessment and justification.

Criteria Dimensions	Levels of Service							
	Early Intervention Level .5	Outpatient Services Level 1	Intensive Outpatient Level II.1	Detox Services Level III	Halfway House Level III.1	Therapeutic Community Level III.5	Residential Treatment Level III.7	Opoid Maintenance Therapy
Dimension 1 Intoxication and/or Withdrawal Potential	No Withdrawal Risk <input type="checkbox"/>	Minimal Risk of Severe Withdrawal <input type="checkbox"/>	Minimal Risk of Severe Withdrawal <input type="checkbox"/>	Is Intoxicated or Experiencing Withdrawal, or is at Risk for Developing Moderate to Severe Withdrawal <input type="checkbox"/>	Minimal Risk of Severe Withdrawal <input type="checkbox"/>	Minimal Risk of Severe Withdrawal <input type="checkbox"/>	Moderate but not Severe Risk of Withdrawal <input type="checkbox"/>	Physiologically Dependent on Opiates and Requires Maint to Prevent Serious Withdrawal <input type="checkbox"/>
Dimension 2 Biomedical Conds & Complications	None or Very Stable <input type="checkbox"/>	None or Stable <input type="checkbox"/>	None or Stable Enough Not to Be a Distraction in Treatment <input type="checkbox"/>	None or Stable and Person is Receiving Concurrent Medical Monitoring <input type="checkbox"/>	Person is Capable of Managing the Symptoms His/Herself <input type="checkbox"/>	None or Stable and Person is Receiving Con-current Medical Monitoring <input type="checkbox"/>	Person Requires Medical Monitoring, but not Intensive Treatment <input type="checkbox"/>	None or Manageable with Outpatient Medical Monitoring <input type="checkbox"/>
Dimension 3 Emotional/ Behavioral Conditions and Complications	None or Very Stable <input type="checkbox"/>	None or Stable <input type="checkbox"/>	None or Mild Severity, with Potential to Distract from Recovery, Person Needs Monitoring <input type="checkbox"/>	None or Minimal, Not Distracting to Recovery <input type="checkbox"/>	None or Minimal, Not Distracting to Recovery <input type="checkbox"/>	Repeated Inability to Control Impulses, Personality Disorder Requires High Structure to Shape Behavior <input type="checkbox"/>	Moderate Severity, Person Needs a 24-Hour Structured Setting <input type="checkbox"/>	None, or Manageable in Outpatient Structured Environment <input type="checkbox"/>
Dimension 4 Treatment Acceptance/ Resistance	Willing to Look at How Current Use May Effect Personal Goals <input type="checkbox"/>	Willing to Cooperate but Needs Motivating and Monitoring Strategies <input type="checkbox"/>	Resistance High Enough to Require Structured Program but not so High as to Render Outpatient Treatment Ineffective <input type="checkbox"/>	Resistance High but Person in Need of Detox <input type="checkbox"/>	Open to Recovery, but needs Structured Environment to Maintain Therapeutic Gains <input type="checkbox"/>	Marked Difficulty with, or Opposition to Treatment, with Dangerous Consequences if not Engaged in Treatment <input type="checkbox"/>	Resistance High and Impulse Control Poor, Despite Negative Consequences, Person Needs Motivating Strategies Available Only in 24-Hour Structured Settings <input type="checkbox"/>	Resistance High Enough to Require Structured Therapy to Promote Treatment Progress but will not Render Outpatient Treatment Ineffective <input type="checkbox"/>

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Dimension 5 Relapse/ Continued Use Potential	Needs Understanding Of, or Skills to Change, Current Use Patterns <input type="checkbox"/>	Able to Maintain Abstinence or Control Use and Pursue Recovery Goals with Minimal Support <input type="checkbox"/>	Intensification of Addiction Symptoms and High Likelihood of Relapse or Continued Use Without Close Monitoring and Support <input type="checkbox"/>	Little Awareness, Unable to Control Use with Dangerous Consequences, Needs Medium Intensity of Services to Prevent Continued Use <input type="checkbox"/>	Understands Addiction, but is at Risk of Relapse in a Less Structured Level of Care Due to Inability to Apply Recovery Skills, at High Risk Without 24-hour Structured Support <input type="checkbox"/>	No Recognition of Skills Needed to Prevent Continued Use, with Dangerous Consequences <input type="checkbox"/>	Unable to Control Use, with Dangerous Consequences, Despite Active Participation in less Intensive Care <input type="checkbox"/>	High Risk of Relapse or Continued Use Without Maintenance and Structured Therapy to Promote Treatment Progress <input type="checkbox"/>
Dimension 6 Recovery Environment	Social Support System or Significant Others Increase Possibility of Personal Conflict about Substance Use <input type="checkbox"/>	Supportive Recovery Environment and/or Person Has the Skills to Cope <input type="checkbox"/>	Environment Unsupportive, but with Structure and Support, the Person Can Cope <input type="checkbox"/>	Environment is Dangerous, Person Needs 24-hour Structure to Learn to Cope <input type="checkbox"/>	Environment Dangerous, or Environment Heavily Invested in Drug Use, or Person is Socially Isolated <input type="checkbox"/>	Environment is Dangerous, Person Lacks Skills to Cope Outside of a Highly Structured 24-hour Setting <input type="checkbox"/>	Environment is Dangerous for Recovery, Person Lacks Skills to Cope Outside of Highly Structured 24-hour Setting <input type="checkbox"/>	Supportive Recovery Environment And/or Person Has Skills to Cope with Outpatient Treatment <input type="checkbox"/>

Recommended ASAM Level of Care: See admission summary.

Early Intervention Level .5
 Outpatient Services Level 1
 Intensive Outpatient Level II.1
 Detox Services Level III
 Halfway House Level III.1
 Therapeutic Community Level III.5
 Residential Treatment Level III.7
 Opioid Maintenance Therapy

Therapist Signature and Title

Date

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