Alpine Springs Counseling, PC

www.alpinespringscounseling.com
(970) 945-7858

Intake & Assessment
DUI & Substance Use Disorder Programs

Client Name:_____ **Today's Date**: _____
PLEASE PRINT LEGIBLY

Location: Avon ♦ Breckenridge ♦ Buena Vista ♦ Carbondale ♦ Dillon ♦ Eagle ♦El Jebel
Glenwood Springs♦ Idaho Springs ♦ Kremmling ♦ Leadville♦ Rifle ♦Salida ♦Vail
CIRCLE ONE / CIRCULO

Type: DUI L1 ED ♦ DUI L2 ED &/or TX ♦ Rise/Recovery Court ♦ DUI L2 4+ ♦ ATC ♦ SSC
Seeking Safety ♦ Individuals ♦ MIPS ♦ RPG
CIRCLE ONE / CIRCULO

CLIENT INFORMATION

Birth Date:_____ **Age**:_____

Social Security #:_____

Home/Cell: _____

Cell Carrier: ☐**AT&T** ☐**Boost** ☐**Cricket** ☐**Straight Talk**

☐**T-Mobile** ☐**Tracfone** ☐**Verizon** ☐**Other:** _____

E-mail: _____
Alpine will send you text messages and/or emails regarding groups and balances. ***OK to leave a message*** ☐**Yes** ☐**No**

Mailing Address:_____

City:_____ **Zip**:_____

Physical Address:_____

City:_____ **Zip**:_____

County: _____

Employer:_____

Employer phone #:_____

Names & Ages of Children

Name:_____ **Age**:_____

Name:_____ **Age**:_____

Name:_____ **Age**:_____

Name:_____ **Age**:_____

If Client is Under Age 18

Mother's Name:_____

Home #:_____ **Work #**:_____

Father's Name:_____

Home #:_____

Work #:_____

CASE RELATED INFORMATION

Have You Been Sentenced?: ☐ Yes ☐ No

Are on unsupervised probation?: ☐ Yes ☐ No

Probation Officer: _____

Case Number:_____

County Charged In: _____

Year Arrested/Got DUI:_____

BAC at time of Arrest:_____ **Refused:** Y N (circle one)

Prior DUI's:_____

If you have a DUI, what were you sentenced to?:

Education Hours Required:_____

Therapy Track/Hours Required:_____

Have you previously attended our agency?: ☐Yes ☐No

When?:_____

Why?:_____

Have you attended with another agency?: ☐ Yes ☐ No

Name of Agency:_____

Education Hours Completed at Previous Agency:_____

Therapy Hours Completed at Previous Agency:_____

Spanish Speaking?: ☐ Yes ☐ No ☐ Bilingual

Emergency Contact:_____

Relation to Contact:_____

Contact Number:_____

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Disclosure Statement

ASC is a substance use treatment program licensed by the Office of Behavioral Health (OBH), CO Department of Human Services. The counseling staff & their qualifications are as follows:

Mary Anne Avery, MA, LPC, CAC III / ATP: MA Counseling, 2014, Adams State Univ. BA Psychology, 2009, University of Colorado, Boulder LPC #13209 CAC III #20794 DVOMB Full Operating Adult Treatment Provider SOMB Full Operating Adult Treatment Provider, Associate Evaluator	**Andrea Brown, MS, CAC II, NCAC I** MS Criminology/Forensic Psychology, 2017 Regis University, Denver BS Sociology/Criminology, 2015 Colorado State University CAC II #08064 NCAC I #150877	**Kelly Norris, LPC** MA Forensic Psychology, 2013 Univ. of Denver BA Social Sciences (Psychology), 2009 University of Southern California LPC # 14493
Carlos F. Abel, CAC II / ATP: CAC II #07438 DORA Registered Psychotherapist	**Narda Reigel, CAC II / ATP**: CAC III #08019 DORA Registered Psychotherapist	**Jeudiel Giordano** CAC In Training DORA Registerd Psychotherapist 0109331
Wendy Caldwell, MA, CAC II / ATP: MA Education, 1993 University of Northern Colorado BA Education, 1986 Arizona State University CAC II #07858 DORA Registered Psychotherapist	**Deb Papp, MSW, LCSW, LAC**: MSW Social Work,2008 Colorado State University BS Sec. Edu. License - Psych & Bio., 1979 Northwest Missouri St University, MO LCSW #9923029 LAC #00289	**Lisa Ansell, MA, LPC, NCC, CBIS** MA, Professional Counseling, Liberty University, Lynchburg, VA BS Psychology, Colorado Christian University, Lakewood, CO LPC #0014645
Jim Coddington III, MSW, CTRTC / ATP: MSW Social Work, 2004 Highlands University Las Vegas, NM BA Social Work, 2003 Highlands University Las Vegas, NM NLC # 106513 DORA Registered Psychotherapist	**Shawna Fishman, MFT, CAC II** MA Counseling Pyschology, 1990 Pepperdine University, CA BA Pyschology, 1988 California State University, CA MFT #01280 CAC In Training	**Sandy Eriksen, LCSW:** MSW Social Work, Newman Univ., 2007 BS Social Work, 2006, Metro State, Denver LCSW # 00001394 DVOMB Full Operating Adult Treatment Provider
Jim Easton, MA, LPC, CAC III / ATP: MA Counseling Psychology 1996 University of Colorado, Denver BA Sociology, 1978 Year Location University of Vermont CAC III # 03046 DVOMB Full Operating Adult Treatment Provider	**Robert Stark, Ph.D., CAC III / ATP**: Ph.D. Psychology, 1989 Colorado State University MA Wildlife Biology, 1979 Colorado State University CAC III #06028 DVOMB Full Operating Adult Treatment Prov.	**Beryimar Perozo, CAC III** MA Educational Leadership, Concordia Univ., 2014 BS Alcohol and Drug Counseling, Metro State MN, 2011 CAC III # 0020891 DORA Registered Psychotherapist 0107970
Michelle Marzo, LPC, LAC: MA Counseling Psych. & Couns. Edu., 2007 University of Colorado, Denver BA French, 1993 Illinois State University LPC #5165 LAC #255	**N. Janeil Sowards LPC, CAC III / ATP**: MA Counseling, 2014 Adams State University BA Psychology, 2009 University of Colorado, Boulder LPC #03162 CAC III #06094 DVOMB Full Operating Adult Treatment Prov.	**Colleen Watson,** MA Clinical Mental Health Counseling Adams State, expected May 2020 BA Criminology, Univ. New Mexico, 2009 CAC In Training DORA Registered Psychotherapist 0109809
Pattie Krueger: CAC # In Training DORA Registered Psychotherapist	**Kirsten (Kris) Trygg, CAC II, BSP**: BS Psychology, 2000 University of Phoenix CAC II #07853	
Penny S. Grant, CAC II: CAC II #07993 DORA Registered Psychotherapist	**Linda Reider, CAC II / ATP**: CAC II #07544 DORA Registered Psychotherapist	
Candace Eves MS Masters in Psychology and Couns., 2008 University of Sheffield, UK BS Human Development and Family Studies Colorado State Unversity, 2005 CAC III #07125	**Traci Schneider Bovino, LCSW, CAC II** LCSW # 09924963 CAC II # 0008292	

Client Signature: _____ **Date**: _____

Staff Signature: _____ **Date**: _____

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Disclosure Continued

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) 894-7800. The Division of Behavioral Health has the general responsibility for regulating practices of licensed substance use disorder treatment programs in the State of Colorado. Questions and complaints may be directed to: Colorado Department of Human Services, Division of Behavioral Health, 3824 W. Princeton Circle, Denver, CO 80236, (303) 866-7400
2. The regulatory requirements applicable to mental health professionals are as follows:
   - ✓ Registered psychotherapist is a psychotherapist listed in the State's 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 Counselor I (CAC I) must be a high school graduate or the equivalent, complete required training hours and 1000 hours of clinically supervised work experience
   - ✓ Certified Addiction Counselor II (CAC II) must meet the CAC I requirements, complete additional training hours above the CAC I, and 2000 hours of clinically supervised work experience
   - ✓ Certified Addiction Counselor III (CAC III) must have a Bachelor's degree in the behavioral health sciences or field; complete additional training above the CAC II, and 2000 hours of clinically supervised work experience.
   - ✓ Licensed Addiction Counselor must have a clinical Master's degree, meet the CAC III requirements, and pass a national examination in addiction treatment
   - ✓ Licensed Social Worker must hold a Master's 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 Master's degree in their profession and have two years of post-masters supervision
   - ✓ Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision
3. 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 licensee
4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's 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
5. I understand that my alcohol and/or drug treatment records are protected under the Federal Confidentiality Regulation, 42 C.F.R., Part 2, governing Confidentiality of Alcohol and Drug Abuse Patient Records. Confidential information cannot be disclosed without my written permission unless otherwise provided for by the regulations
6. 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 last contact with the client, whichever is later. When the client is a child, the records must be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of 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 as a client or as the client's responsible party. Additionally, your signature below indicates that you have received a copy of the Notice of Privacy Practices pertaining to the HIPPA regulations. Exceptions to confidentiality may also be found in the Notice of Privacy Rights you were provided

Client Name (Please Print)	**Client Signature**	**Date**

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Client's Rights & Responsibilities & Grievance Process

Client's Rights & Responsibilities: ASC 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 within 15 hours, for working towards goals to improve their lives, for maintaining a cooperative relationship with the counselor and other group members, for paying posted fees as agreed to, for keeping information about other clients confidential, and for providing necessary forms that allow ASC to carry through on its responsibilities.

Consent to Treatment: Client consents assessment and treatment as the professional staff of ASC may decide and is aware that care and treatment of substance abuse and mental health problems are not exact sciences. 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 ASC to contact them for the purposes of follow-up studies and agree that my 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 be on time. If you are too late you will not be admitted to group. It is strongly advised that Clients attend every session so that they can complete the programs 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 or who is too intoxicated to participate in group will be allowed to attend the session. If a Counselor believes a Client has used such a 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. Honesty concerning Client's opinions and what is going on in his/her life is essential. Confidentiality will be respected. ASC 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 to ask your therapist the reasons 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 Director and/or Clinical Supervisor and resolved at a maximum of fifteen (15) business days from receipt of complaint to Program Director. If necessary and with your written consent, we will bring in another therapist, possibly one not associated with ASC, to help resolve the problem, there will be no additional cost to you for this therapist's services. Grievances will be maintained separately from the Client's clinical chart and will be reported annually to OBH. If after talking to your therapist, perhaps with an additional mediating therapist, you think that you are not getting the treatment, counseling, or care you need, you can see another therapist. If you want to transfer to a therapist outside of ASC, you have every right to do so, and we will make recommendations to you of other psychotherapists in the area if you wish. You also have the right to lodge 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 Department of Human Services 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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Confidentiality, Attendance & Fee Payments

Attendance and Fee Payment: Clients are expected to pay for services at the time of service.

1. If you are having difficulty paying for treatment, please contact the Billing Department at ext 6 or info@alpinespringscounseling.com to make payment arrangements. We want to work with you
2. Intake, Assessment, Book, and Group fees are listed on our website and are subject to change with written notice. Addition fees:
   - $20 for a NSF Check or Credit/Debit Charge Back
   - $20 for additional or duplicate paperwork
   - $20 Discharged prior to the completion of treatment due to lack of attendance etc
3. Client cannot complete the program without paying their balance in full and will not receive credit for unpaid sessions. A Client's balance that exceeds $35.00 may be suspended from the group and a $20.00 re-admit fee may be applied
4. Client who has absconded, suspended, or terminated from ASC will not be allowed to return until it has been arranged with ASC office. Outstanding balance must be paid or payment plan in place
5. 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 ASC for collection of the past due account, the Client will be responsible for all costs of collection, including court costs and reasonable attorney fees
6. ASC has a sliding scale for Clients who qualify and are verified as indigent status. Clients can access the Courts to receive indigent status. Indigent status begins when the approval paper is presented to the treatment provider

Attendance & Additional Agreements:

- I agree to be punctual, attend each week, and stay the entire session.
- If I arrive late, I may not be allowed in
- If I am going to miss a session, I will let the Counselor or Office know in a timely fashion. Failure to attend regularly will result in discharge from treatment
- I understand that drinks are allowed, but food may or may not be
- 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 understand that it is my responsibility to discuss and participate in sessions
- No one is going to force me to talk or reveal difficult material before I am ready to do so

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 law, group members' communications are not protected. As such, confidentiality within the group setting is often based on mutual trust and respect. Participants are asked to honor a code of confidentiality, however privacy is not guaranteed. As a member of this group, **I agree not to disclose to anyone outside the group any information that may help to 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 (Please Print)	**Client Signature**	**Date**

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Release of Information (ROI)
Group & Individual Treatment

Client Name: _____ **Date of Birth**: _____

The above named individual hereby authorizes Alpine Springs Counseling, PC to release and/or obtain confidential information including, but not limited to, attendance, balance, and progress in treatment to/from the persons or agencies listed below via fax, electronic mail or other electronic file transfer mechanisms and discussed by telephone or in person:

_____ INITIALS TMS: Treatment Management System

_____ INITIALS DMV: Department of Motor Vehicles for DUI

_____ INITIALS Court &/or District Attorney for CIRCLE ONE / CIRCULO 5th 9th 11th 14th Other: _____ Judicial District Name (DA.Judge): _____

_____ INITIALS Probation/Parole Officer Name: _____

Originating County: _____

_____ INITIALS COMCOR / DOC; Name: _____

_____ INITIALS Geo Group/Name: _____

_____ INITIALS **Duty to warn**: If a Client has communicated a serious threat of imminent physical violence against a specific person, persons, or place Alpine Springs Counseling will contact appropriate third party agencies including but not limited to the person(s) or facility that is being targeted and law enforcement

Notice About Confidentiality: The confidentiality of alcohol and drug abuse treatment records maintained by this agency is protected by federal law. Generally, the program may not reveal any information about a client to a person who is not an employee of this agency, including the fact that the client is attending Alpine Springs Counseling, unless (1) the client consents in writing; (2) the disclosure is allowed or required by a court order; (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. This includes reporting, if a client is a present danger to self or others, or is gravely disabled. (4) The client reports a grievance against the agency or one of its personnel. (5) The client or client's heir or estate initials a legal suit against the agency or one of its personnel. (6) The client gives written consent to release specific information to specified individuals. (7) The client is suspected of having abused or neglected a child, which counselors are required by state law to report to appropriate authorities. See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR Part 2 for federal regulations. Note that federal law and regulations do not protect any information about a crime committed by a client either at our agency's offices or against any person who works for the program, or about a threat to commit a crime. This is different from telling law enforcement personnel that an individual is a client of the agency or giving additional clinical information about the client. **Disclosure Notice to Receiving Agencies**: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. If applicable, a minimum necessary determination has been applied to this release/ authorization. If you have questions concerning this release please call.

_____ _____

Client Signature **Date**

_____ _____

Staff Signature **Date**

Consent expires two years from this date

COLORADO
Department of Corrections
Division of Adult Parole

Interstate Compact Unit
940 N Broadway
Denver, CO 80203
P 303.763.2408 F 303.861.1548
DOC_interstatetreatment.state.co.us

OUT-OF-STATE OFFENDER CLIENT QUESTIONNAIRE

The following questions must be answered by all adult 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, Probation/Parole supervision, or warrants in any other state? ☐ Yes ☐ No

If yes to 1 or 2, please answer the following questions:

3) In what state was the crime committed?: _____

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.

Form C

Jared Polis, Governor | Dean Williams, Executive Director

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Interlock Enhancement Counseling (IEC)

This is a five (5) month process. During that time you are required to attend:

1) One 2 hour class each month (total of 4 groups, 8 hours)

2) One individual session (30 min) with the counselor each month (total 4 sessions, 2 hrs). During which Interlock reports are reviewed and discuss any issues/concerns

SAMPLE SCHEDULE

MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5
IND (30 MIN)	IND (30 MIN)	IND (30 MIN)		IND (30 MIN)
GROUP (2 HRS)	GROUP (2 HRS)	GROUP (2 HRS)	GROUP (2 HRS)	

- You MUST have the interlock in your car before you can start
- You MUST be successful for the entire 5 months to complete the program (Meaning no or few fails. This process can be extended if poor performance)
- Anyone with an Interlock can participate
- The program may be used in conjunction with Education and Treatment (Tracks B, C, D (**not** A), IEC may be counted towards therapy hours, if clinically appropriate)
- This training will **not** shorten length of time with Interlock (Except in event client has had multiple issues/fails with Interlock and has been sentenced to an addition year of Interlock. See DMV for details).

BENEFITS:

- Successful completion may mean an addition 10 hours to count towards therapy (Track B, C, D only. Does not apply to Track A or Education only)
- You may do this at the same time as when you are in education/therapy (Meaning, track B, C, & D may be done up to 5 weeks early, ONLY if IEC program successfully completed.)

Please check one:
☐ I **AM** **interested** in the IEC program
☐ I am **NOT** **eligible** for the IEC program (Track A or EDU only)
☐ I am **NOT** **interested** in the IEC program

Client Name (Please Print) _____ **Client Signature** _____ **Date** _____

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SMART Goals & Service Plan

Intake Date: _____ **Review (6 month):**_____

Update (as Needed):_____ **Discharge Date:** _____

Problem Statement (What the client sees as a problem, ASI domain/client report)

1. _____

2. _____

Goals (Personal DUI & other behavior to stop future DUI (Specific, Measurable, Attainable, Relevant, Time)

1. _____

2. _____

Objectives–Action Steps for Goal 1

1. _____

2. _____

Objectives–Action Steps for Goal 2:

1. _____

2. _____

Interventions (ex. DUI Group, Interlock, individual therapy):

1._____

2._____

3._____

Strengths to use to meets your goals, Participation in Treatment Planning Process

1._____

2._____

Resources, Participation by Others in the Treatment Planning Process

1._____

2._____

Client Signature: _____ **Date**: _____

Staff Signature: _____ **Date**: _____

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 receiveing 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 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

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 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

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

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
☐ ATU, Adults only
☐ Inpatient
☐ Group home (Adult)
☐ Residential facility (MH Adult)
☐ Sober living
☐ Supported housing
☐ Independent living
☐ Foster home (Youth)
☐ Residential Treatment/Group (Youth)
☐ Boarding home (Adult)
☐ Nursing home
☐ Residential facility (other)
☐ Homeless
☐ Assisted 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
☐ Mental retardation
☐ Non-ambulatory
☐ Brain Injury
☐ Psychiatric
☐ Downs Syndrome
☐ Attention Deficit Disorder
☐ Other
☐ Cerebral Palsy
☐ Seizure disorder/Epilepsy
☐ Autism
☐ Other neurological
☐ Development delay
☐ Significant hearing impairment/Deaf
☐ Significant speech impairment/Non-Verbal
☐ Significant vision impairment/Blind

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

Primary Source of income/support:
☐ Wages
☐ Public Assistance
☐ Retirement/Pension
☐ Disability
☐ Other
☐ None

Primary Source of Payment:
☐ Active duty military/Dept Gov. Health Plan
☐ Medicaid
☐ Other
☐ Other Health Insurance
☐ Blue Cross/Blue Shield
☐ Medicare
☐ Self Pay
☐ Other Gov. payments
☐ Colorado ATR
☐ MSO Funds
☐ Worker's Compensation

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

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 commitment
☐ Other healthcare provider (medical, mental)
☐ Social/Human Services
☐ Crisis system
☐ DUI / DWAI / DWI Criminal Justice
☐ Individual (self, family, friend)
☐ Other Community referral
☐ School (educational)
☐ STIRRT Residential Continuing Care
☐ Non DUI Criminal Justice (Probation, Parole, SB-94, Community Corrections)

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 at 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)

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

_____Nicotine	_____Alcohol	_____Marijuana/Cannabis	_____Cocaine
_____Methamphetamine	_____Heroin	_____Hallucinogens	_____Ketamine
_____Amphetamine	_____LSD	_____Clonazepam	_____Pain Pills
_____Barbiturate	_____Opiates	_____Tranquilizers	_____Inhalants
_____Sedatives	_____Bupenorphine	_____Flunitrazepam	_____Gamma-Hydroxybutyrate
_____PCP	_____Other stimulant	_____Anabolic steroids	_____Over the counter drug

Primary Drug of Choice	**Secondary Drug of Choice**	**Tertiary Drug of Choice**
Age of 1st Use: _____	Age of 1st Use: _____	Age of 1st Use: _____
Use in 30 Days: _____	Use in 30 Days: _____	Use in 30 Days: _____
Source of Use: _____	Source of Use: _____	Source of Use: _____
How it was used: _____	How it was used: _____	How it was used: _____

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

Visit a medical emergency room? _____Get admitted to a medical hospital? _____

Visit a psychiatric emergency room? _____Get admitted to a psychiatric hospital?_____

Number of DUI/DWAI arrests in the last **30 days** prior to this admission? : _____

Number of all other arrests in the last **30 days** prior to this admission (not DUI)?_____

Have you attended any self-help meetings **30 days** prior to admission? ☐ No ☐ Yes, how many?_____

Do you currently use a Tobacco product?

☐ Former smoker/tobacco user
☐ Never
☐ Current smoker/tobacco user – every day
☐ Current smoker/tobacco user – periodically

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):

_____Nicotine	_____Alcohol	_____Marijuana/Cannabis	_____Cocaine
_____Methamphetamine	_____Heroin	_____Hallucinogens	_____Ketamine
_____Amphetamine	_____LSD	_____Clonazepam	_____Pain Pills
_____Barbiturate	_____Opiates	_____Tranquilizers	_____Inhalants
_____Sedatives	_____Bupenorphine	_____Flunitrazepam	_____Gamma-Hydroxybutyrate
_____PCP	_____Other stimulant	_____Anabolic steroids	_____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

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:

	In the past 30 days?	In your lifetime?
Experienced serious depression, sadness, hopelessness, loss of interest, or difficulty with daily functioning?	□ Yes □ No	□ Yes □ No
Experienced serious anxiety/tension/uptightness, unreasonable worry, or inability to feel relaxed?	□ Yes □ No	□ Yes □ No
Experienced hallucinations-saw things or heard voices that were not there?	□ Yes □ No	□ Yes □ No

	In the past 30 days?	In your lifetime?
Experienced trouble understanding, concentrating, or remembering?	□ Yes □ No	□ Yes □ No
Experienced trouble controlling violent behavior, or episodes of rage or violence, including when you have been under the influence of alcohol or drugs?	□ Yes □ No	□ Yes □ No
Experienced serious thoughts of suicide?	□ Yes □ No	□ Yes □ No
Attempted suicide?	□ Yes □ No	□ Yes □ No
Been prescribed medication for any psychological or emotional problems?	□ Yes □ No	□ Yes □ 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:

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

*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 □ Gonorrhea
□ Tuberculosis □ Genital Herpes □ Venereal Warts □ 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
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:

	In the past 30 days	In your lifetime		In the past 30 days	In your lifetime
Your mother	□ Yes □ No	□ Yes □ No	Sexual partner/Spouse	□ Yes □ No	□ Yes □ No
Your father	□ Yes □ No	□ Yes □ No	Other family members		
Siblings	□ Yes □ No	□ Yes □ No	(specify)_____	□ Yes □ No	□ Yes □ No
Children	□ Yes □ No	□ Yes □ No	Neighbors	□ Yes □ No	□ Yes □ No
Close friends	□ Yes □ No	□ Yes □ No	Co-workers	□ Yes □ No	□ Yes □ 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) □ Part time (regular hours)
□ Student □ Part time (irregular hours)
□ Military Service □ Retired/disability
□ Unemployed □ 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						☐ Smoke ☐ Oral
ALCOHOL Beer, Wine						☐ Oral
ALCOHOL Hard liquor						☐ Oral
CANNABIS Marijuana, Hash, Oils						☐ Smoke ☐ Oral
COCAINE Rock, Crack, Powder						☐ Inject ☐ Smoke ☐ Snort
METHAMPHETAMINE Crystal Meth, Crank, Ice						☐ Inject ☐ Smoke ☐ Snort
AMPHETAMINE Speed, Diet pills, White crosses						☐ Oral
HALLUCINOGENS LSD, Acid, Mushrooms, Peyote						☐ Eye Drops ☐ Oral ☐ Smoke
OPIATES Morphine, Heroin, Opium, Methadone						☐ Inject ☐ Smoke ☐ Oral
PAIN PILLS Demerol, Darvon, Percocet, Percodan, Tylenol with Codeir						☐ Inject ☐ Oral
SEDATIVES Downers, Reds, Yellows, Quaaludes, 71						☐ Oral
TRANQUILIZERS Valium, Xanax, Ativan						☐ Inject ☐ Oral
INHALANTS Gas, Glue, Solvent, Paint, Poppers, Rus						☐ Inhale
PCP Angel Dust						
OTHER (please list)						
OTHER (please list)						

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	□ Sleep problems (too much or too little)	□ Achy joints or muscles
□ Nausea, vomiting or diarrhea	□ Anxiety, depression or irritability	□ Poor concentration
□ Increased heart rate or blood pressure	□ Sweating	□ Runny nose or eyes
□ Little or no energy	□ Significant increase or decrease in appetite	□ Headaches
□ Significant weight loss or weight gain	□ Seeing or feeling things that aren't there	□ 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**	Opiod Maintenance **Therapy**
Dimension 1 Intoxication and/or Withdrawal Potential	No Withdrawal Risk ❑	Minimal Risk of Severe Withdrawal ❑	Minimal Risk of Severe Withdrawal ❑	Is Intoxicated or Experiencing Withdrawal, or is at Risk for Developing Moderate to Severe Withdrawal ❑	Minimal Risk of Severe Withdrawal ❑	Minimal Risk of Severe Withdrawal ❑	Moderate but not Severe Risk of Withdrawal ❑	Physiologically Dependent on Opiates and Requires Maint to Prevent Serious Withdrawal ❑
Dimension 2 Biomedical Conds & Complications	None or Very Stable ❑	None or Stable ❑	None or Stable Enough Not to Be a Distraction in Treatment ❑	None or Stable and Person is Receiving Concurrent Medical Monitoring ❑	Person is Capable of Managing the Symptoms His/Herself ❑	None or Stable and Person is Receiving Con-current Medical Monitoring ❑	Person Requires Medical Monitoring, but not Intensive Treatment ❑	None or Manageable with Outpatient Medical Monitoring ❑
Dimension 3 Emotional/ Behavioral Conditions and Complications	None or Very Stable ❑	None or Stable ❑	None or Mild Severity, with Potential to Distract from Recovery, Person Needs Monitoring ❑	None or Minimal, Not Distracting to Recovery ❑	None or Minimal, Not Distracting to Recovery ❑	Repeated Inability to Control Impulses, Personality Disorder Requires High Structure to Shape Behavior ❑	Moderate Severity, Person Needs a 24-Hour Structured Setting ❑	None, or Manageable in Outpatient Structured Environment ❑
Dimension 4 Treatment Acceptance/ Resistance	Willing to Look at How Current Use May Effect Personal Goals ❑	Willing to Cooperate but Needs Motivating and Monitoring Strategies ❑	Resistance High Enough to Require Structured Program but not so High as to Render Outpatient Treatment Ineffective ❑	Resistance High but Person in Need of Detox ❑	Open to Recovery, but needs Structured Environment to Maintain Therapeutic Gains ❑	Marked Difficulty with, or Opposition to Treatment, with Dangerous Consequences if not Engaged in Treatment ❑	Resistance High and Impulse Control Poor, Despite Negative Consequences, Person Needs Motivating Strategies Available Only in 24-Hour Structured Settings ❑	Resistance High Enough to Require Structured Therapy to Promote Treatment Progress but will not Render Outpatient Treatment Ineffective ❑

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

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** ❑	Opiod Maintenance **Therapy** ❑

_____ _____

Therapist Signature and Title Date