

# Eccentex

6101 W. Centinela Ave, Suite 110

Culver City, CA 90230



## SUBSTANCE ABUSE ASSESSMENT

<b>Client:</b>	Test, Joe	<b>Date:</b>	12-SEP-2019
<b>Site:</b>	Eccentex	<b>Time In - Out:</b>	02:30 PM - 03:55 PM
<b>Case Manager:</b>	Psareas, Nadine	<b>Admission:</b>	12-SEP-19
<b>Case ID:</b>	29346	<b>Counselor:</b>	Psareas, Nadine
<b>DOB:</b>		<b>Primary Problem:</b>	
<b>Program:</b>	Substance Abuse Treatment	<b>Address:</b>	

### Presenting problem / Primary complaint

PP1	What is the PRIMARY reason for your having this assessment or admission for treatment?	
PP2	Was this assessment because of a DUI/DWI?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PP3	If YES, what was your Blood-Alcohol (BAC) level?	
PP4	Who referred you to this Agency for this assessment or admission?	Referral Name: Referral Agency:
PP5	Where was this assessment completed?	Site: Eccentex
PP6	Have you been in a controlled environment in the past 30 days?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PP7	If Yes, how many days in the past 30 days?	1
PP8	Where was this controlled environment?	

### Demographic information

DEMO1	What is your marital status?	NA
DEMO2	Are you satisfied with this situation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
DEMO3	Of what race do you consider yourself	None selected
DEMO4	Client gender	
DEMO5	What is your Date of Birth? (MM/DD/YYYY)	
DEMO6	What is your current age?	
DEMO7	Where were you born? (City/State/Country)	
DEMO8	Where were you mostly raised? (City/State/Country)	
DEMO9	What is your religious preference?	None
DEMO10	How long have you lived at the address you provided us?	Years: Months:
DEMO11	Is this residence owned by you or your family?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
DEMO12	If answer is "Yes" please specify who is owner?	<input type="radio"/> Family <input type="radio"/> Self
DEMO12	If answer is "No" please specify:	<input type="radio"/> Rent <input type="radio"/> Dormitory <input type="radio"/> Other

### Medical History

M1	Please rate your health	<input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Excellent
M2	How many times in your life time have you been in a medical hospital overnight?	0
M3	When was your most recent hospitalization? YYYY	
M4	What was the reason for this hospitalization?	
M5	Do you have any medical conditions, including communicable diseases (TB, STD, and Hepatitis) that interfere or impact your life?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
M6	If yes, what diseases do you have?	
M7	Are you taking any prescribed medication for a medical (not psychiatric) problem?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
M8	If yes, specify	
M9	Have you been tested for HIV/AIDS?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
M10	Do you have the result of the HIV/AIDS test?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
M11	If yes, specify date YYYY	

M12	Who is your Primary Care Physician or Family Doctor?	
M13	Approximately when was your last physical exam? (format mm/yyyy)	
M14	(For woman) Are you currently pregnant?	<input type="radio"/> Yes <input type="radio"/> No
M15	How many days in the past 30 days have you experienced any medical problems?	0
M16	If you have experienced medical problems, what was the nature of these problems?	
M17	Do you receive any pension or disability payments for a physical disability	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
M18	If yes, specify	\$
M19	How worried or bothered have you been about physical health problems in the past 30 days?	Not at all
M20	How important is it for you to receive additional treatment for any physical health problems?	Not at all

### Education, Employment and Military History

ED1	Highest Grade Completed	GED			
ED2	What was the name of your High School				
ED3	What year did you graduate?				
ED4	List the names of colleges and trade/technical schools attended and the year graduated (YYYY), e.g., City College 2001; State College 2003	Graduation Year	College Name	Degree	Major
ED5	Do you have any professional skills and/or trade?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer			
ED6	If yes, specify				
ED7	Employment Status	Unemployed-Not Looking for Work			
ED8	Where are you employed?				
ED9	What is your position or job title there?				
ED10	What has been your usual employment status for the majority of the past 3 years?	Unemployed-Not Looking for Work			
ED11a	How long was your longest full time employment?				
ED11b	Where was this employment?				
ED12	What was your position or job title there?				
ED13	What was your gross income for the past calendar year?	\$			
ED14	How many days were you paid for working in the past 30 days?				
ED15	What was your net income for the past 30 days?	\$			
	<b>How much have you received from these other sources?</b>				
ED16a	Family, friends or significant other?	\$			
ED16b	Illegal sources?	\$			
ED16c	Social Security, pension, or disability benefits?	\$			
ED16d	Unemployment Compensation?	\$			
ED16e	Welfare?	\$			
ED17	Does anyone contribute to your support in any way?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer			
ED18	If yes, who helps support you?				
ED19	Does this constitute the majority of your support?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer			
ED20	How many people depend on you for the majority of their food, shelter, etc ?	0			
ED21	Do you have valid driver's license?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer			
ED22	Do you have an automobile available for you to use?	<input type="radio"/> Yes <input type="radio"/> No			
ED23	<b>Are you or were you a member of the Armed Forces?</b>	<input type="radio"/> Yes <input type="radio"/> No			
ED24	If yes, specify Branch				
ED25	Length of service in years and months	Years: Months:			
ED26	Date discharged (YYYY)				
ED27	Type of discharged	N/A			
ED28	Were you incarcerated while in the Armed Forces	<input type="radio"/> Yes <input type="radio"/> No			
ED29	If Yes, Offense				
ED30	Are you currently under treatment for any diseases incurred during military service?	<input type="radio"/> Yes <input type="radio"/> No			
	<b>If yes, please indicate the disease, type of treatment and the treating physician.?</b>				
ED31a	Please indicate the type of disease.				
ED31b	If yes, what is the type of treatment.				
ED31c	If yes, who is treating you.				
ED32	How many days in the past 30 days have you experienced any employment problems or issues?	0			
ED33	How worried or bothered have you been about any employment problems or issues in the past 30 days?	Not at all			
ED34	How important is it for you to receive counseling for any employment problems or issues?	Not at all			

### Drug and Alcohol History

		What age did you first use this drug?	When did you last use	Drug of Choice	Use Past 30 days	Lifetime Yrs.	Route of Administration	Have you used this drug before, during or after sex
DA1	Alcohol			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA2	Alcohol to intoxication			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				
DA3	Amphetamine (including meth)			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA4	Barbiturates			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA5	Cannabis			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA6	Cocaine			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA7	Ecstasy			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA8	Hallucinogens			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA9	Heroin/Morphine			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA10	Inhalants			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA11	Methadone			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA12	Other Opioids (list)			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No

DA13	Sedative/ Hypnotic Tranquilizers/Anxiolytics			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA (a)	Other substance			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No
DA14	More than one substance in a day			<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Third <input type="radio"/> None				<input type="radio"/> Yes <input type="radio"/> No

DA15	Have you ever been voluntarily abstinent from your primary drug of choice?							<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does not answer
DA16	How long ago did your last period of abstinent end?							Years:    Months:
DA17	How long was your last period of voluntary abstinent from your primary drug of choice?							
DA18	How much money would you say you have spent on alcohol during the past 30 days?							\$
DA19	How many times have you had alcohol DTs?							
DA20	How many times have you had treatment for Substance Abuse?							
DA21	How many of these were for Detox only?							
DA22	How many days have you attended AA or had any sort of treatment for alcohol problems in the past 30 days?							0
DA23	How much money would you say you have spent on drugs during the past 30 days?							\$
DA24	How many times have you overdosed on drugs?							
DA25	Have you ever used needles to administer drugs?							<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
DA26	If yes, when was the last time you did this?							
DA27	How many days have you attended NA or had any sort of treatment for drug problems in the past 30 days?							0
DA28	If you have received treatment for alcohol or drug abuse, in the past, where and when were these treatments; and what type of treatment was it? e.g., Sunset Center, 1999, Residential							Where: Date: Type: IOP
DA29	How many days in the past 30 days have you experienced any alcohol-related problems?							0
DA30	How worried or bothered have you been about any alcohol-related problems in the past 30 days?							Not at all
DA31	How important is it for you to receive counseling or treatment for any alcohol problems?							Not at all
DA32	How many days in the past 30 days have you experienced any drug-related problems?							0
DA33	How worried or bothered have you been about any drug-related problems in the past 30 days?							Not at all
DA34	How important is it for you to receive counseling or treatment for any drug problems?							Not at all

### Legal

LE01	Are you on probation							<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
LE02	If yes, specify Officer's Name							
LE02a	Court / Jurisdiction							
LE03	Are you on parole							<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
LE04	If yes, specify Officer's Name							
LE05	Court / Jurisdiction							
		<b>Arrested/Charged</b>	<b># times</b>	<b># of Convictions</b>	<b>Drug/Alcohol Involved</b>			
LE06	<input type="checkbox"/> Arson							<input type="radio"/> Yes <input type="radio"/> No
LE07	<input type="checkbox"/> Assault							<input type="radio"/> Yes <input type="radio"/> No
LE08	<input type="checkbox"/> Burglary/Larceny/B&E							<input type="radio"/> Yes <input type="radio"/> No
LE09	<input type="checkbox"/> Contempt of Court							<input type="radio"/> Yes <input type="radio"/> No
LE10	<input type="checkbox"/> Disorderly Conduct							<input type="radio"/> Yes <input type="radio"/> No
LE11	<input type="checkbox"/> Disturbing the peace							<input type="radio"/> Yes <input type="radio"/> No
LE12	<input type="checkbox"/> Driving While Intoxicated							<input type="radio"/> Yes <input type="radio"/> No
LE13	<input type="checkbox"/> Drug Charges							<input type="radio"/> Yes <input type="radio"/> No
LE14	<input type="checkbox"/> Forgery							<input type="radio"/> Yes <input type="radio"/> No
LE15	<input type="checkbox"/> Homicide/Manslaughter							<input type="radio"/> Yes <input type="radio"/> No
LE16	<input type="checkbox"/> Major Driving Violations							<input type="radio"/> Yes <input type="radio"/> No
LE17	<input type="checkbox"/> Minor in Possession							<input type="radio"/> Yes <input type="radio"/> No

LE18	<input type="checkbox"/> Parole/Probation Violation			<input type="radio"/> Yes <input type="radio"/> No
LE19	<input type="checkbox"/> Prostitution			<input type="radio"/> Yes <input type="radio"/> No
LE20	<input type="checkbox"/> Public Intoxication			<input type="radio"/> Yes <input type="radio"/> No
LE21	<input type="checkbox"/> Rape or other sex-related crime			<input type="radio"/> Yes <input type="radio"/> No
LE22	<input type="checkbox"/> Robbery			<input type="radio"/> Yes <input type="radio"/> No
LE23	<input type="checkbox"/> Shoplifting/Vandalism or Theft			<input type="radio"/> Yes <input type="radio"/> No
LE24	<input type="checkbox"/> Vagrancy			<input type="radio"/> Yes <input type="radio"/> No
LE25	<input type="checkbox"/> Weapons Offense			<input type="radio"/> Yes <input type="radio"/> No
LE26	<input type="checkbox"/> Other			<input type="radio"/> Yes <input type="radio"/> No
LE27	How long in total were you incarcerated in your life?			Year : Month : Day :
LE28	How long was your last incarceration?			Year : Month : Day :
LE29	What was it for?			N/A

LE30	Are you presently awaiting charges, trial or sentencing?	<input type="radio"/> Yes <input type="radio"/> No
LE31	For what?	N/A
LE32	How many days in the past 30 days where you detained or incarcerated?	0
LE33	How many days in the past 30 days have you engaged in illegal activities for profit?	0
LE34	How worried or bothered have you been about any legal problems in the past 30 days?	Not at all
LE35	How important is it for you to receive counseling or for legal problems?	Not at all

### Family History and Family Relationships

FR01	What is the first and last name of your biological father?	
FR02	What is the first and last name of your biological mother?	
FR03	Do they remain together as a couple?	<input type="radio"/> Yes <input type="radio"/> No
FR04	If not together, please indicate never married, separated, divorced, one or both deceased?	Parents never married
FR05	If not together, what age were you when they separated, divorced, or died?	
FR06	How many brothers do you have?	
FR07	How many sisters do you have?	
FR08	If married or living with a significant other, what is his or her name?	
FR09	How many years have you been in this significant relationship?	Years: Months:
FR10	Are you satisfied with living arrangements?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Indifferent
FR11	How many children do you have?	
FR12	What are their name(s) and current ages?	
FR13	What has been your usual living arrangement for most of the past 3 years?	N/A
FR14	Do you live with anyone who has an alcohol or drug use problem?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
FR15	How many close/best friends do you have?	
FR16	With whom do you spend most of your time?	N/A
FR17a	How many days in the past 30 days have you had serious conflicts with anyone in your family?	0
FR17b	How many days in the past 30 days have you had serious conflicts with anyone other than a family member?	0

FR18	Have you had a close reciprocal relationship with the identified people in your life?		Past 30 Day	In lifetime		Past 30 days	In lifetime
		<b>Father</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Significant other</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a
		<b>Mother</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Child/children</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a
		<b>Siblings</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Friends</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a

FR19	Have you ever had a significant period in your life when there were serious problem getting along with the identified people?		Past 30 Day	In lifetime		Past 30 days	In lifetime
		<b>Father</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Child/children</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a
		<b>Mother</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Friends</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a
		<b>Siblings</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Neighbors</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a
		<b>Significant other</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<b>Co-Workers</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a
	<b>Other Family</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> n/a				

		In the past 30 days	In your lifetime
FR20	Have you been emotionally abused?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer By whom:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer By whom:
FR21	Have you been physically abused?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer By whom:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer By whom:
FR22	Have you been sexually abused?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer By whom:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer By whom:
FR23	Would you like to talk to a counselor about any abuse history?	<input type="radio"/> Yes <input type="radio"/> No	

**Have any of the following biological family members had an alcohol, drug or mental health problem?**

		Alcohol	Drug	Mental	
	<b>Father's Side</b>				
FR25	Grandfather	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	
FR26	Grandmother	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	
FR27	Father	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	
FR28	Uncles	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	
FR29	Aunts	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not know	
	<b>Mother's Side</b>				
FR30	Grandfather	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	
FR31	Grandmother	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	
FR32	Mother	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	
FR33	Uncles	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	
FR34	Aunts	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Know	
	<b>Siblings</b> <i>from oldest to youngest</i>				
FR35		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	
FR36		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	
FR37		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	
FR38		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer	
FR38	How worried or bothered have you been about family or social-related problems in the past 30 days?				Not at all
FR39	How important is it for you to receive counseling or treatment for family or social-related problems?				Not at all

**Psychiatric History**

	How many times have you been treated for any psychological or mental health problem	# of times
PS1	In a hospital / residential / inpatient setting	Location
PS2	As an outpatient / private patient	Comment
PS3	Do you receive any disability payments for a mental health problem	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
	Have you experienced any of the following symptoms	In the past 30 days In the lifetime
PS4	Serious depression	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS5	Serious anxiety	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS6	Eating disorder such as anorexia or bulimia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS7	Auditory or visual hallucinations	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS8	Serious lost of temper, rage, or violence	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS9	Cut on yourself or did other self-injurious behaviors	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS10	Serious thoughts of suicide	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS11	Attempted suicide	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS12	Trouble concentrating, understanding or remembering things	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS13	Been prescribed medication for a psychological or mental health condition	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Does Not Answer
PS14	If yes, specify medication(s)	
PS15	Have you ever been diagnosed with any mental health or psychological condition(s)?	<input type="radio"/> Yes <input type="radio"/> No Diagnoses
PS16	How worried or bothered have you been about psychological or mental health problems in the past 30 days?	Not at all
PS17	How important for you to receive counseling for psychological or mental health problem?	Not at all

**Collateral Information**

## Other Diagnostic / Screening Tools

### Substance Abuse Subtle Screening Inventory (SASSI-3)

If the SASSI was administered and scored, please enter the raw score for each scale in the column below

Scale	Raw Score	T-Score	Percentile
FVA			
FVOD			
SYM			
OAT			
SAT			
DEF			
SAM			
FAM			
COR			
RAP			

### University of Rhode Island Change Assessment (URICA) Scale:

There are FIVE possible responses to each of the items in the questionnaire:

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly Agree

1	As far as I am concerned, I don't have any problem that needs changing	1
2	I think I might be ready for some self-improvement	1
3	I am doing something about the problems that have been bothering me	1
4	It might be worthwhile to work on my problem	1
5	I am not the one with a problem. It doesn't make much sense for me to be here	1
6	It worries me that I might slip back on a problem I have already changed, so I am here to seek help	1
7	I am finally doing some work on my problem	1
8	I've been thinking that I might want to change something about myself	1
9	I have been successful in working on my problem, but I'm not sure I can keep up the effort on my own.	1
10	At times my problem is difficult, but I'm working on it	1
11	Being here is pretty much of a waste of time for me because the problem doesn't have to do with me	1
12	I'm hoping this place will help me to better understand myself	1
13	I guess I have faults, but there is nothing that I really need to change	1
14	I am really working hard to change	1
15	I have a problem and I really think I should work on it	1
16	I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem	1
17	Even though I'm not always successful in changing, I am at least working on my problem.	1
18	I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it	1
19	I wish I had more ideas on how to solve my problem	1
20	I have started working on my problems, but I would like help	1
21	Maybe this place will be able to help me	1
22	I may need a boost right now to help me maintain the changes I've already made	1
23	I may be part of the problem, but I don't really think I am	1
24	I hope that someone here will have some good advice for me	1
25	Anyone can talk about changing; I'm actually doing something about it	1
26	All this talk about psychology is boring. Why can't people just forget about their problems?	1
27	I'm here to prevent myself from having a relapse of my problem	1
28	It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved	1
29	I have worries but so does the next guy. Why spend time thinking about them?	1
30	I am actively working on my problem	1
31	I would rather cope with my faults than try to change them	1
32	After all I have done to try to change my problem, every now and again it comes back to haunt me	1



**ASAM Rating**

Directions to Counselor: It is your responsibility to rate each client on the six dimensions of the ASAM Criteria from 1=absent or minimal to 4=serious or major impairment. Generally, but any case may be different, no treatment is usually needed with a rating of 0 or 1; a rating of 2 generally suggests some treatment is indicated (perhaps an OP program or an IOP); a rating of 3 generally suggests more intensive intervention is indicated, perhaps IOP; and, a rating of 5 suggests a serious condition and perhaps immediate action needs to occur for client safety (detoxification and medical) or day treatment or residential treatment is indicated. Remember, each case is different. The above is merely a general guideline for rating the client based on your opinion of the client and the assessment data. Remember, for each dimension rated a 2 or 3 or 4, type in you reasons for rating the client 2 or higher.

**Level of Functioning Key**

- 4: Serious symptoms or major impairment.
- 3: Moderate symptoms or difficulty.
- 2: Mild symptoms or some difficulty.
- 1: Acceptable response to psychosocial stressors.
- 0: Absent or minimal.

	Dimension	Level of Functioning	Notes
1	Detoxification potential	0	
2	Biomedical conditions and complications	0	
3	Emotional behavioral conditions and complications	0	
4	Motivation for Change	0	
5	Continued Use/Relapse potential	0	
6	Recovery environment	0	

**Diagnostic impression:**

Axis I Primary:		
Axis I Secondary:		
Axis II:		
Axis III:		
Axis IV:		<input type="checkbox"/> None <input type="checkbox"/> Problems with primary support group <input type="checkbox"/> Problems related to the social environment <input type="checkbox"/> Educational problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Economic problems <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> Problems related to interaction with the legal system/ crime <input type="checkbox"/> Other psychosocial and environmental problems
Axis V:		GAF

Summary:

Recommendations:

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