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| AOD/SUD INTAKE AND ASSESSMENT |

INTAKE INSTRUCTIONS

Per Alcohol and/or other Drug Program Certification Standards (12020) Program staff shall review each completed health questionnaire that was completed by a participant. The health questionnaire can help identify a participant’s treatment needs but it is the responsibility of staff to gather additional information on the following items: Social, economic and family history, education, employment history, criminal history, legal status, medical history, alcohol and/or other drug history, and previous treatment.

Per Title 22 CCR 51341.1 (b)(13): Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders, and the assessment of treatment needs.

Gather the following information from Client.

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| CLIENT INFORMATION  Client’s First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Participant’s Medi-Cal PSP#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client’s Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admission Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

EMERGENCY CONTACT INFORMATION

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| Emergency Contact | Relationship | Contact Address (street, City, State, Zip) | Contact Phone Number |

Release for Emergency Contact obtained for this time period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL INFORMATION

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| Sex Assigned at Birth:  Male  Female  Intersex  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown or Declined to State  Gender Identity:  Male  Female  Intersex  Gender Queer  Gender Non-Conforming  Male to Female  Female to Male  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown or Declined to State  Preferred Pronoun:  He/Him  She/Her  They/Them  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown or Declined to State |

REFERRAL REASON

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| Reason for the Client’s Referral: |

**Primary Assigned Counselor**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ALCOHOL AND DRUG HISTORY | | | | | | | | |
| **Check if ever used:** | **AGE AT FIRST USE** | **CURRENT SUBSTANCE USE** | | | | | | |
| None/  Denies | Current  Use | Current  Intox. | Current  Withdrawal | In Remission | Client-perceived Problem? | |
| ALCOHOL |  |  |  |  |  |  | Y | N |
| AMPHETAMINES (SPEED/UPPERS, CRANK, ETC) |  |  |  |  |  |  | Y | N |
| COCAINE/CRANK |  |  |  |  |  |  | Y | N |
| OPIATES (HEROIN, OPIUM, METHADONE, OXYCONTIN) |  |  |  |  |  |  | Y | N |
| HALLUCINOGENS (LSD, MUSHROOMS, PEYOTE, ECSTASY) |  |  |  |  |  |  | Y | N |
| SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR |  |  |  |  |  |  | Y | N |
| PSP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB) |  |  |  |  |  |  | Y | N |
| INHALANTS (PAINT, GAS, GLUE, AREOSOLS) |  |  |  |  |  |  | Y | N |
| CANNABIS/MARIJUANA/HASHISH |  |  |  |  |  |  | Y | N |
| TOBACCO/NICOTINE |  |  |  |  |  |  | Y | N |
| CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.) |  |  |  |  |  |  | Y | N |
| OVER THE COUNTER: |  |  |  |  |  |  | Y | N |
| OTHER SUBSTANCE: |  |  |  |  |  |  | Y | N |
| COMPLIMENETARY ALTERNATIVE MEDICATION |  |  |  |  |  |  | Y | N |

PREVIOUS DRUG AND/OR ALCOHOL TREATMENT HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Previous  Recovery Treatment (if known) (e.g. Outpatient, Residential, Detoxification) | Name of Previous Treatment Facility (if known) | Dates of Previous Treatment  (if known) | Treatment  Completed  (Yes or No)  (if known) |
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Medical History

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| --- | --- | --- | --- |
|  | **Name:** | **Phone#:**  **(if known)** | **Last Date of Service**  **(if known)** |
| 1. **Primary Physician:** |  |  |  |
| 1. **Other medical provider(s):** |  |  |  |
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| 1. **Date records requested:**   **From whom, if applicable:** |  | | |

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| **Relevant Medical History** (complete checklist and comment on those checked below): ***Check only those that are relevant*** | | | | | | | | | | | | | |
| **General Information:** | Weight Changes (if known): | | | Baseline Weight (if able to obtain): | | | | | | BP (if known): | | |
| *Cardiovascular/Respiratory:* | Chest Pain | | Hypertension | | | Hypotension | | Palpitation | | | Smoking | |
| *Genital/Urinary/Bladder:* | Incontinence | | Nocturia | | Urinary Tract Infection | | Retention | | | | Urgency | | |
| *Gastrointestinal/Bowel:* | Heartburn | | Diarrhea | | | Constipation | | | Nausea | | Vomiting | | |
| Ulcers | | Laxative Use | | | Incontinence | | |  | |  | | |
| *Nervous System:* | Headaches | | Dizziness | | | Seizures | | | Memory | | Concentration | | |
| *Musculoskeletal:* | Back Pain | | Stiffness | | | Arthritis | | | Mobility/Ambulation | | | | |
| *Gynecology:* | Pregnant | | Pelvic Inflam. Disease | | | Menopause | | |  | | | | |
| *Skin:* | Scarring | | Lesion | | | Lice | | | Dermatitis | | | Cancer | |
| *Endocrine:* | Diabetes | | Thyroid | | | Other: | | | | | | | |
| *Respiratory:* | Bronchitis | | Asthma | COPD | | Other: | | | | | | | |
| *Dental Issues:* |  | | | | | | | | | | | | |
| *Other(s):* |  | | | | | | | | | | | | |
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| Significant Accident/Injuries/Surgeries: | |  | | | | | | | | | | |
| Hospitalizations: | |  | | | | | | | | | | |
| Physical Disabilities: | |  | | | | | | | | | | |
| Chronic Illness: | |  | | | | | | | | | | |
| HIV disease: | |  | | | | | | | | | | |
| Liver disease: | |  | | | | | | | | | | |
| TBI/ LOC | |  | | | | | | | | | | |

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| **Alternative healing practice/date** (if known) (e.g., acupuncture, hypnosis, herbs, supplements, etc.) | | | |
| **Date** | **Provider/Type** | **Reason for Treatment** | **Outcome (was it helpful and why)** | |
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| **Current/ previous medications** (include all prescribed- psychotropic & non-psychotropic, OTC, and holistic/ alternative remedies): | | | | | | | | | | | | |
|  | **Rx Name** | | **Effectiveness/Side Effects**  **(if known)** | | | **Dosage**  **(if known)** | | **Date Started (if known)** | | **Prescriber**  **(if known)** | **Current**  **(if known)** | **Past**  **(if known)** |
| *Psychotropic* |  | |  | | |  | |  | |  |  |  |
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| *Non-Psychotropic* |  | |  | | |  | |  | |  |  |  |
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| **Allergies/Adverse Reactions/ Sensitivities** | | No Reported Allergies  Unknown Allergies  Check & List:  Food  Drugs(Rx/OTC/ILLICT)  Other(s): | | | | | | | | | | |
| **Date of last physical exam (if known):** | | | | | | | | | **Date of last dental exam (if known):** | | | |
| **Referral made to primary care or specialty?** | | | | **YES** | **NO** | | **If yes, list:** | | | | | |
| **Additional Medical Information (if any)**: | | | | | | | | | | | | |

MENTAL HEALTH HISTORY

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| --- |
| Psychiatric Hospitalizations:  Yes  No  Unable to Assess  Outpatient Treatment:  Yes  No  Unable to Assess  Risk factors:  Aggressive/Violent Behaviors  Self Harm  Yes  Client was referred to the County ACCESS line 1-800-491-9099  Mental Health disorders that are pre-existing, contribute to substance use/abuse, or have been exacerbated by substance use (if known): |

PSYCHOSOCIAL HISTORY

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| Family problems that are contributing to, or are exacerbated by substance use:  Quarrels  Domestic Violence  Family Abuses Alcohol/Drugs  Family worried about client’s use  Separated/Divorced |
| Family History (if known): |
| Social problems that are contributing to, or are exacerbated by substance use:  Mild  Moderate  Severe  None  Describe (if known): |

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| Economic Problems that are contributing to, or are exacerbated by substance use:  Mild  Moderate  Severe  None  Describe (if known): |
| Cultural factors which may influence presenting problems: (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, socioeconomic status, living environment, etc.:  Describe (if known): |
| **SEXUAL ORIENTATION:**  **Unknown  Heterosexual/Straight**  **Lesbian**  **Gay**  **Bisexual**  **Queer**  **Gender Queer**  **Questioning**  **Declined to State**  **Other:** |

EDUCATION

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| Education Problems that are exacerbated by substance use:  Mild  Moderate  Severe  None  Comments (if known):  Highest Education Completed:  Less than High School  GED  Completed High School  Some College  Completed College  Greater than College |

EMPLOYMENT HISTORY

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| Client Currently Employed  Yes  No  Profession: |
| Substance use/abuse has caused or contributed to:  Absenteeism  Tardiness  Accidents  Working while hung-over  Trouble concentrating  Decreased job performance  Consumed substances while at work  Lost job in past due to substance abuse  No work problems  Comments (if any): |

CRIMINAL HISTORY/LEGAL STATUS

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criminal Justice History/Violent Incidents of Individual and/or Family** | **Within last 90 days** | | **Past** | |  | **Criminal Justice History/Violent Incidents of Individual and/or Family** | **Within last 90 days** | | **Past** | |
|  | **Y** | **N** | **Y** | **N** |  |  | **Y** | **N** | **Y** | **N** |
| Assault on persons |  |  |  |  |  | Probation |  |  |  |  |
| Threat to persons |  |  |  |  |  | Parole |  |  |  |  |
| Property Damage |  |  |  |  |  | Adjudicated |  |  |  |  |
| Weapons Involved |  |  |  |  |  | Diversion |  |  |  |  |
| Legal History |  |  |  |  |  | Other: |  |  |  |  |

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| Describe criminal justice involvement/incidents (include level of community threat/safety, dates, types of crimes, outcomes, etc.), if known: |
| Narrative continued in Addendum |
| Describe any relevant family involvement with criminal justice (include level of community threat/safety, dates, types of crimes, outcomes, etc.) if known:  Narrative continued in Addendum |

ASSESSMENT ITEMS REQUIRED FOR ALL PERINATAL PROGRAMS

(DMC & Non-DMC)

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| Client Currently in a relationship?  Yes  No Length of relationship: \_\_\_\_\_\_\_\_\_\_ |
| History of Sexual Abuse?  Yes  No History of physical abuse?  Yes  No  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many Children does the Client have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ages of Children: #1\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_ #3\_\_\_\_\_\_\_\_ #4 or more \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessed Knowledge of parenting skills:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Skills most needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessed Education/Knowledge of harmful effects that alcohol and drugs have on the caregiver and fetus, or the caregiver and infant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client needs or will receive cooperative child care?  Yes (And will be provided)  No  Client needs to access the following ancillary services which are medically necessary to prevent risk to fetus or infant(If checked, describe in comments):  Dental Services  Social Services  Community Services  Educational/Vocational Training  Other: Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client needs transportation to and from Medically necessary treatment?  Yes  No  Client needs transporting or help arranging transportation to and from Medically necessary treatment?  Yes (explain)  No  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| SUD Formulation  Instructions: Consider all information gathered in the intake for the SUD Formulation. The formulation should identify each problem that is contributing to client’s substance use disorder. All issues identified during the intake and assessment process must be listed as a problem statement on the treatment plan. However some problem statements can de deferred as determined appropriate by the treatment staff. Do not include specific diagnosis unless completed by a Therapist or MD and within their scope of practice. 22 CCR § 51341.1 (b) (20) Definition of Therapist; <http://www.dhcs.ca.gov/services/adp/pages/dmc_FAQs.aspx> & 22 CCR § 51341.1(h)(2)(A)(i)(a) |
|  |

Information for Physician or Therapist to Make SUD Diagnosis:

DSM-5 Diagnosis may only be made by a Therapist or MD

SUD Counselors may only gather the information below regarding signs and symptoms and may only list a DSM-5 SUD Diagnosis if reported by client.

SUD Diagnosis reported by client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BASIS FOR DIAGNOSIS**

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| --- | --- | --- | --- |
| A pattern of substance use leading to clinically significant impairment or distress as manifested by at least 2 of the following, occurring within a 12-month period. A diagnosis may be supported with a specifier if the beneficiary is on agonist therapy (maintenance) or was/is in a controlled environment. | | | |
| **Met** | **Symptom** | **Substance(s)** | **When Symptom Was Experienced** |
|  | 1) The substance is often taken in larger amounts or over a longer period than was intended. |  |  |
|  | 2) There is a persistent desire or unsuccessful efforts to cut down or control the use of the substance. |  |  |
|  | 3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recovered from its effects. |  |  |
|  | 4) Craving, or a strong desire or urge to use the substance. |  |  |
|  | 5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home. |  |  |
|  | 6) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. |  |  |
|  | 7) Important social, occupational, or recreational activities are given up or reduced because of the use of the substance. |  |  |
|  | 8) Recurrent substance use in situations in which it is physically hazardous. |  |  |
|  | 9) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the use of the substance. |  |  |
|  | 10) Tolerance, as defined by either of the following: a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect; and/or b) A markedly diminished effect with continued use of the same amount of the substance. |  |  |
|  | 11) Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for the substance; and/or b) The substance is taken to relieve or avoid withdrawal symptoms. |  |  |
|  | Mild Substance Use Disorder (2-3 Symptoms): |  |  |
|  | Moderate Substance Use Disorder (4-5 Symptoms): |  |  |
|  | Severe Substance Use Disorder (6 or More Symptoms): |  |  |
|  | In Early Remission (no symptoms, except for craving, for 3 to under 12 months) |  |  |
|  | In Sustained Remission (no symptoms, except for craving, for more than 12 months) |  |  |
|  | On Maintenance Therapy (if taking a prescribed agonist medication and none of the criteria have been met for the agonist medication except symptoms 10 and 11) |  |  |

\*Symptoms 10 and 11 are not applicable if the client is using sedative/hypnotic/anxiolytic, opioid, or stimulant medication as prescribed consistent with physician’s orders (e.g. not combining with synergistic substances, not taking more frequently or in greater quantity than prescribed, not operating machinery, etc.)

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| Additional Comments (if any): |

SIGNATURE SECTION

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| Name of staff completing assessment, Title  Signature/Credentials Date |