|  |
| --- |
| **This form is not for claiming, service must be documented in a progress note in order to be claimed** |
| **SUD Intake and Assessment** |
| Client: |   |   |   |
|  | InSyst # | Last Name | First Name |
| Location: |   | Episode Opening Date: |   |
| Agency: |   | RU: |   |
| Services were provided in:  |   | by [ ]  interpreter or [ ]  clinician |
|  |
| **ASSESSMENT – SUD INTAKE & ASSESSMENT – Per Client Report** |
| [ ]  **Health Screening Questionnaire Reviewed with Client (check if reviewed)****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 IA, IV.45: 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: |
| Episode Opening Date: |   | Birthdate: |   | Preferred Language: |   |
| Preferred Last Name: |   | Preferred First Name: |   |
| What is your pronoun? | [ ]  She/Her [ ]  He/Him [ ]  They/Them [ ]  Unknown/Not Reported[ ]  Other:  |
| Sex Assigned At Birth: | [ ]  Decline to State [ ]  Male [ ]  Female [ ]  Intersex [ ]  Other/Non-Binary:  |
| Gender Identity: | [ ]  Unknown [ ]  Male [ ]  Female [ ]  Intersex [ ]  Gender Queer [ ]  Decline to state[ ]  Other: Transgender: [ ]  Male to Female [ ]  Female to Male |
| Sexual Orientation: | [ ]  Unknown [ ]  Bisexual [ ]  Declined to State [ ]  Gay [ ]  Gender Queer [ ]  Lesbian[ ]  Heterosexual/Straight [ ]  Questioning [ ]  Queer[ ]  Other:  |
| Emergency Contact: |   | Relationship: |   |  |
| Contact Address: |   |   | ContactPhone: |   |
|  | Street | Apt./Unit |  |  |
|  |   |   |   |  |  |
|  | City | State | Zip |  |  |
|  | [ ]  Release for Emergency Contact: Clinician attests that client signed release for duration of treatment. |
| **Assessment Sources of Information** (Check all that apply):[ ]  Client [ ]  Family/Guardian [ ]  Hospital [ ]  Other:  |
| Reason For Referral (Please indicate referral source, precipitating circumstances and client’s chief complaint):  |
| **ALCOHOL AND DRUG HISTORY – Per Client Report** |
| Check if ever used | Age at first use | Current Substance Use |
|  |  | None/Denies | Current Use | Current Intox. | Current Withdrawal | In Remission | Client-Perceived Problem |
|  |  |  |  |  |  |  | Yes | No |
| Alcohol |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Amphetamines (Speed/Uppers, Crank, etc) |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Cocaine/Crank |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Opiates (Heroin, Opium, Methadone, OxyContin |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Hallucinogens (LSD, Mushrooms, Peyote, Ecstasy) |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Sleeping Pills, Pain Killers, Valium, OR similar |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| PCP (Phencyclidine) OR Designer Drugs (GHB) |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Inhalants (Paint, Gas, Glue, Aerosols) |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Cannabis/Marijuana/Hashish |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Tobacco/Nicotine |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Caffeine (Energy Drinks, Sodas, Coffee, etc.) |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Over the counter |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Other substances |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Complimentary Alternative Medications |   |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Additional Comments:  |
| **Prior Treatment – Per Client Report** |
| Number of prior treatment admissions in life (not including detoxification):  |
| Name of last program:  | Where:  |   |
| Exit date:  | Exit Status: | [ ]  Complete [ ]  Incomplete | Number of days there:  |
| Number of detox admissions in life: |   | Date of last detox episode: |   |
| **Prior Periods of Abstinence – Per Client Report** |
| Have you ever had a period of abstinence from drugs and alcohol? | [ ]  Yes [ ]  No If yes, please answer the following:  |
| When? (give dates): | From: |   | to : |   |
| How long did you remain abstinent most recently? – Please select one from below:[ ]  Under 1 week [ ]  Under 1 month [ ]  From 1-3 months [ ]  From 3-6 months [ ]  From 6-12 months [ ]  Over 1 year |
| After the period of abstinence, when did you return to your normal level of use? – Please select one from below:[ ]  Under 1 week [ ]  Under 1 month [ ]  From 1-3 months [ ]  From 3-6 months [ ]  From 6-12 months [ ]  Over 1 year |
| **Medical History – Per Client Report** |
|  | **Name** | **Phone (if known)** | **Last Date of Service (if known)** |
| a. Primary Care Physician |   |   |   |
| b. Other medical provider(s) |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| c. Physical Exam in last 12 months? | [ ]  Yes [ ]  No [ ]  If no, a physical exam goal will be added to the treatment plan. |
|  | Date if available:  |   | [ ]  A copy was provided or is in the chart. |
| Who do we contact for a copy? |   |
|  | Provider Name |
|  |   |
|  | Provider Address |
|  |   |   |   |
|  | City | State | Phone |
| d. Last Dental Appointment | Approximate date: |   |
| Do you need to see a dentist? | [ ]  Yes [ ]  No |
| **MEDICAL HISTORY – Per Client Report****Relevant Medical History: Indicate or check only those that are relevant** |
|  | Weight (lbs):  | Height (in):  | Sitting BP:  | Supine BP:  |
| General Information: | Weight changes in last 6 months: | [ ]  Increased | [ ]  Decreased | [ ]  N/A |
|  | Temp:  | Respiration:  | General Appearance:  |
| 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/Ambulatory |
| Gynecology: | [ ]  Pregnant | [ ]  Pelvic Inflammatory Disease | [ ]  Menopause | [ ]  Breast Feeding |
|  | Last LMP: |   |
| Skin: | [ ]  Scar | [ ]  Lesion | [ ]  Lice | [ ]  Dermatitis | [ ]  Cancer |
| Endocrine: | [ ]  Diabetes | [ ]  Thyroid | [ ]  Other:  |
| Respiratory: | [ ]  Bronchitis | [ ]  Asthma | [ ]  COPD | [ ]  Live with a smoker |
|  | [ ]  Other: |   |
| [ ]  Others (Check if relevant and describe): |   |
| Other: | [ ]  Significant Accident/Injuries/Surgeries: |   |
| [ ]  Hospitalizations: |   |
| [ ]  Physical Disabilities: |   |
| [ ]  Chronic Illness: |   |
| [ ]  HIV Disease: |   |
| [ ]  Age of Menarche and Birth Control Method: |   |
| [ ]  History of Head Injury:  |   |
| [ ]  Cardiac screening questions (required to be documented prior to starting stimulants):  |
| [ ]  Yes [ ]  No | History of cardiac diagnosis (including heart murmur): |   |
| [ ]  Yes [ ]  No | History of palpitations, chest pain, syncope: |   |
| [ ]  Yes [ ]  No | Family history of sudden death less than age 30:  |   |
| [ ]  If any of these three answered yes, EKG ordered?: |   |
| [ ]  None of the above: |   |
| Relevant Medical/Dental Considerations for Treatment: |   |
| **Current Disability Status – Per Client Report** |
| [ ]  Developmental/Learning Disorder: |   |
| [ ]  Hearing/Speech: |   |
| [ ]  Independent Living Difficulty: |   |
| [ ]  Mental/Emotional/Cognitive: |   |
| [ ]  Mobility: |   |
| [ ]  No Disability: |   |
| [ ]  Self-Care Difficulty: |   |
| [ ]  Service Animal: |   |
| [ ]  Speech: |   |
| [ ]  Visual: |   |
| [ ]  Relevant Disability Consideration for Treatment |   |
| **Alternative Healing Practice****(if known) (e.g. acupuncture, hypnosis herbs, supplements, etc.) – Per Client Report** |
| Current? | Year Began | Duration | Type | Reason for Treatment | OutcomeWas it helpful and why?) |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
| **Current Medications****Include all prescribed, over the counter, and holistic/complimentary/alternative remedies. Per Client Report** |
|  | Medication Name | Effectiveness/Side Effects if known | Dosage if known | Date Started if known | Prescriber if known |
| Psychotropic |   |   |   |   |   |
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|  |   |   |   |   |   |
| Non-Psychotropic |   |   |   |   |   |
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|  |   |   |   |   |   |
| **Previous Medications****Include all prescribed, over the counter, and holistic/complimentary/alternative remedies. – Per Client Report** |
|  | Medication Name | Effectiveness/Side Effects if known | Dosage if known | Date Started if known | Prescriber if known |
| Psychotropic |   |   |   |   |   |
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| Non-Psychotropic |   |   |   |   |   |
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| **Allergies, Adverse Reactions, and Sensitivities – Per Client Report** |
| [ ]  Yes:  | [ ]  No | [ ]  Unknown |
| [ ]  No new allergies reported |
| Referral made to primary care or dental care or specialty: [ ]  No [ ]  Yes | If yes, list:  |
| Additional Medical Information, if any:  |
| **Mental Health History – Per Client Report** |
| Psychiatric Hospitalizations: [ ]  Yes [ ]  No [ ]  Unable to Assess |
| Outpatient Treatment: [ ]  Yes [ ]  No [ ]  Unable to Assess |
| Risk Factors: Do you have a history of [ ]  Aggressive/Violent Behaviors or [ ]  Self-Harm? |
| In the past week how many times have you: |
| Been irritable?  |
| Had an outburst of anger?  |
| Felt like hurting another person?  |
| Felt like hurting yourself?  |
| [ ]  Client was referred to the County ACCESS line (800) 491-9099 |
| [ ]  Tarasoff Warning Required |
| Mental Health disorders that are pre-existing, contribute to substance use/abuse, or have been exacerbated by substance use (if known):  |
| **Psychosocial History – Per Client Report** |
| Family problems that are contributing to, or are exacerbated by substance use: |
| [ ]  Quarrels | [ ]  Domestic Violence | [ ]  Family Abuses/Alcohol/Drugs |
| [ ]  Separated/Divorced | [ ]  Family worried about client’s use |
| Family History, if known:  |
| Social problems that are contributing to, or are exacerbated by substance use: |
| [ ]  Mild | [ ]  Moderate | [ ]  Severe | [ ]  None |
| Describe, if known:  |
|   |
| 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, homeless or other housing needs etc.: |
| Describe, if known:  |
| Housing/Living Arrangements: Current | Current (how long?):  | Stable?:  |
| Housing/Living Arrangements: Current | Current:  | Stable?:  |
| **Education – Per Client Report** |
| Education problems that are exacerbated by substance use: |
| [ ]  Mild | [ ]  Moderate | [ ]  Severe | [ ]  None |
| Comments:  |
| Highest Education Completed: |
| [ ]  Less than High School | [ ]  GED | [ ]  Completed High School |
| [ ]  Some College | [ ]  Completed College | [ ]  Greater than College |
| **Employment History – Per Client Report** |
| Client currently employed:  | [ ]  Yes [ ]  No |
| Profession:  |
| Substance use/abuse has caused problems or contributed to: |
| [ ]  Absenteeism | [ ]  Tardiness | [ ]  Accidents | [ ]  Working while hung over | [ ]  Trouble concentrating |
| [ ]  Decreased job performance | [ ]  Consumed substance while at work | [ ]  No work problems |
| [ ]  Lost job in past due to substance abuse |
| Comments, if known:  |
| **Criminal History / Legal Status – Per Client Report** |
| Criminal Justice History/Violent Incidents of Individual and/or Family | Within last 90 days | Past |
|  | **Y** | **N** | **U** | **Y** | **N** | **U** |
| Assault on persons | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Threat to persons | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Property damage | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Weapons involved | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Legal History | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Probation | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Parole | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Adjudicated | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other: | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| For funding purposes only, have you ever been arrested? | [ ]  Yes [ ]  No |
| Describe criminal justice involvement/incidents (include level of community threat/safety, dates, types of crimes, outcomes, etc.),if known: |
| [ ]  Drug Court | [ ]  DUI | [ ]  PC-1000 | [ ]  Child Custody | [ ]  Other:  |
|   |
| Describe any relevant family involvement with criminal justice (include level of community threat/safety, dates, types of crimes, outcomes, etc.) if known: |
| [ ]  Restraining order | Who issued:  | For Whom:  |
|   |
| **Following Items Only Required for Perinatal Programs / Optional for Other Programs– Per Client Report** |
| 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:  |
| Client knowledge of parenting skills:  |
| Skills most needed:  |
| Client 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:  |
| **SUD Formulation – Per Client Report** |
| **Instructions:** Consider all information gathered in the intake for the SUD Formulation. 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 LPHA and within their scope of practice. IA, IV. 45. Definition of LPHA; [CA Department Health Care Services](http://www.dhcs.ca.gov/services/adp/pages/dmc_FAQs.aspx) & IA, IV. 50. |
|   |
| **Information for LPHA to make SUD Diagnosis – Per Client Report** |
| DSM-5 Diagnosis may only be made by a LPHA or MD, SUD Counselors may only gather the self-report information below regarding signs and symptoms and may only list a DSM-5 SUD Diagnosis if reported by client. |
| SUD Diagnosis **as reported by client (leave blank if no diagnosis reported) :**  |   |
| **BASIS FOR DIAGNOSIS** |
| 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)** | **Provide specific examples and timeframes for each substance** |
| [ ]  | 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. |   |   |
| [ ]  | 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.) |
| Additional Comments (if any):  |
|  |   |  |
| Signature of SUD Counselor\* | Printed Name/Credentials | Date |
|  |   |  |
| Signature of LPHA (required)\* | Printed Name/Credentials | Date |
|  |  |  |

\*When the intake/assessment is conducted by a SUD Counselor, the LPHA who is making the determination of medical necessity, must review this document and by signing, they are attesting that they have incorporated the information into that determination.