AOD/SUD INTAKE AND ASSESSMENT

INTAKE INSTRUCTIONS

Program staff shall review each completed health screening questionnaire that was completed by a participant. The health screening 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.

Program Staff shall inform the client about Duty to Warn, Duty to Protect: Most of the information gathered during the Intake and the course of treatment is considered private and confidential. The exception to the rules of privacy and confidentiality occur if a client reports clear intent to harm themselves or someone else. As mandated reporters, it is the therapist and/or counselor responsibility to notify the authorities and in some instances, warn the third party of potential harm. (W&IC 5150;Tarasoff)

Gather the following information from Client:

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

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

☐ Release for Emergency Contact obtained for this time period: _____

PERSONAL INFORMATION

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

Reason for the Client's Referral:

Primary Assigned Counselor: _____

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)

MEDICAL HISTORY

	Name:	Phone#: (if known)	Last Date of Service (if known)
a. Primary Physician:			
b. Other medical provider(s):			
c. Date records requested: From whom, if applicable:			

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):*			

☐ Significant Accident/Injuries/Surgeries:
☐ Hospitalizations:
☐ Physical Disabilities:
☐ Chronic Illness:
☐ HIV disease:
☐ Liver disease:
☐ TBI/ LOC

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)

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							
Non-Psychotropic							

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

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess

Risk factors: ☐ Yes ☐ No

Check all that apply: ☐ Aggressive/Violent Behaviors ☐ Thoughts of Self Harm
☐ Thoughts of harming another person

Mandated report required? ☐ Yes ☐ No If Yes, see report dated _____

☐ 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

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):

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):

SEXUAL ORIENTATION: ☐ **Unknown** ☐ **Heterosexual/Straight** ☐ **Lesbian** ☐ **Gay** ☐ **Bisexual** ☐ **Queer** ☐ **Gender Queer** ☐ **Questioning** ☐ **Declined to State** ☐ **Other:**

EDUCATION

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

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	
	Y	N	Y	N
Assault on persons				
Threat to persons				
Property Damage				
Weapons Involved				
Legal History				

Criminal Justice History/Violent Incidents of Individual and/or Family	Within last 90 days		Past	
	Y	N	Y	N
Probation				
Parole				
Adjudicated				
Diversion				
Other:				

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)

☐ Section Not Applicable

Date of birth or projected delivery date: _____

Client must provide one of the following documents:

☐ Medically confirmed pregnancy ☐ Hospital discharge paperwork

OR ☐ Need to obtain proof of pregnancy or delivery

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:_____

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

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.)

Additional Comments (if any):

SIGNATURE SECTION

Name of staff completing assessment, Title

Signature/Credentials Date