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.

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 Abuse	Current Dependence	In Recovery	Client-perceived Problem?	
ALCOHOL		☐	☐	☐	☐	☐	Y ☐	N ☐
AMPHETAMINES (SPEED/UPPERS, CRANK, ETC)		☐	☐	☐	☐	☐	Y ☐	N ☐
COCAINE/CRANK		☐	☐	☐	☐	☐	Y ☐	N ☐
OPIATES (HEROIN, OPIUM, METHADONE)		☐	☐	☐	☐	☐	Y ☐	N ☐
HALLUCIENOGENS (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 ☐
MARIJUANA/ HASHISH		☐	☐	☐	☐	☐	Y ☐	N ☐
TABACCO/ NICOTINE		☐	☐	☐	☐	☐	Y ☐	N ☐
CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.)		☐	☐	☐	☐	☐	Y ☐	N ☐
OVER THE COUNDER:		☐	☐	☐	☐	☐	Y ☐	N ☐
OTHER SUBSTANCE:		☐	☐	☐	☐	☐	Y ☐	N ☐
COMPLIMENETARY ALTERNATIVE MEDICATION		☐	☐	☐	☐	☐	Y ☐	N ☐

PREVIOUS DRUG AND/OR ALCOHOL TREATMENT HISTORY

Type of Previous Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Previous Treatment Facility	Dates of Previous Treatment	Treatment Completed (Yes or No)

MEDICAL HISTORY

	Name:	Phone#:	Last Date of Service
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:	Baseline Weight (if able to obtain):			BP:
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	☐ TBI/ LOC	☐ Menopause	
Skin:	☐ Scar	☐ Lesion	☐ Lice	☐ Dermatitis	☐ Cancer
Endocrine:	☐ Diabetes	☐ Thyroid	☐ Other:		
Respiratory:	☐ Bronchitis	☐ Asthma	☐ COPD	☐ Other	

☐ *Others:*

☐ Significant Accident/Injuries/Surgeries: _____

☐ Hospitalizations: _____

☐ Physical Disabilities: _____

☐ Chronic Illness: _____

☐ HIV disease: _____

☐ Liver disease:

Alternative healing practice/date (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- psychotropics & non-psychotropics, OTC, and holistic/ alternative remedies):

	Rx Name	Effectiveness/Side Effects	Dosage	Date Started	Prescriber	Current	Past
Psychotropic							
Non-Psychotropic							

Allergies/Adverse Reactions/ Sensitivities	Check if Yes and List ☐ Food ☐ Drugs(Rx/OTC/ILLICT) ☐ Unknown Allergies ☐ Other:		
Date of last physical exam:		Date of last dental exam:	
Referral made to primary care or specialty	YES ☐	NO ☐	If yes, list:

Additional Medical Information:

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess

Risk factors: ☐ Aggressive/Violent Behaviors ☐ Self Harm

☐ 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:

PSCYHOSOCIAL 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:

Social problems that are contributing to, or are exacerbated by substance use:
☐ Mild ☐ Moderate ☐ Severe ☐ None

Describe:

Economic Problems that are contributing to, or are exacerbated by substance use:
☐ Mild ☐ Moderate ☐ Severe ☐ None

Describe:

Cultural factors which may influence presenting problems: (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, socioeconomic status, living environment, etc.:

Describe:

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:

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:

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				

	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.):

☐ Narrative continued in Addendum

Describe any relevant family involvement with criminal justice (include level of community threat/safety, dates, types of crimes, outcomes, etc.)

☐ Narrative continued in Addendum

ASSESSMENT ITEMS REQUIRED FOR ALL PERINATAL PROGRAMS

(DMC & Non-DMC)

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:_____

APPROVED DSM-5 SUBSTANCE USE DISORDERS

DSM-5 Diagnosis _____

(Full diagnosis must be written out. ICD 9 or ICD 10 codes are insufficient.)

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 recover 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.)

Clinical Formulation

Instructions: Consider all information gathered in the intake for the Clinical 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.

http://www.dhcs.ca.gov/services/adp/pages/dmc_FAQs.aspx

22 CCR 5134.1.(h)(2)(A)(i)(a)