Client:

CMBHS

Clinical Management of Behavioral Health Services

Case Management AST022

Assessment Information

Assessment Number

Assessment Date *

Assessment Type *

Contact Type *

Assessment Site *

Referred By *

Comments

Client Issue

Presenting Problem *

In the Past 30 days *

	What Substances you have been using?	Route of Administration	Frequency of Use	Age of first use?
Primary				
Secondary				
Tertiary				

What substances do you seek? *

How many days have you used? *

How many days have you not used? *

Comments

Literacy, Language or Auditory challenges? * ◯ Yes ◯ No

Comments

Other Current Service Providers

Provider Type	Provider Name	Phone	Ext

Comments

Staff Info

Interviewer

Primary Counselor

Comments

General Education Information

What is the highest grade in school you completed? *

Did you ever need extra help in school? * Yes No

If Yes, select: English as a Second Language; Special Education; Speech Therapy; Mobility Aid; Behavioral Health Services; Alternative School

In the last 12 months have you been bullied? * Yes No

Are you currently in school? * Yes No N/A

Would you like assistance with your educational status? * Yes No

Would you like assistance with obtaining a GED? * Yes No

Comments

Employment

Are you currently employed * Yes No

What is your employment status? *

Reason for not in Labor force? *

Would you like assistance with your employment status? * Yes No

What is your primary source of income? *

When you work, type of work do you do?

Maternal Alcohol Use

To your knowledge, did your mother ever drink alcohol that caused problems for her or others around her? * Yes No Unknown

Did your mother drink alcohol when you were young? * Yes No Unknown

Did your mother drink alcohol while she was pregnant with you? * Yes No Unknown

Has anyone ever said anything to you about your mother's drinking during her pregnancy with you? * Yes No Unknown

Comments

Current Trauma

Do you currently feel safe where you live? * Yes No

Do you currently feel safe with the people in your life? * Yes No

Comments

Family Social tab

Current Social Status

What is your living situation? ◯ Dependent ◯ Independent ◯ Homeless

If dependent: ◯ Dependent Family Home ◯ Supported Housing ◯ Assisted Living

◯ Nursing Home ◯ Hospital ◯ Correctional Facility ◯ Other

In the last 30 days have you been released from a secured environment such as residential substance use disorder treatment program jail or prison? ◯ Yes ◯ No

If yes, in the year before you entered the controlled environment did you use opioids? ◯ Yes ◯ No

Marital status ◯ Divorced ◯ Never Married ◯ Now married Separated ◯ Widowed

How many children do you have under the age of 18? ☐

List your Children

No	Child Name	Age	Gender	Legal Custody
1				
2				
3				
4				

Are you currently working on Reunification? ◯ Yes ◯ No

Would you like assistance with Reunification? ◯ Yes ◯ No

Comments

Physical Health

Current Information

Do you currently have a chronic medical condition? ◯ Yes ◯ No

If Yes Please explain

Are you currently taking any prescribed medications for medical reasons? ◯ Yes ◯ No

If Yes what are they?

Are you enrolled in Medication Assisted Treatment? ◯ Yes ◯ No

Are you prescribed any of the following ?

☐ Naloxone ☐ Methadone ☐ Buprenorphine
☐ Suboxone ☐ Subutex ☐ Vivitrol

If any were marked, have you recently stopped prescription use of Vivitrol (naltrexone), methadone, or buprenorphine (Suboxone, Subutex)? ◯ Yes ◯ No

Have you experienced a non-fatal overdose? ◯ Yes ◯ No

If yes, have you ever been administered naloxone or Narcan? ◯ Yes ◯ No

In the past 30 days, how many days have you been hospitalized? *

Have you given birth in the last 18 months? ◯ Yes ◯ No

If yes, have you used opioids in the past 3 years? ◯ Yes ◯ No

Are you currently pregnant? ◯ Yes ◯ No

Do you think you could be pregnant? ◯ Yes ◯ No ◯ Unknown

Are you using tobacco? ◯ Yes ◯ No ◯ N/A

Would you like assistance to cut back or quit? ◯ Yes ◯ No

Would you like assistance with

☐ Your Physical health
☐ Obtaining Medical Insurance
☐ Your Dental Health
☐ Your Vision care
☐ Obtaining Medical Prescription
☐ HIV Medical Care
☐ STD/STI Services
☐ HCV Services
☐ Prenatal Care
☐ Reproductive/Sexual Health

Comments

Mental Health

Historical Information

Other than a problem with substance use, have you been told you have mental health difficulties or disorders? * ◯ Yes ◯ No

If Yes what were you told?

Have you ever tried to commit suicide? * ◯ Yes ◯ No

Comments

Current Information

Are you currently seeing a Licensed Professional of the Healing Arts for any mental health condition or problem? ◯ Yes ◯ No

If Yes what are you being treated for?

If Yes, are you taking any prescription medications? * ◯ Yes ◯ No

If Yes what are they?

Are you currently having thoughts of killing yourself? * ◯ Yes ◯ No

Would you like assistance with your mental health? * ◯ Yes ◯ No

Comments

Do you frequently have difficulties with any of the following:

Concentrating and paying attention?	*	Yes	No
Understanding what adults are telling you?	*	Yes	No
Remembering things?	*	Yes	No
Following rules and instructions?	*	Yes	No
Getting along with others without arguing or fighting?	*	Yes	No
Being on time?	*	Yes	No
Keeping enough money to last you throughout the month?	*	Yes	No
Doing things that later you wish you hadn't done?	*	Yes	No
Getting really upset at little things or what people have told are little?	*	Yes	No
Forgetting or missing appointments?	*	Yes	No
Being surprised when you are in trouble?	*	Yes	No
Have you ever tried to commit suicide?	*	Yes	No
Have you wished you were dead or wished you could go to sleep and not wake up?	*	Yes	No

Comments

High Risk behaviors

Have you ever

* Injected drugs? ◯ Yes ◯ No

* Shared injecting equipment? ◯ Yes ◯ No

* Shared equipment for snorting drugs? ◯ Yes ◯ No

* Had unprotected sex without condoms or latex barriers? ◯ Yes ◯ No

* Had unprotected sex with someone who injects drugs? ◯ Yes ◯ No

* Engaged in self-injurious behaviors? ◯ Yes ◯ No

* Do you have tattoos or piercings? ◯ Yes ◯ No

* Have you had a persistent couch (longer than three months) and not visited a doctor? ◯ Yes ◯ No

* Have you been tested (screened for TB) within the past year? ◯ Yes ◯ No

Briefly describe current risk behaviors:

Comments

Substance Use

* Age at first use of any substance? ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18

* Have you ever sought Substance Use Treatment before today? ◯ Yes ◯ No

If yes what treatment have you received?

Please supply the number of treatment episodes the client received for each treatment service

Number of Episodes	Treatment Services Received

Sum of number of prior treatment episodes

Comments

Recommendation

Client selected support needs

- [ ] Education
- [ ] Obtaining Medical Insurance
- [ ] Trauma
- [ ] Sober Activity
- [ ] GED
- [ ] Social Living Environment
- [ ] Your Dental Health
- [ ] Obtaining Medical Prescription
- [ ] Reunification Services
- [ ] Recovery Coach
- [ ] Your Vision Care
- [ ] Living Situation
- [ ] Employment
- [ ] HIV Medical Care
- [ ] Family Support
- [ ] Support Group
- [ ] Mental Health
- [ ] Social Welfare Programs
- [ ] Veterans Affairs
- [ ] STD/STI Services
- [ ] Housing Environment, Paying for Housing
- [ ] Food Assistance
- [ ] Legal
- [ ] HCV Services
- [ ] Tobacco
- [ ] Prenatal Care
- [ ] Financial Assistance Programs
- [ ] Children's Services and Needs
- [ ] Your Physical Health
- [ ] Reproductive/ Sexual Health
- [ ] Child Welfare System
- [ ] Community Support
- [ ] Transportation Assistance

*Comments