Client:

CMBHS

Clinical Management of Behavioral Health Services

Detoxification Assessment

Assessment Information

(Note: All are Required fields)

Assessment Number

Assessment Date

Assessment Type

Contact Type

Assessment Site

Referred By

Comments

(optional)

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

General Education Information

*What is the highest grade in school you completed?

If you didn't finish school, why did you leave?

*What is the longest time you have worked at the same job? ◯ 30 days ◯ 180 days ◯ 1 year ◯ 2-4 years ◯ 5+ years

* Have you ever received income from SSI? ◯ Yes ◯ No ◯ Unknown

* Have you gotten so high or sick from alcohol or drugs that it kept you from fulfilling work or school obligations? ◯ Yes ◯ No

*Have you spent less time at work or school so that you could drink or use drugs? ◯ Yes ◯ No

*Are you currently in school? ◯ Yes ◯ No

*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? *

What is your primary source of income? *

Are you currently active duty in the United States military? * ◯ Yes ◯ No ◯ N/A

Have you ever served in the military? * ◯ Yes ◯ No

Did you serve in the National Guard, Reserves, Coast Guard or any of the Active Duty Services? ◯ Yes ◯ No

If you served in the military what was the discharge status on your Defense Department Form 214? ◯ Medical ◯ Honorable ◯ Other than Honorable ◯ Unknown

Would you like assistance with your Veterans Affairs Services? ◯ Yes ◯ No

Comments

Family Social tab Current Social Status (Note: All fields are required)

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

If Dependent
◯ Dependent Family Home ◯ Support Housing ◯ Assisted Living ◯ Nursing Home
◯ Hospital ◯ Correctional Facility ◯ Other

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

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

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

Have you spent less time with your support system so that you could drink or use drugs?
◯ Yes ◯ No

In the past 30 days, how many times have you attended self-help groups? (e.g. AA, NA, etc.)
◯ No attendance in the past month ◯ 1-3 times in the past month ◯ 4-7 times in the past month ◯ 8-15 times in the past month
◯ 16-30 times in the past month ◯ Some attendance in the past month, but frequency unknown

Comments
[ ]

Legal tab

Current Information

*What is your current legal status?
◯ NA ◯ Jail or Prison ◯ Probation ◯ Parole ◯ Diversion Program ◯ Awaiting Trial ◯ Awaiting Sentencing

* In the past 30 days, how many times have you been arrested?
[ ]

Would you like assistance with your legal status?
◯ Yes ◯ No

Comments
[ ]

Physical Health tab

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

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

Are you pregnant or 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

Do you have any allergies? ◯ Yes ◯ No

If Yes what are they?

Would you like assistance with ☐ Your Physical health ☐ Obtaining Medical Insurance ☐ Your Dental Health ☐ Your Vision care ☐ Obtaining Medical Prescription

Comments

Clinical Institute Withdrawal Assessment (CIWA) -Alcohol Scale, Revised

Nausea and Vomiting

*Do you feel sick to your stomach? Have you vomited?
Observation only

no nausea	*mild nausea with no vomiting*	*intermittent nausea with dry heaves*	*constant nausea, frequent dry heaves and vomiting*
◯ 0	◯ 1 ◯ 2 ◯ 3	◯ 4 ◯ 5 ◯ 6	◯ 7

Tremor

*Arms extended and fingers spread apart.
Observation only

no tremors	*not visible but can be felt fingertips to finger tips*	*moderate with patient's arms extended*	*Severe even with arms not extended*
◯ 0	◯ 1 ◯ 2 ◯ 3	◯ 4 ◯ 5 ◯ 6	◯ 7

Paroxysmal Sweats

*Sweating
Observation Only

no sweat visible	*barely perceptible palms moist*	*Head of sweat obvious on forehead*	*drenching sweat*
◯ 0	◯ 1 ◯ 2 ◯ 3	◯ 4 ◯ 5 ◯ 6	◯ 7

Anxiety

*Do you feel nervous?
Observations only

no anxiety	*mild anxious*	*moderately anxious or guarded*	*acute panic*
◯ 0	◯ 1 ◯ 2 ◯ 3	◯ 4 ◯ 5 ◯ 6	◯ 7

Tactile Disturbances

*Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?
Observation only.

none	*very mild itching pins and needles*	*mild itching pins and needles*	*moderate itching*	*moderate severe hallucination*	*severe hallucination*	*extremely severe hallucinations*	*continuous hallucinations*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7

Auditory Disturbances

*Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?
Observation only.

not present	*very mild harshness or ability to frighten*	*mild harshness*	*moderate harshness*	*moderate severe harshness*	*severe harshness*	*extremely severe harshness*	*continuous harshness*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7

Visual Disturbances

*Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?
Observation only.

not present	*very mild sensitivity*	*mild sensitivity*	*moderate sensitivity*	*moderate severe hallucination*	*severe hallucination*	*extremely severe hallucination*	*continuous hallucination*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7

Headaches, Fullness in Head

*Does your head feel different? Does it feel like there is band around your head? Do not rate for dizziness or lightheadedness.
Rate severity.

not present	*very mild*	*mild*	*moderate*	*moderate severe*	*severe*	*very severe*	*extremely severe*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7

Agitation

*Observation

normal activity	*somewhat more than normal*	*moderately fidgety and restless*	*paces back and forth during most of the interview or constantly thrashing about*
◯ 0	◯ 1 ◯ 2 ◯ 3	◯ 4 ◯ 5 ◯ 6	◯ 7

Orientation and Clouding of Sensorium

*What day is this? Where are you? Who am I?

oriented and can do serial additions	*cannot do serial addition or is uncertain about date*	*disoriented for date by no more than 2 days*	*disoriented for date by more than 2 days*	*disoriented for place/or person*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

Total CIWA-Ar Score

☐ **Maximum possible score = 67**

Very mild withdrawal	*Mild withdrawal*	*Modest withdrawal*	*Several Withdrawal*
0 to 9 Points	**10 to 15 Points**	**16 to 20 Points**	**21 to 67 Points**

Clinical Opiate Withdrawal Scale (COWS)

* Resting Pulse Rate ☐ beats/minutes

pulse rate 80 or below	*pulse rate 81-100*	*pulse rate 101-120*		*pulse rate 120+*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

Sweating

*Observation

no report of chill or flushing	*subjective reports*	*flushed or observable moistness on face*	*beads of sweat on brow or face*	*sweat streaming from face*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

Restlessness

*Observation

Unable to sit still	*reports difficulty sitting*	*frequently shifting*	*unable to sit*
serial additions	*still but is able to do so*	*or extraneous movement of legs/arm*	*for more than a few seconds*
◯ 0	◯ 1 ◯ 2	◯ 3 ◯ 4	◯ 5

Pupil Size

*Observation

pupil pinned or normal size	*pupils possibly*	*pupil moderately dilated*	*pupils so dilated that*
for room light	*larger* than normal		*only the rim of the iris is visible*
◯ 0	◯ 1	◯ 2 ◯ 3 ◯ 4	◯ 5

Bone and Joint Ache

*Observation

not present	mild diffuse discomfort	*patient reports*	*patient is rubbing joints or muscles*
		severe diffuse aching of joint and muscles	*and is unable to sit still due to discomfort*
◯ 0	◯ 1	◯ 2 ◯ 3	◯ 4

Running nose or tearing

*Observation

not present	nasal stuffiness	*nose running or tearing*	*nose constantly running*
	or unusually moist eyes		*or tears streaming down cheeks*
◯ 0	◯ 1	◯ 2 ◯ 3	◯ 4

GI Upset

*Observation

no GI symptoms	stomach cramps	*nausea*	Vomiting or diarrhea	*multiple episodes of*
		or loose stool		*diarrhea or vomiting*
◯ 0	◯ 1	◯ 2	◯ 3 ◯ 4	◯ 5

Tremor

*Observation outreach hands

no tremor	tremor can be felt but not observed	*slight tremor observable*	*Gross tremor or muscle twiching*
◯ 0	◯ 1	◯ 2 ◯ 3	◯ 4

Yawning

*Observation

no yawning	*yawning once or twice during assessment*	*yawning three or more times during assessment*	*yawning several times/minute*
◯ 0	◯ 1	◯ 2 ◯ 3	◯ 4

Anxiety or Irritability

*Observation

none	patient reports *increasing irritability or anxiousness*	*patient obviously irritable or anxious*		*patient so irritable or anxious that patient in the assessment is difficult*
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

Gooseflesh skin

*Observation

skin is smooth			piloerection can be felt	prominent piloerection
◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

Total COWS Score

[ ]

Maximum possible score = 48

Mild	*Moderate*	*Moderately Severe*	*Severe*
5 to 12 Points	**13 to 24 Points**	**25 to 36 Points**	**More than 36 Points**

Mental Health tab

Historical Information

(Note: These are required fields.)

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? [ ]

Has your use of alcohol or drugs caused emotional or psychological problems? ◯ Yes ◯ No

Comments [ ]

Current Information

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

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

Comments [ ]

Substance Use tab

(Note: These are required fields.)

Age at first use of any substance?

○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14
○ 15 ○ 16 ○ 17 ○ 18 ○ 19+

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

In the past when you stopped using, have you had any of the following:

☐ Shakes/Tremors
☐ Cravings
☐ Profuse sweating
☐ Anxiety
☐ Blackouts
☐ Vomiting
☐ Seizures
☐ Hallucinations (Visual, Tactile, Auditory)
☐ Memory Lapses
☐ Nausea
☐ Delirium Tremors(DT)
☐ Headaches

Comments

Diagnosis Tab

Strengths and Limitations

Client's Strengths *

Client's Limitations *

Calculated Severity Score *

Order of Treatment Services

Note: Principle Diagnosis in this Episode of Care is line 1 in the Order of Treatment Services.

Order	Code / Descriptor *	Justification
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		

Minimum search 3 chars Code/ 5 chars Descriptor

Comments

Recommendation tab

Priority Population Status

Comments

Client selected support needs

- ☐ Veterans Affairs
- ☐ Education
- ☐ Employment
- ☐ Legal
- ☐ Tobacco
- ☐ Physical Health
- ☐ Dental Health
- ☐ Vision Care
- ☐ Medical Insurance
- ☐ Medical Prescription
- ☐ Mental Health
- ☐ Living Situations
- ☐ Child Welfare System
- ☐ Social Welfare Programs
- ☐ Reunification Services
- ☐ Family Support
- ☐ Housing Environment, Paying for Housing
- ☐ Community Support
- ☐ Financial Assistance Programs
- ☐ Transportation Assistance
- ☐ Children's Services and Needs
- ☐ Sober Living Environment
- ☐ Sober Activity
- ☐ Recovery Coach
- ☐ Support Group
- ☐ Food Assistance