Client:

CMBHS

Clinical Management of Behavioral Health Services

Substance Use Assessment 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? *

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

In what grade OR at what age did you start using alcohol or drugs? * Grade Age

Did you start using alcohol or drugs after problems in school began? * Yes No

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

What area of school caused you the most problems? * Math Language Arts Physical Education

What is the longest time the client has held a fulltime 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

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?

Have you ever engaged in illegal activities for profit? Yes No

If Yes Please explain

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

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

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 Family History

Were you raised by someone other than your biological/birth parents? * ◯ Yes ◯ No

How many living situations (different primary caregiver) did you have while you were growing up? *

Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? * ◯ Yes ◯ No

Did a parent or other adult in the household often:

Swear at you, insult you, put you down or humiliate you? OR
Act in a way that made you afraid that you might by physically hurt? * ◯ Yes ◯ No

Push, grab, slap, or throw something at you? OR
Ever hit you so hard that you had marks or were injured? * ◯ Yes ◯ No

Did an adult or person at least 5 years older than you ever:
Touch or fondle you or have you touch their body in a sexual way? OR
Attempt or actually have oral, anal or vaginal intercourse with you? * ◯ Yes ◯ No

Did you often feel that:

No one in your family loved you or thought you were important or special? OR
Your family didn't look out for each other, feel close to each other, or support each other? * ◯ Yes ◯ No

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? * ◯ Yes ◯ No

Were your parents ever separated or divorced? * ◯ Yes ◯ No

Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her? OR
Sometimes, often kicked, bitten, hit with a fist, or hit with something hard? OR
Ever repeatedly hit at least a few minutes or threatened with a gun or knife? * ◯ Yes ◯ No

Comments

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

Living Situation

As an adult, have you ever lived on your own? * ◯ Yes ◯ No ◯ NA

How long have you lived on your own at any one time? * ◯ NA ◯ 3 months ◯ 6 months ◯ 1 Year ◯ 2 Years ◯ 3 Years ◯ 5 Years ◯ Over 5 Years

Have you ever

Been homeless? ◯ Yes ◯ No

Been without any family, friends, or caretakers? ◯ Yes ◯ No

Had state protective services involved with your family?

As a child? ◯ Yes ◯ No

Since being an adult? ◯ Yes ◯ No

Had a history of Intimate Partner Violence? ◯ Yes ◯ No

Been bullied at home? ◯ Yes ◯ No

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

Current Social Status

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

If Dependent ◯ Dependent Family Home ◯ Support 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

* Have you gotten so high or sick from alcohol or drugs that it kept you from fulfilling your family obligations?

◯ Yes ◯ No

* Have you spent less time with your support system so that you could drink or use drugs?

◯ Yes ◯ No

* Have you spent a lot of time getting alcohol or drugs, using them or recovering from their use?

◯ Yes ◯ No

* Has your use of alcohol or drugs caused problems with your support system?

◯ 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
◯ No attendance in the past month ◯ 1-3 times in the past month ◯ 4-7 times in the past month

* In the past 30 days, how many times have you attended community support group?

◯ 8-15 times in the past month ◯ 16-30 times in the past month ◯ Some attendance in the past month, but frequency unknown

Do you do anything for fun?

◯ Yes ◯ No If Yes Please explain

Does anything stop you from doing above?

◯ Physical Limitations ◯ Transportation ◯ Education/Employment
◯ Family ◯ Finances ◯ Substance Use

Do you have any spiritual practices? ◯ Yes ◯ No If Yes Please explain

How many people do you trust? ◯ 0-2 ◯ 3-5 ◯ 5+

How many people do you rely upon? ◯ 0-2 ◯ 3-5 ◯ 5+

Do any of your close friends or family use alcohol or other drugs? ◯ Yes ◯ No

Do you and/or your friends/family have access to naloxone or Narcan to reverse an overdose? ◯ Yes ◯ No

In the Past 12 months have you:

- ☐ Changed your friends
- ☐ Changed the type of clothing (gang colors, and symbols, gang type clothing)
- ☐ Experienced school problems (truancy, lost interest, suspended, detention)
- ☐ Distanced yourself from your support system
- ☐ Been involved in criminal justice system

Do you need any help with the following?

- ☐ Family Support
- ☐ Social Welfare Programs
- ☐ Food Assistance
- ☐ Housing Environment, Paying for Housing
- ☐ Sober Living Environment
- ☐ Transportation Assistance
- ☐ Community Support
- ☐ Sober Activity
- ☐ Children Services and Needs
- ☐ Financial Assistance Programs
- ☐ Recovery Coach
- ☐ Child Welfare System
- ☐ Support Group

Comments

Historical Information

When you were growing up, did any of your household members go to prison? * ◯ Yes ◯ No

If Yes, whom: ◯ Mother ◯ Father ◯ Stepparent ◯ Sibling ◯ Grand parent ◯ In Home Relative ◯ Non-Relative In Home ◯ Foster Parent

Were you ever in trouble with the law? * ◯ Yes ◯ No

Were you ever arrested? * ◯ Yes ◯ No

Past Legal Status? * ◯ Past Probation ◯ Past Parole ◯ Past Incarceration

Comments

Current Information

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

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

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

Who is your point of contact for Legal issues?

Comments

Physical Health Tab

In the past 12 months

Do you have a history of medical conditions or medical problems In the past 12 months?	◯ Yes	◯ No
* Have you used larger amounts of alcohol or drugs or used them for a longer time than you planned?	◯ Yes	◯ No
* Have you tried to cut down on alcohol and drugs and were unable to do it?	◯ Yes	◯ No
* Have you gotten so high or sick from alcohol or drugs that it caused an accident or became a danger to you or others?	◯ Yes	◯ No
* Have you gotten so high or sick from alcohol or drugs that it caused physical health or medical problems?	◯ Yes	◯ No
* Have you increased the amount of alcohol or drugs you were taking so that you could get the same effects as before?	◯ Yes	◯ No
* Have you gotten sick or had withdrawals when you quit drinking or missed taking a drug?	◯ Yes	◯ No
* Have you continued to drink or take drugs to avoid withdrawals or to keep from getting sick?	◯ Yes	◯ No
Has your physical health been so bad that it resulted in hospitalization?	◯ Yes	◯ No

Comments

Current Information

(Note: These are all required fields)

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 past 18 months? ◯ Yes ◯ No

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

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

Do you have any allergies? ◯ Yes ◯ No If Yes what are they?

Would you like assistance with (optional)

- ☐ 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 Tab

Historical Information

Did you receive childhood mental health services? ◯ Yes ◯ No ◯ Unknown

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?

Was a household member depressed or mentally ill? * ◯ Yes ◯ No

Did a household member attempt suicide? * ◯ Yes ◯ No

Have you experienced changes in sleep, eating or your weight? * ◯ Yes ◯ No

Have you ever:

Heard voices no one else could hear or seen objects or things which others could not see? ◯ Yes ◯ No

Felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? ◯ Yes ◯ No

Had a period of time

When you were so full of energy and your ideas came very rapidly? ◯ Yes ◯ No

When you talked nearly non-stop? ◯ Yes ◯ No

When you needed little sleep? ◯ Yes ◯ No

Experienced feeling of sadness that were unbearable? ◯ Yes ◯ No

Lost pleasure in all or almost all activities? ◯ Yes ◯ No

Felt worthless or have excessive or inappropriate guilt? ◯ Yes ◯ No

Been unable to make decisions, concentrate or think? ◯ Yes ◯ No

Getting along with others without arguing or fighting? ◯ Yes ◯ No

Had difficulty managing anger? ◯ Yes ◯ No

Experienced excessive anxiety and worry? ◯ Yes ◯ No

Believed you could do almost anything? ◯ Yes ◯ No

Engaged in self-injurious behavior? ◯ Yes ◯ No

Tried to hurt or kill a person? ◯ Yes ◯ No

Tried to hurt or kill an animal? ◯ Yes ◯ No

Intentionally damaged property that was not yours? ◯ Yes ◯ No

* How many times have you been treated for psychological problems in a hospital/residential treatment setting? ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 6+

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

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

Substance Use tab

High Risk behavior

(Note: All are required fields)

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
Been pregnant?	◯ 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

Comments

Substance Use

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: (Mark all that the client has experienced)

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

Comments

* Order of Treatment Services

Diagnosis Tab

Strengths and Limitations

* Client's Strengths

* Client's Limitations

Calculated Severity Score

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			
14			
15			
16			
17			
18			

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