Counseling And Recovery Services

Patient Intake & Assessment

Instructions: Please complete every page included in this packet. Do not leave any blanks. Please indicate "N/A" if a question does not apply to you.

Name		Date of Birth		Gender	☐ Male ☐ Female
Current Address		How long? Yrs./Mos.		County	
City/State/ Zip		Is this clinic convenient for you?	☐YES ☐NO	Is there a child-proof storage area in the home?	☐YES ☐NO
Spiritual Preference		Do you have medical insurance?	☐YES ☐NO	Do you have Medicare/ Medicaid?	☐YES ☐NO
Does anyone contribute the majority of your support?	☐YES ☐NO	How many people depend on you for the majority of their food, shelter, etc?		Are any of your children currently in foster care?	☐YES ☐NO

List everyone who lives at your current residence:

Name	Relation to you	Their age	Name	Relation to you	Their age
1.			3.		
2.			4.		

Check one in each category:

Sexual Orientation	Ethnicity	Marital Status	Living Situation	Income	Current Employment Status
☐ Heterosexual	☐ White	☐ Never married	☐ Live alone	☐ None	☐ Part-time
☐ Bisexual	☐ Black	☐ 1st time married	☐ Live with spouse/common	☐ Salary	☐ Full-time
☐ Lesbian	☐ Hispanic	☐ Remarried	☐ A family member	☐ Public Assist	☐ Unemployed
☐ Gay	☐ Asian	☐ Widowed	☐ With a friend	☐ Retirement	☐ Homemaker
☐ Transgender	☐ Native Am	☐ Cohabitating	☐ A group	☐ Disability	☐ Student
☐ Other	☐ Multiethnic	☐ Divorced	☐ Homeless	☐ Family/Friends	☐ Retired
Gender Expression	☐ Other	☐ No Children	☐ Other relatives	☐ Illegal Gains	☐ Disabled
☐ M ☐ F ☐ X			☐ Other	☐ Other	☐ Other

What are your cultural influences & background? _____

_____

What has been your usual employment pattern over the past 3 years?

☐	Full-time (35+ hours per week)	☐	Military Service
☐	Part-time (regular hours)	☐	Retired/disability
☐	Part-time (Irregular hours)	☐	Not in workforce
☐	Student	☐	In controlled environment

What is the highest education level you have completed?

☐	10th grade or less	☐	Associates Degree
☐	11th grade	☐	3+ yrs in college
☐	12th grade / GED	☐	Bachelor's Degree
☐	1 yr. of college	☐	Post-bachelor's

Were you in the military?	☐	NO	☐	YES	If "Yes":	Branch		Years		Discharge	

How well do you feel you read & write?	☐	Not at all	☐	Below Average	☐	Average	☐	Above Average	☐	Very Well	

Do you require special accommodations or assistive technologies?	☐	NO	☐	YES	IF "Yes", what type:

What is your usual occupation?		How long was your longest full-time job?	
What are your career goals?			

What do you hope to gain from methadone maintenance treatment?

☐ Stop using opiates and/or other drugs.	☐ Improve my current educational/vocational situation.	☐ Improve my economic/financial situation.
☐ Improve my current employment situation.	☐ Improve my medical/psychological well being.	☐ Improve my current legal status.
☐ Improve my relationships.	☐ Other:	☐ Other:

FAMILY/SOCIAL HISTORY

Have you had significant periods in which you have experienced serious problems getting along with the following:

	PAST 30 DAYS	PAST 60 DAYS	IN LIFE TIME
Mother	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Father	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Sister/Brother	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Sexual Partner/Spouse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Children	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Other Significant Family Member	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Close Friends	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Neighbors	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Co-Workers	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Other	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Have you experienced or witnessed any of the following?

	PAST 6 MONTHS	PAST YEAR	IN LIFE TIME
Abuse (verbal or emotional)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Neglect	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Violence	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Sexual Assault	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

With whom do you usually spend your free time?		How many friends are opiate users?		How many friends are on methadone?	
Is there a history of family addiction? ☐YES ☐NO	What is the relation to you?		For what drug type?		
Did they get help for their problem? ☐YES ☐NO					
What is your birth order in your family?	☐Only child ☐1st Born ☐2nd Born ☐3rd Born ☐ 4th Born ☐5th Born			Total Siblings	
Why did you leave home?					

PSYCHOLOGICAL HISTORY/STATUS

In the last 2-4 weeks, have you had a significant period (not a direct result of drug/alcohol use), in which you have experienced:

☐	Serious Depression	☐	Preoccupation w/ sex	☐	Attempted suicide
☐	Serious Anxiety or tension	☐	Engaged in compulsive behaviors	☐	Serious thoughts of self-harming behavior
☐	Trouble understanding, concentrating or remembering	☐	Trouble controlling violent behavior	☐	Engaged in self-harming behavior
☐	Hallucinations	☐	Suicidal thoughts	☐	Engaged in pleasurable activities with high potential for painful consequences.

How many times have you been treated for any psychological or emotional problems?	Hospital	Out-patient	Do you receive a pension for a psychiatric disability?		☐YES ☐NO
Current Diagnosis:		Physician's Name & Phone #			
Are you currently on medication(s)for this disorder?	☐YES ☐NO	Are you willing/does your physician know you are seeking methadone treatment?			☐YES ☐NO
How many days in the last 30 have you been affected by your disabilities and/or disorders psychologically & socially?					
If affected, how does it affect you?					
What day of the week is it?		Who is the President of the United States?			
What city are you in?		Current month and year?			

Do you currently have serious thoughts or plans to:	Harm yourself?	☐ Yes ☐ No	Harm someone else?	☐ Yes ☐ No

Does the patient appear to need a Behavioral Management Treatment Plan?	☐ Yes ☐ No

SUBSTANCE ABUSE HISTORY ☐ TRANSFER-IN

Print Name_____ **Date of Birth** _____

Have you been using opiates/ heroin for more than one year?	☐YES ☐NO	How long?			Have you used opiates in the last 24 hours?	☐YES ☐NO
Are you or recently have been enrolled in methadone program?	☐YES ☐NO	How long?		Where?		

	# of days in past 30 Days	How much	Lifetime Use (Years)	Age at First Use	Route of Administration						
					Oral	Nasal	Smok-ing	IV Use	Non-IV	Other	No use
Heroin					❑	❑	❑	❑	❑	❑	❑
Street Methadone (non-treatment)					❑	❑	❑	❑	❑	❑	❑
Other Opiates/Analgesics (Opium/Demerol/Morphine/ Hydrocodone & Oxycodone)					❑	❑	❑	❑	❑	❑	❑
Hypnotics/ Sedatives/ Anxiolytics					❑	❑	❑	❑	❑	❑	❑
Cocaine/Crack					❑	❑	❑	❑	❑	❑	❑
Cannabis (marijuana/hashish)					❑	❑	❑	❑	❑	❑	❑
Alcohol					❑	❑	❑	❑	❑	❑	❑
Amphetamines/ Methamphetamines					❑	❑	❑	❑	❑	❑	❑
Hallucinogens (LSD/Psychedelics/ PCP/Mushrooms/Peyote)					❑	❑	❑	❑	❑	❑	❑
Barbiturates					❑	❑	❑	❑	❑	❑	❑
Inhalants					❑	❑	❑	❑	❑	❑	❑
Tobacco					❑	❑	❑	❑	❑	❑	❑

DO NOT LEAVE ANY BLANKS:

Regarding heroin and/or use of other opiates, in the past 12 months have you:	**Y**	**N**
Taken opioids in larger amounts or for longer periods of time than intended?	☐	☐
Found you're not successful in your efforts to cut-down or control use?	☐	☐
Found yourself spending more time in trying to obtain and/or trying to recover from the effects of using it?	☐	☐
Had cravings or strong urges to use opioids?	☐	☐
Been unable to fulfill major role obligations because of opioid use?	☐	☐
Continued use of opioids despite it causing problems with family & friends?	☐	☐
Given up or reduced important social, occupational, or recreational activities because of drug use?	☐	☐
Used opioids in situations where it was physically hazardous?	☐	☐
Used opioids even though it made a physical or psychological problem worse?	☐	☐
Found a need for increased amounts to achieve the desired effect?	☐	☐

DO NOT LEAVE ANY BLANKS:

Regarding heroin and/or use of other opiates, in the past 12 months have you:	**Y**	**N**
Found yourself using the drug again to relieve or avoid withdrawal symptoms?	☐	☐
Please answer the following questions:		
How many times in your life have you been treated for substance abuse?		
Approximate date of last time you were in treatment:		
Location of treatment center:		
How many of these were for detox only?		
How many times have you overdosed?		
List the prescription drugs or over-the-counter medications you are currently taking.		

What issues have caused you to seek treatment today? _____

_____

I acknowledge that the information provided is accurate and true.

_____ _____ _____

Patient Signature **TDL/ID #** **Date**

LEGAL STATUS/HISTORY

Information will be kept confidential.

Type of Offense	Total arrests	Type of Offense	Total arrests	Type of Offense	Total arrests
Public Intoxication	☐	Gambling/bookmaking	☐	Arson/weapons	☐
DWI	☐	Prostitution/pimping	☐	Vandalism/vagrancy/ loitering	☐
Use of Illegal Drugs	☐	Burglary or auto theft	☐	Sex offenses	☐
Sale/distribution/manufacturing	☐	Other theft	☐	Probation/Parole Violations	☐
Forgery/Fraud	☐	Robbery	☐	Other	☐
Buying/receiving stolen property	☐	Assault	☐		

Do you have a suspended driver's license?	☐YES ☐NO	For what reason?		
Do you need to complete an offender education course to get your license back?	☐YES ☐NO	Name/Address/Telephone of Supervision Officer:		
What is you current legal status?	☐Clear	☐Warrants out	☐Awaiting trial or sentencing	
☐Probation	☐Parole	☐Work-release	☐Other	
For which offense?		When does your current parole/ probation end?		

What are your treatment preferences?

Check appropriately: one choice only	YES	NO	DOESN'T MATTER	Check appropriately:	YES	NO	DOESN'T MATTER
This location is convenient for me.	☐	☐	☐	I prefer a female Counselor.	☐	☐	☐
I require special accommodations.	☐	☐	☐	I prefer family involvement.	☐	☐	☐
A.M. clinic hours are ok.	☐	☐	☐	I don't mind written/reading assignments.	☐	☐	☐
I prefer outpatient over in-patient treatment.	☐	☐	☐	I don't mind going to 12-Step meeting such as NA/AA.	☐	☐	☐
I prefer a male counselor.	☐	☐	☐	I prefer controlled use of drugs over freedom from all drugs use.	☐	☐	☐

STANDARD COURSE OF TREATMENT

The following outlines the course of treatment. I understand I am to ask questions if I do not understand.

- If you are new to methadone maintenance treatment or beginning a new treatment experience with Counseling And Recovery Services you will be involved in the titration phase of treatment whereby you will be medically monitored to ensure you become stabilized on methadone. Your input is very important during this process.
- Upon stabilization you will begin to meet with your assigned counselor on a regular basis to begin developing a Treatment Plan whereby you and your counselor will determine how, based on your strengths, needs, abilities, and preferences, will accomplish the goals <u>you</u> set for yourself while in treatment.
- You will be encouraged to refrain from all illicit or unapproved drug use so that when you complete at least 30 days in treatment you may progress to the next level in the treatment process and receive take-home medication for the weekend. Until then, you will be required to attend the clinic daily, except for Sunday. All take-out schedules are determined by time in treatment and other important criteria. You may become eligible for additional take-home medication as you transition from one phase of treatment to the next.
- Should you <u>not</u> transition or progress through the treatment process as expected, you may be required to attend specialty groups and/or increase the number of counseling sessions you are required to have with your counselor.
- If at anytime you choose to voluntarily terminate your treatment with Counseling And Recovery Services, or discharged during the course of treatment for any reason, the staff at Counseling And Recovery Services will assist you with a transfer to another methadone maintenance clinic, a detoxification center, and/or help you become familiar with community resources (such as Narcotics Anonymous & Relapse Prevention Groups) to help you continue your recovery from opiate addiction.

_____ _____

Patient Signature **Date**

_____ _____

Intake Counselor Signature **Date**