INITIAL AODA INTAKE ASSESSMSENT

NAME: ________________________________DOB___________________
DATE:_____________ HS 75
2002

DATE:_____________

PRESENTING ISSUES (symptoms):

PSYCH/SOCIAL HISTORY (education, vocation, legal issues, trauma hx):

FAMILY HISTORY (include family medical hx, mood issues, substance abuse hx):

MEDICAL HISTORY:

PCP/DR.________________________________ AT_________________________

MEDICATIONS: Name:___________________mg_____#_______refills_______
Name:___________________mg_____#_______refills_______

REFERRAL TO PHYSICIAN: Yes______No_____ DR:_____________________
At:______________________

SUBSTANCE ABUSE HISTORY;

Prior Treatment:____

At:____

SUBSTANCES USED PATTERN OF USE

Age/Duration Frequency/amount Method

Past Year:

When you are using___________________what does it do for you?

Last use of substance?_______________________Amount__________________

SYMPTOM CHECKLIST

When you first started using ________________________on a regular basis, how many_______________did it take to feel the effects? In the past year, how many to feel the effects?

Tolerance up 50%? Yes______No_____ Tolerance down? Yes_____No_____ (referral needed?)

What have you experienced after using the night before? After quitting for a period of time?
Describe:____
____

Do you have a history of memory loss or blackouts? Yes_____No_____

When you start using________________do you frequently find that you use more than intended, or that you stay for longer periods of time than you intended?

Has you use of _______________ever caused you to miss work come in late or be fired from a job?

Has you use of __________________caused any problems in your relationship? Are family, or friends concerned about your use of ___________________?

Any extended family member have problems with drug or alcohol use? Which ones?

What are your feelings about your use of ________________________?

MENTAL STATUS EXAM:

DIAGNOSIS:____________________

REFERRAL FOR COGNITIVE, VOCATIONAL, PSYCHOMETRIC TESTING?

Yes________No________To:____

Therapist Signature__________________________________Date:_______________

TREATMENT PLAN

IDENTIFIED ISSUES:

MOTIVATIONAL STAGE:

Pre-contemplative
Contemplative
Preparation
Action
Maintenance

CLIENT GOALS:

SHORT TERM GOALS/BEHAVIORAL DESCRIPTION. INTERVENTIONS

LONG TERM GOALS/BEHAVIORAL DESCRIPTION. INTERVENTIONS

UPC IDENTIFIED LEVEL OF CARE:____________________________________

LEVEL OF CARE ASSIGNED BASED ON CLIENT NEEDS:________________

INDIVIDUAL'S STATEMENT – WILLINGNESS TO ACCEPT RECOMMENDED LEVEL OF CARE:

CRITERIA FOR DISCHARGE:

CLIENT SIGNATURE_________________________________DATE:_______________

THERAPIST SIGNATURE:_____________________________DATE:______________

CLINICAL SUPERVISORS SIGNATURE:________________DATE:______________

TB SCREENING

YES NO

1. Does the client have signs and symptoms of TB such as a Persistent cough, coughing or spitting up blood. Unintentional weight loss, loss of appetite, fever, chills, night sweats, hoarseness or chest pain?

2. Does the client have any of the following socioeconomic risk factors: Homeless: Living in a shelter or prison/jail: Injecting drug use: Crack user, or immigrant from an area with a high incidence of TB, such as Haiti, Africa, Southeast Asia, South/Central America, or the Caribbean?

3. Has the client been around anyone with active TB within the last 90 days?

4. Has the client had a chest X-Ray within the past three months?

5. Has the client had a TB skin test? When was the most recent test? What was the outcome (reading)?

6. Has the client had TB diagnosed prior to admission to the program?

7. Has the client ever been under treatment for TB? If yes, when? How long did the client take medication, and did the client complete treatment?

8. Is the client currently under treatment for TB at the time of admission to the program?

CLIENT SIGNATURE:______________________________

THERAPIST SIGNATURE:___________________________

DATE:_________________________