HEALTH-CARE FOR THE HOMELESS, INC.

ADDICTION ASSESSMENT TOOL

DATE:

DAT E OF BIRTH: | AGE: | GENDER:

CLIENT REPORTS:

DRUG / ALCOHOL HISTORY:

Name	Days Per Week	$ Per Day	Route	Last Use (am / pm)	Age of 1st Use	Pattern of Use
Cocaine						
Heroin						
ETOH						
Marijuana						

SUBSTANCE ABUSE TREATMENT HISTORY:

Date	Program	Days in Tx.	Completed?		Days Clean	Notes (Barriers/Supports/Significant Insights)
			Yes	No		

WITHDRAWAL SEVERITY ASSESSMENT:

	YES	NO	Details
Seizures			
Overdose			
Blackouts			
Tremors			
D.T 's			
Current Heroin Withdrawal			
Have you ever tried to quit on your own?			

DIMENSION I: Detox/Withdrawal (check-off level): O Level I O Level II O Level III O Level IV

NOTES: ____________________

MEDICAL HISTORY (See Interdisciplinary Assessment Form and Medical Notes)

DIMENSION II: Physical Health (check off level): O Level I O Level II O Level III O Level IV

NOTES: ____________________

CLIENT LAST NAME: | FIRST: | HCH#:

HIV RISK ASSESSMENT

Have you ever used drugs intravenously? ☐ No ☐ Yes

How many sexual partners have you had in the last year? What is your sexual orientation?

Male?

Female?

Condoms?

Have you had anv **STD's** in the last 6 months? ☐ No ☐ Yes

If Yes, What:

In the last 6 months, have you been tested for HIV? ☐ No ☐ Yes

Results: ☐ Positive ☐ Negative

Have you had a TB test in the last 2 vears? ☐ No ☐ Yes

If Yes, What:

DIMENSION IV: Treatment Acceptance (check level): O Level I O Level II O Level III O Level IV

NOTES:

LEGAL HISTORY [PAST 2 YEARS]

Date(s)	Charge	Drug Related?	Time Incarcerated	Clean Time After Release

NOTES:

PENDING CHARGES/COURT DATES:

PAROLE/PROBATION? ☐ No ☐ Yes If yes, until when:

PSYCHO-SOCIAL HISTORY:

What is the highest grade in school you completed?

What was the last job you worked? When?

Why did you leave?

Where are you staying? Mailing address:

Is this a drua free. stable situation? ☐ No ☐ Yes

What is your religion/spiritual orientation?

Is this something that is or could be important to your recovery? ☐ No ☐ Yes

DIMENSION V: Relapse Potential (check-off ***level):*** O Level I O Level II O Level III O Level IV

NOTES:

FAMILY HISTORY:

Relation	*Age(s)*	*Medical/Mental Health/Addictions Problems (In recovery? On medication?)*	*Cause and Age of Death*	*Relationship (How often do you see, talk with? Could you go to them for help? Could you stay with them?)*
Mother				
Father				
Sisters				
Brothers				
Children				
Other				

APPEARANCE:

	O Neatly Dressed	O Dirty/Torn Clothing	O Bloodshot Eyes	O Track Marks
O Poor Eye Contact	O Trouble Staying Awake	O Smells of Alcohol	O Good Eye Contact	O Down Cast
O Alert	O Poor Hygiene			

Other: ______________________________

SPEECH AND THOUGHT:

	O Articulate	O Slurred	O Incoherent	O Illogical
O Circumstantial/Tangential	O Disoriented	O Racing Thoughts	O Pressured	O Memory Impaired
O Coherent	O Concrete			

Other: ______________________________

MOOD / AFFECT:

	O Appropriate	O Quiet	O Stable	O Depressed
O Flat	O Labile	O Sad	O Euphoric	O Anxious
O Angry	O Irritable	O Hyperactive	O Suicidal	O Homicidal
O Hopeless	O Worthless			

Other: ______________________________

MENTAL HEALTH HISTORY (see Interdisciplinary Assessment Form and Mental Health Notes)

DIMENSION III: Emotional Condition *(check-off level)* O Level I O Level II O Level III O Level IV

RISK OF ENDANGERING SELF OR OTHERS: Homicidal? Suicidal Attempts? Suicidal Thoughts?

Do you have a plan? If so, explain: ______________________________

NOTES:

____

____

____

____

CLIENT LAST NAME: ______ **FIRST:** ______ **HCH#:** ______

DIMENSION VI: Recovery Environment (check-off *level)*: O Level I O Level II O Level III O Level IV

NOTES: ______

Impression /Diagnoses: ______

PLAN

Attend Phase I Group ______ x week, beginning on ______ for treatment readiness.

Attend Phase ______ Group ______ x week

Attend Weekly Counseling with ______ to begin on ______

Attend ______ NA/AA Meetings weekly.

Refer client to: ______ for ______

______ for ______

______ for ______

Based on ASAM criteria, the appropriate level of treatment for this client is:

O Outpatient O Intensive Outpatient O 28-Day O Detox O Methadone

SIGNATURE(S)

Addiction Provider: ______

Signature: ______ Date: ______