Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#3. MENTAL HEALTH/SUBSTANCE ABUSE – ASSESSMENT / RECORDS

Addiction assessment form (*BAL 19*)
Addiction discharge summary (*BAL 21*)
Addiction recovery verification of attendance form (*BAL 24*)
Addiction severity index (*HCLA 17*)
Addiction severity index (*LOS 5R*)
Addiction treatment behavioral contract (*BAL 25*)
Addiction treatment check list (*BAL 26*)
Addiction treatment plan – Diagnosis and formulation of problems (*BAL 22*)
CAGE addiction assessment (*BAL 8*)
CIWA-A/narcotic withdrawal (*POR 10*)
Clinical assessment for alcohol and drug client - Client Form B (*WES 1b*)
Mental health questionnaire (*LOS 4*)
Mini mental state examination (*BAL 9*)
Protocol for evaluating alcohol/other drug-using battered women (*ASC 1*)
Psychiatric evaluation (*BAL 47*)
Psychiatric follow-up visit (*BAL 48*)
Psychiatric status (*HCLA 13*)
Psychiatric/social needs assessment (*SEA 2*)
Psychological evaluation (*HOM 9*)
Psychosocial assessment (*BAL 49*)
Psychosocial case management assessment (*BAL 51*)
Psychosocial report (*CAM 1*)
Zung depression scale (*BAL 10*)

BAL 19-1

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): ○ Level I ○ Level II ○ Level III ○ Level IV

NOTES: _____

MEDICAL HISTORY (See Interdisciplinary Assessment Form and Medical Notes)

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

NOTES: _____

CLIENT LAST NAME:		FIRST:		HCH#:	

HIV RISK ASSESSMENT

Have you ever used drugs intravenousiy? ☐ No ☐ Yes

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

Male?

Female?

Condoms?

Have you had any 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 years? ☐ No ☐ Yes

If Yes, What:

DIMENSION IV: Treatment Acceptance *(check level):* ○ Level I ○ Level II ○ Level III ○ 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 drug 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):* ○ Level I ○ Level II ○ Level III ○ 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:

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

Other: _____

SPEECH AND THOUGHT:

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

Other: _____

MOOD / AFFECT:

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

Other: _____

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

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

○ Outpatient ○ Intensive Outpatient ○ 28-Day ○ Detox ○ Methadone

SIGNATURE(S)

Addiction Provider: _____

Signature: _____ Date: _____

BAL 21

Health Care for the Homeless, Inc.
ADDICTION DISCHARGE SUMMARY

ADMISSION DATE:	DISCHARGE DATE:	S.S.#:	
DATE OF BIRTH:	GENDER:	RACE:	MARITAL STATUS:

REASON FOR DISCHARGE:

[ ] Completed Treatment - No Drug Use
[ ] Completed Treatment - Some Drug Use
[ ] Transferred to Another SAMIS Clinic within Program
[ ] Transferred to Non-SAMIS Clinic within Program
[ ] Referred to Outside Program
[ ] Non-Compliance with Program Rules
[ ] Left Before Completing Program
[ ] Incarcerated
[ ] Deceased

ENVIRONMENT AT DISCHAGE:

[ ] Outpatient [ ] Day Treatment [ ] Residential (28-Day) [ ] Prison [ ] Methadone [ ] Intensive Outpatient

EMPLOYMENT STATUS:

HIGHEST GRADE COMPLETED:	COMPLETED EDUCATIONAL/VOCATIONAL PROGRAM?	NUMBER OF TIMES ARRESTED DURING TREATMENT:
	☐ Yes ☐ No	

TYPE OF INSURANCE:

TREATMENT PLAN OBJECTIVES ACHIEVED:

	YES	NO	NA		YES	NO	NA		YES	NO	NA		YES	NO	NA
Employment				Medical				Drug Use				Legal			
Psychosocial				Education				Skill Development							

PROGRAM VIOLATIONS:

TREATMENT RECOMMENDATIONS:

PROGNOSIS:

COUNSELOR SIGNATURE: DATE:

ADDICTION COORDINATOR: DATE:

CLIENT LAST NAME: FIRST: HCH#:

BAL 24

HEALTH CARE FOR THE HOMELESS, INC.

ADDICTION RECOVERY VERIFICATION OF ATTENDANCE FORM

[please print]

NAME OF GROUP/MEETING	LOCATION	DATE	VERIFIED BY

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

i:/bradshaw/forms/addictionrecoveryverification/feb2001

HOMELESS HEALTH CARE LOS ANGELES HCLA 17-1

Addiction Severity Index

Today's Date: Staff: Client ID #

Last Name: First Name:

Instructions

1. Leave NO blanks. Where appropriate code items:
   X = question not answered
   N = question not applicable

   Use only one character per item.

2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up. (see Manual)

3. Space is provided after sections for

Severity Ratings

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given atrea. For a detailed description of severity ratings' derivation procedures and conventions, see manual.

SUMMARY OF PATIENT'S RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

MEDICAL STATUS

*1. How many times in your life have you been hospitalized for medical problems?
(*Include o.d.'s, d.t.'s, exclude detox.*) ☐☐

2. How long ago was your last hospitalization for a physical problem? ☐☐ Years ☐☐ Months

3. Do you have any chronic medical problems which continue to interfere with your life? ☐
   0 - No 1 - Yes Specify _____

   _____

4. Are you taking any prescribed medication on a regular basis for a physical problem? ☐
   0 - No 1 - Yes

5. Do you receive a pension for a physical disability (*Exclude psychiatric disability.*) ☐
   0 - No 1 - Yes Specify _____

   _____

6. How many days have you experienced medical problems in the past 30? ☐☐

FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐

8. How important to you now is treatment for these medical problems ? ☐

INTERVIEWER SEVERITY RATING

9. How would you rate the patient's need for medical treatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? ☐
    0 - No 1 - Yes

11. Patient's inability to understand? ☐
    0 - No 1 - Yes

Comments:

HCLA 17-2

DRUG/ALCOHOL USE

Client ID #_____

	DAYS	YEARS	RT OF ADM.**
1. Alcohol - Any use at all			
2. Alcohol - To Intoxication			
3. Heroin			
4. Methadone			
5. Other opiates/analgesics			
6. Barbituates			
7. Other Sed/hyp/tranq.			
8. Cocaine			
9. Amphetamines			
10. Cannabis			
11. Hallucinogens			
12. Inhalants			
13. More than one substance per day/ Including alcohol			

Note: See manual for representative examples for each drug class

**ROUTE OF ADMINISTRATION:

1 = Oral, 2 = Nasal, 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

14. Which substance is the major problem? ☐☐

Please code as above or 00 - No problem;
15 - Alcohol & Drug (Dual addiction);
16 - Polydrug; *when not clear, ask patient.*

15. How long was your last period of voluntary abstinence from this major substance? ☐☐
(00 - Never abstinent)
Months

16. How many months ago did this abstinence end? ☐☐
(00 - Still abstinent)

*17. How many times in your life have you:
Had Alcohol d.t.'s ☐☐
Overdosed on Drugs? ☐☐

*18. How many times in your life have you been treated for:
Alcohol ☐☐
Drug abuse ☐☐

*19. How many of these were detox only?
Alcohol ☐☐
Drug ☐☐

20. How much would you say you spent during the past 30 days on:
Alcohol ☐☐☐☐
Drug ☐☐☐☐

21. How many days gave you been treated in an outpatient setting for alcohol or drugs in the past 30 days *(Include NA, AA).* ☐☐

22. How many days in the past 30 days have you experienced:
Alcohol problems ☐☐
Drug problems ☐☐

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

23. How troubled or bothered have you been in the past 30 days by these:
Alcohol problems ☐
Drug problems ☐

24. How important to you now is treatment for these:
Alcohol problems ☐
Drug problems ☐

INTERVIEWER SEVERITY RATING

25. How would you rate the patient's need for treatment for:
Alcohol ☐
Drug Abuse ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation? 0 - No 1 - Yes ☐

27. Patient's inability to understand? 0 - No 1 - Yes ☐

Comments:

LOS 5R-1

HOMELESS HEALTH CARE LOS ANGELES
ADDICTION SEVERITY INDEX

Today's Date: _____ Staff: _____ Client ID# _____

Last Name: _____ First Name: _____

INSTRUCTIONS

1. Leave No Blanks - Where appropriate code items: X = question not answered
   N = question not applicable
   Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. **Note: These severity ratings are optional.**

Fifth Edition

SUMMARY OF PATIENTS RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

☐☐☐☐

MEDICAL STATUS

* (1.) How many times in your life have you been hospitalized for medical problems? ☐☐
(Include o.d.'s, d.t.'s, exclude detox.)

2. How long ago was your last hospitalization for a physical problem ☐☐ YRS. ☐☐ MOS.

3. Do you have any chronic medical problems which continue to interfere with your life? ☐
   0 - No
   1 - Yes _____
   Specify

(4.) Are you taking any prescribed medication on a regular basis for a physical problem? ☐
0 - No 1 - Yes

(5.) Do you receive a pension for a physical disability? *(Exclude psychiatric disability.)* ☐
0 - No
1 - Yes _____
Specify

(6.) How many days have you experienced medical problems in the past 30? ☐☐

FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(7.) How troubled or bothered have you been by these medical problems in the past 30 days? ☐

Comments

(8.) How important to you now is treatment for these medical problems? ☐

INTERVIEWER SEVERITY RATING

(9.) How would you rate the patient's need for medical treatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(10.) Patient's misrepresentation? ☐
0 - No 1 - Yes

(11.) Patient's inability to understand? ☐
0 - No 1 - Yes

LOS 5R-2

Client ID#_____

DRUG/ALCOHOL USE

	PAST 30 Days	LIFETIME USE Yrs.	Rt of adm.
01 Alcohol - Any use at all			
02 Alcohol - To Intoxication			
03 Heroin			
04 Methadone			
05 Other opiates/ analgesics			
06 Barbiturates			
07 Other sed/ hyp/tranq.			
08 Cocaine			
09 Amphetamines			
10 Cannabis			
11 Hallucinogens			
12 Inhalants			

13 More than one substance per day (Incl. alcohol). ☐☐ ☐☐

Note: See manual for representative examples for each drug class

* Route of Administration: 1 = Oral, 2 = Nasal 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

14 Which substance is the major problem? *Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient.* ☐☐

15. How long was your last period of voluntary abstinence from this major substance? *(00 - never abstinent)* ☐☐ MOS.

16. How many months ago did this abstinence end? *(00 - still abstinent)* ☐☐

* 17 How many times have you:

Had alcohol d.t.'s ☐☐

Overdosed on drugs ☐☐

* 18 How many times in your life have you been treated for:

Alcohol Abuse: ☐☐

Drug Abuse: ☐☐

* 19 How many of these were detox only?

Alcohol ☐☐

Drug ☐☐

20 How much would you say you spent during the past 30 days on:

Alcohol ☐☐☐☐

Drugs ☐☐☐☐

Comments

21 How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days *(Include NA, AA).* ☐☐

22 How many days in the past 30 have you experienced:

Alcohol Problems ☐☐

Drug Problems ☐☐

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

23 How troubled or bothered have you been in the past 30 days by these:

Alcohol Problems ☐

Drug Problems ☐

24 How important to you now is treatment for these:

Alcohol Problems ☐

Drug Problems ☐

INTERVIEWER SEVERITY RATING

25 How would you rate the patient's need for treatment for:

Alcohol Abuse ☐

Drug Abuse ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26 Patient's misrepresentation? 0 - No 1 - Yes ☐

27 Patient's inability to understand? 0 - No 1 - Yes ☐

LOS 5R-3

EMPLOYMENT/SUPPORT STATUS

Client ID#_____

*(1.) Education completed *(GED = 12 years)* YRS. [ ][ ] MOS. [ ][ ]

*(2.) Training or technical education completed MOS. [ ][ ]

3. Do you have a profession, trade or skill? [ ]
   0 - No
   1 - Yes _____ Specify

(4.) Do you have a valid driver's license? [ ]
   0 - No 1 - Yes

(5.) Do you have an automobile available for use? *(Answer No if no valid driver's license.)* [ ]
   0 - No 1 - Yes

6. How long was your longest full-time job? YRS. [ ][ ] MOS. [ ][ ]

*(7.) Usual (or last) occupation. [ ]
_____ *(Specify in detail)*

(8.) Does someone contribute to your support in any way? [ ]
   0 - No 1 - Yes

(9.) (ONLY IF ITEM 8 IS YES) Does this constitute the majority of your support? [ ]
   0 - No 1 - Yes

10. Usual employment pattern, past 3 years. [ ]
   1 - full time (40 hrs/wk)
   2 - part time (reg. hrs)
   3 - part time (irreg., daywork)
   4 - student
   5 - service
   6 - retired/disability
   7 - unemployed
   8 - in controlled environment

(11.) How many days were you paid for working in the past 30? (include "under the table" work.) [ ][ ]

How much money did you receive from the following sources in the past 30 days?

(12.) Employment (net income) [ ][ ][ ][ ]

(13.) Unemployment compensation [ ][ ][ ][ ]

(14.) DPA [ ][ ][ ][ ]

(15.) Pension, benefits or social security [ ][ ][ ][ ]

(16.) Mate, family or friends (Money for personal expenses). [ ][ ][ ][ ]

(17.) Illegal [ ][ ][ ][ ]

Comments

(18.) How many people depend on you for the majority of their food, shelter, etc.? [ ]

(19.) How many days have you experienced employment problems in the past 30? [ ][ ]

FOR QUESTIONS 20 & 21 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(20) How troubled or bothered have you been by these employment problems in the past 30 days? [ ]

(21.) How important to you *now* is counseling for these employment problems? [ ]

INTERVIEWER SEVERITY RATING

(22.) How would you rate the patient's need for employment counseling? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(23.) Patient's misrepresentation? [ ]
   0 - No 1 - Yes

(24.) Patient's inability to understand? [ ]
   0 - No 1 - Yes

LOS 5R-4

Client ID#_____

LEGAL STATUS

1. Was this admission prompted or suggested by the criminal justice system (judge, probation/ parole officer, etc.)

0 - No 1 - Yes ☐

(2.) Are you on probation or parole?

0 - No 1 - Yes ☐

How many times in your life have you been arrested and charged with the following:

*(03) - shoplifting/vandalism ☐☐
*(04) - parole/probation violations ☐☐
*(05) - drug charges ☐☐
*(06) - forgery ☐☐
*(07) - weapons offense ☐☐
*(08) - burglary, larceny, B & E ☐☐
*(09) - robbery ☐☐
*(10) - assault ☐☐
*(11) - arson ☐☐
*(12) - rape ☐☐
*(13) - homicide, manslaughter ☐☐
*(14A) - prostitution ☐☐
*(14B) - contempt of court ☐☐
*(14C) - other ☐☐

*(15) How many of these charges resulted in convictions? ☐☐

How many times in your life have you been charged with the following:

*(16) Disorderly conduct, vagrancy, public intoxication ☐☐

*(17) Driving while intoxicated ☐☐

*(18) Major driving violations (reckless driving, speeding, no license, etc.) ☐☐

*(19) How many months were you incarcerated in your life? ☐☐ MOS.

20. How long was your last incarceration? ☐☐ MOS.

21. What was it for? *(Use code 3-14, 16-18. If multiple charges, code most severe)* ☐☐

(22) Are you presently awaiting charges, trial or sentence? 0 - No 1 - Yes ☐

(23) What for *(If multiple charges, use most severe).* ☐☐

(24) How many days in the past 30 were you detained or incarcerated? ☐☐

Comments

(25) How many days in the past 30 have you engaged in illegal activities for profit? ☐☐

FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(26) How serious do you feel your present legal problems are? *(Exclude civil problems)* ☐

(27) How important to you *now* is counseling or referral for these legal problems? ☐

INTERVIEWER SEVERITY RATING

(28) How would you rate the patient's need for legal services or counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(29) Patient's misrepresentation? 0 - No 1 - Yes ☐

(30) Patient's inability to understand? 0 - No 1 - Yes ☐

LOS 5R-5

Client ID#_____

FAMILY/SOCIAL RELATIONSHIPS

(1) Marital Status ☐

1 - Married
2 - Remarried
3 - Widowed
4 - Separated
5 - Divorced
6 - Never Married

2 How long have you been in this marital status? ☐☐ YRS. ☐☐ MOS.
(If never married, since age 18).

(3.) Are you satisfied with this situation? ☐
0 - No
1 - Indifferent
2 - Yes

*(4.) Usual living arrangements (past 3 yr.) ☐
1 - With sexual partner and children
2 - With sexual partner alone
3 - With children alone
4 - With parents
5 - With family
6 - With friends
7 - Alone
8 - Controlled environment
9 - No stable arrangements

5. How long have you lived in these arrangements. ☐☐ YRS. ☐☐ MOS.
(If with parents or family, since age 18).

(6.) Are you satisfied with these living arrangements? ☐
0 - No
1 - Indifferent
2 - Yes

Do you live with anyone who:
0 = No 1 = Yes

6A. Has a current alcohol problem? ☐

6B. Uses non-prescribed drugs? ☐

(7.) With whom do you spend most of your free time: ☐
1 - Family 3 - Alone
2 - Friends

(8.) Are you satisfied with spending your free time this way?
0 - No 1 - Indifferent 2 - Yes ☐

(9.) How many close friends do you have? ☐

Direction for 9A-18: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

9A. Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

Mother	☐
Father	☐
Brothers/Sisters	☐
Sexual Partner/Spouse	☐
Children	☐
Friends	☐

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

0 - No 1 - Yes	PAST 30 DAYS	IN YOUR LIFE
(10) Mother	☐	☐
(11) Father	☐	☐
(12) Brothers/Sisters	☐	☐
(13) Sexual partner/spouse	☐	☐
(14) Children	☐	☐
(15) Other significant family_____	☐	☐
(16) Close friends	☐	☐
(17) Neighbors	☐	☐
(18) Co-Workers	☐	☐

Did any of these people (10-18) abuse you: 0 =No; 1 = Yes

18A. Emotionally (make you feel bad through harsh words)?	☐	☐
18B. Physically (cause you physical harm)?	☐	☐
18C. Sexually (force sexual advances or sexual acts)?	☐	☐

(19.) How many days in the past 30 have you had serious conflicts:

A with your family? ☐☐
B with other people? (excluding family) ☐☐

FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

(20) Family problems ☐
(21) Social problems ☐

How important to you now is treatment or counseling for these:

(22) Family problems ☐
(23) Social problems ☐

INTERVIEWER SEVERITY RATING

(24) How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(25) Patient's misrepresentation? ☐
0 - No 1 - Yes

(26) Patient's inability to understand? ☐
0 - No 1 - Yes

Comments

LOS 5R-6

Client ID#_____

PSYCHIATRIC STATUS

*(1) How many times have you been treated for any psychological or emotional problems?

In a hospital

As an Opt. or Priv. patient

(2) Do you receive a pension for a psychiatric disability? ☐

0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes	PAST 30 DAYS	IN YOUR LIFE
(3) Experienced serious depression	☐	☐
(4) Experienced serious anxiety or tension	☐	☐
(5) Experienced hallucinations	☐	☐
(6) Experienced trouble understanding, concentrating or remembering	☐	☐
(7) Experienced trouble controlling violent behavior	☐	☐
(8) Experienced serious thoughts of suicide	☐	☐
(9) Attempted suicide	☐	☐
(10) Been prescribed medication for any psychological/emotional problem	☐	☐

(11) How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT"S RATING SCALE

(12) How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐

(13) How important to you now is treatment for these psychological problems? ☐

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient:

0 - No 1 - Yes

(14) Obviously depressed/withdrawn ☐

(15) Obviously hostile ☐

(16) Obviously anxious/nervous ☐

(17) Having trouble with reality testing thought disorders, paranoid thinking ☐

(18) Having trouble comprehending, concentrating, remembering. ☐

(19) Having suicidal thoughts ☐

Comments

INTERVIEWER SEVERITY RATING

(20) How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(21) Patient's misrepresentation? ☐
0 - No 1 - Yes

(22) Patient's inability to understand? ☐
0 - No 1 - Yes

Severity Profile

PROBLEMS	1	2	3	4	5	6	7
Medical							
Employment							
Alcohol							
Drug							
Illegal Activity							
Family/Social							
Psychiatric							

BAL 25

HEALTH CARE FOR THE HOMELESS

ADDICTIONS TREATMENT BEHAVIORAL CONTRACT

DATE OF CONTRACT: _____ CLIENT DATE OF BIRTH: _____

CLINICIAN: _____ TREATMENT PROGRAM: _____

I, _____ understand and agree to comply with the following treatment recommendations. I understand that I must follow these conditions in order to remain in my treatment program. In signing this contract, I agree to meet the following conditions:

_____I will attend my therapy sessions on time with one absence allowed for an emergency.

_____I will attend _____ support group meetings per week and document my attendance.

_____I will get a support group sponsor and meet with him/her_____ times each week, and if requested will have my sponsor talk with my therapist to confirm I am doing this.

_____I will call 911 or the Crisis Line, if I feel I might kill or hurt myself or someone else (or this local emergency number _____)

_____Other condition: _____

_____Other condition: _____

I am committing myself to honoring this contract for the following time period:____/_____/_____ to

____/____/____ or until a specific event takes place as follows: _____

_____

I understand that if I do not comply with these requirements, the consequences will be as follows:

_____

_____

I understand that I will retain a copy of this contract and a copy will be kept by the program staff.

I will remain free from all mind altering substances unless prescribed by a physician. If I am taking any prescribed medications, I will take them in the way the doctor instructs me.

CLIENT/GUARDIAN'S NAME:	SIGNATURE	DATE
COUNSELOR'S NAME:	SIGNATURE	DATE
ADDICTION COUNSELOR SIGNATURE		DATE

CLIENT LAST NAME:	FIRST:	HCH#:

BAL 26

HEALTH CARE FOR THE HOMELESS

ADDICTION CHECK-LIST

DIAGNOSIS: _____

☑ 1.	A.A.T. DATE (Initial Assessment)	____/____/____
☑ 2.	I.A.F. (INTERDISCIPLINARY ASSESSMENT FORM)	____/____/____
☑ 3.	PROGRAM HANDBOOK REVIEWED	____/____/____
☑ 4.	CONSENT FOR THE RELEASE OF INFORMATION	____/____/____
☑ 5.	DATE OF ADMISSION (1st TX Session - Individual/Group)	____/____/____
☑ 6.	SAMIS FORM COMPLETED	____/____/____
☑ 7.	ASI DATE	____/____/____
☑ 8.	ITP DATE	____/____/____
☑ 9.	ITP REVIEW TARGET DATE (30, 60, 90 DAYS)	____/____/____
☑ 10.	AFTERCARE PLAN	____/____/____
☑ 11.	SAMIS and DISCHARGE SUMMARY (Actual Date Client completes program or a no-show for 30 days)	____/____/____
☑ 12.	CONFIDENTIALITY	____/____/____
☑ 13.	TB SCREENING	____/____/____
☑ 14.	C.A.G.E. ASSESSMENT	____/____/____

CLIENT LAST NAME: _____ FIRST: _____ HCH#: _____

BAL 224

HCH Addiction Treatment Plan
Diagnosis and Formulation of Problems

Diagnosis:

Axis I: _____. ___ ___ _____. ___ ___ _____. ___ ___

Axis II: _____. ___ ___

Axis III: _____

Axis IV: Problems with or related to: (check all those that apply) ***state actual problem on list below***

- ☐ Primary support group
- ☐ Occupation
- ☐ Access to health care
- ☐ Social Environment
- ☐ Housing
- ☐ Legal System
- ☐ Education
- ☐ Economic
- ☐ Other

Axis V: Current GAF _____

Number	I = Initial Assessment R = Case Review	Addiction Problem List	Date	Date/Status
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Date - Date problem is identified	Status Changes: RTX = Resolved by Treatment
Date/Status - Date of status change	N/RTX = Not resolved by Treatment
I = Identified in Initial Assessment	CANC = Cancelled (removed from treatment plan) **(Progress note must state why)**
R = Identified in Case Review	DEF = Deferred to long term status

ALL NOTATIONS OF STATUS CHANGE MUST BE DATED IN "DATE/STATUS" COLUMN

Client Name:	HCH Number:
Date of Treatment Plan:	Admit Date:

BAL 22-2

HCH Treatment Plan
Program Goals

Problem: _____

_____

_____

_____

Goal: _____

_____

_____

_____

Objective: _____

_____

_____

_____

Completion Date: _____

Monitoring Staff: _____

Objective: _____

_____

_____

_____

Completion Date: _____

Monitoring Staff: _____

Objective: _____

_____

_____

_____

Completion Date: _____

Monitoring Staff: _____

Client Name:	HCH Number:
Date of Treatment Plan:	Admit Date:

DAL 22-5

HCH Treatment Plan

Problem # ____

Description: _____

Statement of Goal	Target Date	Date/Status

Objectives	Target Date	Date/Status
1.		
2.		
3.		
4.		

Status of Goal or Objectives can be: 1) Attained
2) Cancelled
3) Revised

Number each **Goal and each Objective.**
For each objective include in parentheses the person responsible for measuring or verifying completion, e.g., (Counselor), (Nurse), etc.

Client Name:	HCH Number:
Date of Treatment Plan:	Admit Date:

BAL 8

Client:_____ **Date:**_____
Social Security #:_____

CAGE Addiction Assessment

Have you ever been in a substance abuse program before or are you in one now?

Have you felt you ought to cut down on your drinking or drug use?

Have people annoyed you by criticizing your drinking or drug use?

Have you felt bad or guilty about your drinking or drug use?

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

Needs further assessment

No further assessment needed

PoR 10

CIWA-A Scale

Temp _____ Pulse _____ Resp _____ BP _____ BAL _____	Score
Nausea and Vomiting 0 None 1 Mild nausea with no vomiting 4 Intermittent nausea with dry heaves 7 Nausea, dry heaves, vomiting	
Tremor (arms extended, fingers spread) 0 No tremor 1 Not visible - can be felt fingertip to fingertip 4 Moderate with arms extended 7 Severe even with arms not extended	
Sweating (observation) 0 No sweat visible 1 Barely perceptible, palms sweats 4 Beads of sweat visible 7 Drenching sweats	
Tactile Disturbances 0 None 1 Very mild itching, pins and needle or numbness 2 Mild itching or pins and needles, burning or numbness 3 Moderate itching, pins and needles, burning or numbness 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Fused	
Visual Disturbances - Ask, "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?" 0 Not present 1 Very mild sensitivity 2 Mild sensitivity 3 Moderate sensitivity 4 Moderately severe hallucinations (Intermittently fused) 5 Severe hallucinations 6 Extremely severe hallucinations 7 Fused	
Auditory Disturbances - Ask, "Are you more aware or sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" 0 Not present 1 Very mild harshness or ability to frighten 2 Mild harshness or ability to frighten 3 Moderate harshness or ability to frighten 4 Moderately severe hallucinations (occasionally fused) 5 Severe hallucinations 6 Extremely severe hallucinations 7 Fused	
Orientation and clouding of Sensorium (What day is this? What is this place? 0 Oriented and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disoriented for date by no more that 2 calendar days 3 Disoriented for date by more than 2 calendar days 4 Disoriented for place and/or person Reorient to time, place and person if necessary	
Anxiety (Observation, Do you feel nervous?) 0 No anxiety; at ease 1 Mildly anxious 4 Moderate anxious or guarded, (Anxiety Inferred) 7 Equivalent to panic states as seen in severe delirium acute schizophrenic reactions	
Agitation (Observation) 0 Normal activity 1 Somewhat more than normal activity 4 Moderately fidgety and restless 7 Pacing, or thrashing about constantly	
Headache, fullness in head. Ask, "Does your head feel different? Does it feel like a band around your head?" Do no rate for dizziness or light-headedness. Otherwise, rate severity. 0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely servere	
Insomnia 0 Able to sleep uninterrupted 1 Complains of difficulty falling asleep 4 Awake one-half of time 7 Awake throughout night	

R (Rev. 02/93) Date: Time: NURSE _____ TOTAL SCORE _____

Narcotic Withdrawal Scale

(Fultz & Senay, 1975)

Underline signs & symptoms, and circle grade.

Grade 1: lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, insomnia

Grade 2: dilated pupils, piloerection, muscle twitching, myalgia, arthralgia, abdominal pain

Grade 3: tachycardia, hypertension, tachypnea, fever, anorexia, nausea, extreme restlessness

Grade 4: diarrhea, vomiting, dehydration, hyperglycemia, hypotension, curled-up position

Staff_____

Date_____

Time_____

Wes 1b

Multnomah Clinical Assessment

Multnomah County, Oregon

Client Form B

Full Name_____

Date _____

If you have any problems with reading or writing please ask for help.

SID#	DCC Client ID

Evaluator's Name:_____

Client Name: _____

General Information

- 1. What was your last name at birth? _____
- 2. Sex: ☐ Male ☐ Female
- 3. Date of birth (mm/dd/yy): _____ Age: _____

• Evaluator Use Only ☐ Known ☐ Estimated

- 4. What other names have you used (a.k.a.)? _____
- 5. You are:

☐ 01- White (non-Hispanic)
☐ 02- Black (non-Hispanic)
☐ 03- Native American
☐ 04- Alaskan Native
☐ 05- Asian or Pacific Islander
☐ 06- Hispanic-Mexican
☐ 07- Hispanic-Puerto Rican
☐ 08- Hispanic-Cuban
☐ 09- Other Hispanic
☐ 10- Southeast Asian
☐ 11- Other Race

6. Do you speak English at home? ☐ Yes ☐ No
7. Do you speak another language? ☐ Yes ☐ No If yes, specify: _____

• Evaluator Use Only Interpreter: ☐ Foreign Language ☐ Hearing impaired ☐ No

8. Current address: _____ Street
☐ None
_____ City State Zip

- 9. In what county do you live? _____
10. How long have you lived at this address? Months _____ Years _____
- 11. Address (where you receive mail): _____ Street
_____ City State Zip

- 12. Home phone: _____
- 13. Message phone: _____
14. Work phone: _____
15. Work hours: _____
16. Do you have a valid driver's license? ☐ Yes ☐ No
17. License #: _____ State: _____
18. Do you own an automobile? ☐ Yes ☐ No
19. Do you have valid car insurance? ☐ Yes ☐ No
20. Contact in case of emergency:

_____ Name
_____ Address
_____ State Zip
_____ Telephone
_____ Relationship to you

Client Name: _____

Military History

- 21. Are you a veteran? ☐ Yes ☐ No
- 22. Type of discharge? ☐ Honorable ☐ Dishonorable ☐ General

Medical Insurance

- 23. Please check the type of insurance you have, or check "None" if you do not have insurance:

☐ Oregon Health Plan ☐ Medicaid ☐ Private ☐ None
☐ Medicare ☐ VA ☐ Other public

- 24. What is the plan name? _____
- 25. What is the plan number? _____
- 26. Who referred you for an assessment? _____
  Contact Name Agency
  _____
  Address Telephone

- Evaluator Use Only

☐ Assessment ☐ Screening	☐ Walk in ☐ Phone
Referral source 1: (see back of data sheet)	Referral source 2: (see back of data sheet)

Medical History

27. Names of doctor(s): Telephone:

_____ _____

_____ _____

28. List any medications you are taking:

Name	How much	How often	Prescribed by whom

29. When was the last time you received any type of health care (emergency room, hospitalization, doctor visit)? ____/____/____

30. What for? _____

(Skip to #36 if you are male.)

Women Only:

- 31. Are you pregnant? ☐ Yes ☐ No
  32. If yes, when is the baby due? ____/____/____
  33. If yes, are you getting prenatal care? ☐ Yes ☐ No

Client Name: _____

- 34. Have you been pregnant in the last 12 months? ☐ Yes ☐ No

35. Check any of the problems you have had:

- ☐ Pelvic inflammatory disease
- ☐ Painful sex/intercourse
- ☐ Problems with PMS or menopause
- ☐ Periods: Irregular, painful, heavy bleeding

- 36. Do you get a pension for a physical (not mental) disability? ☐ Yes ☐ No

Education History

- 37. What is the highest grade you have completed? (0 thru 25)_____
- 38. Do you have a high school diploma or GED? ☐ Yes ☐ No
- 39. Are you now enrolled in school or training? ☐ Yes ☐ No

Employment History and Financial Status

- 40. Please check your work situation now:

- ☐ 1- Full time (35 hours or more)
- ☐ 2- Part-time (17 - 34 hours)
- ☐ 3- Irregular (less than 17 hours)
- ☐ 4- Not working and looking for work
- ☐ 5- Not working and not looking for work (retired, student, disabled)

(Skip to # 42 if you checked either #4 or #5)

41. Employer (optional):

_____
Employer

_____
Address Telephone

_____
Your position

42. How much money do you make in a month? _____

43. Longest period of continuous employment in adult life?_____

44. How long has it been since you were last employed?

- ☐ 12 months
- ☐ 24 months
- ☐ 36 months
- ☐ Never been legally employed
- ☐ 48 months
- ☐ 60 months
- ☐ More than 5 years

- 45. Please check your primary source of household income:

- ☐ Wages/salary
- ☐ Social Security
- ☐ SSI Federal
- ☐ OSIP - State
- ☐ Public Assistance/Welfare
- ☐ Dividends/Interest
- ☐ Pension
- ☐ Unemployment
- ☐ Veterans
- ☐ Alimony/Child Support
- ☐ Other
- ☐ None

46. Do you receive food stamps? ☐ Yes ☐ No

- 47. What is your total monthly household income? _____ Refused ☐

Client Name: _____

- 48. In each age group listed, enter the total number of people that depend on this household income, including yourself:

  _____ Ages 0-5 _____ Ages 6-17 _____ Ages 18-64 _____ Ages 65 +

- 49. Please check the box that describes your employment situation now:

  - ☐ 0- Able to work or working now
  - ☐ 1- Student
  - ☐ 2- Homemaker
  - ☐ 3- Retired
  - ☐ 4- Unable to work for physical or psychological reasons
  - ☐ 5- Incarcerated
  - ☐ 6- Seasonal worker
  - ☐ 7- Temporary layoff

Family and Interpersonal History

- 50. Current relationship status:

  - ☐ 1- Never married
  - ☐ 2- Married
  - ☐ 3- Widowed
  - ☐ 4- Divorced
  - ☐ 5- Separated
  - ☐ 6- Living as married

51. Some programs have specialized treatment based on sexual orientation. For this purpose, how do you identify yourself?

  ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual

- 52. What is your current living situation?

  - ☐ 01- In my own home/apartment
  - ☐ 23- In my spouse's/partner's home
  - ☐ 03- In relatives'/adult children's home
  - ☐ 04- In a foster home
  - ☐ 05- In an institution/group home/ cooperative housing
  - ☐ 06- In a friend's home
  - ☐ 97- In a shelter/ homeless
  - ☐ 98- Unknown

53. Do you live in Section 8 or subsidized housing? ☐ Yes ☐ No

- Evaluator Use Only

☐ Independent	☐ Dependent	☐ Homeless	☐ Public Housing

Living Arrangement Definitions

Independent: Includes single unit housing such as hotels, SRO room, apartments or houses. Does not include supervised settings or public assisted housing.

Homeless: No fixed address (includes shelters).

Dependent: Includes dependent adults and children living in a supervised setting (such as halfway or group homes).

Public Housing: Housing assisted or supported by government funds.

Legal History

- 54. Number of times arrested in your lifetime? _____
- 55. Number of times arrested in last 2 years? _____
- 56. Number of times arrested for DUII in the past 5 years? _____
- 57. Are you on probation or parole? ☐ Yes ☐ No

  If yes, to whom do you report? _____

58. What is your current involvement with the criminal justice system?

  - ☐ Pretrial
  - ☐ Presentence
  - ☐ Bench probation
  - ☐ Formal probation
  - ☐ Drug court/STOP program
  - ☐ Formal parole

Client Name: _____

59. Do you have a history of conviction for the following offenses?

	Dates of Offenses
DUII, Driving while suspended, etc.	_____
Drug charges	_____
Forgery or larceny	_____
Burglary or Robbery	_____
Domestic Violence, Assault	_____
Weapons charges	_____
Manslaughter, homicide	_____
Other charges	_____

60. In the last 6 months has your urine or blood been tested for alcohol or other drug use? ☐ Yes ☐ No

61. Who tested you? _____

62. What were the test results? _____

63. How much time have you spent in your life incarcerated? _____

64. How long was your last incarceration? _____

65. Why were you incarcerated? _____

66. What was your longest period of incarceration? _____

Client Name: _____

Alcohol Use Questionnaire

1. How old were you when you had your first drink? _____
2. Do you drink more now to get the same effect? (1D) ☐ Yes ☐ No
   Do you drink less now to get the same effect? (1D) ☐ Yes ☐ No
3. When did you last have a drink? _____
4. How many drinks do you usually have each time you drink? _____
5. In the last 30 days, how many days did you drink? _____
6. Has there been a time in your life when you drank daily? ☐ Yes ☐ No

   For how long? _____ (3D) When was that? _____
7. Have you cut down on your drinking since your DUII arrest? (4D) ☐ Yes ☐ No
8. Are you able to stop drinking when you want to? (4D) ☐ Yes ☐ No
9. Where do you do most of your drinking? ☐ Alone ☐ With others?
10. Can you stop drinking without a struggle? (4D) ☐ Yes ☐ No
11. Have you gotten into trouble at work or school because of drinking? (6D) ☐ Yes ☐ No
12. Have you ever neglected your responsibilities to yourself or your family because of drinking?(6D) ☐ Yes ☐ No
13. Has your drinking caused you to lose a job? (6D) ☐ Yes ☐ No
14. Has there been a time when you drank in larger amounts or for longer periods than you intended? (3D) ☐ Yes ☐ No
15. Have you missed work or school (or taken sick leave) because of drinking? (6D) ☐ Yes ☐ No
16. Have you awakened in the morning after drinking the night before and found that you could not remember a part of the evening before? ☐ Yes ☐ No
17. Have you ever passed out when drinking? ☐ Yes ☐ No
18. Do you ever have a drink the "morning after" to get rid of a hangover? (2D) ☐ Yes ☐ No
19. Have you ever been told that you have liver trouble or cirrhosis? (7D) ☐ Yes ☐ No
20. Have you ever had delirium tremens (D.T.'s), hands shaking, heard voices, or seen things that were not there after heavy drinking? (2D) ☐ Yes ☐ No

Client Name: _____

21. Would you like assistance with drinking problems at this time? ☐ Yes ☐ No

22. Have you ever gone to anyone for help about your drinking? ☐ Yes ☐ No

23. Have you ever been in a hospital because of drinking?(6D) ☐ Yes ☐ No

24. Have you ever been prescribed Antabuse? ☐ Yes ☐ No

25. Have you continued to drink when you knew you had a physical illness that might be made worse by drinking? ☐ Yes ☐ No

26. Have you, your physician, or someone else, thought you were having physical problems due to drinking? ☐ Yes ☐ No

27. Do you have any relative that has or had a drinking problem? ☐ Yes ☐ No

What relative is it? _____

Client Name: _____

Drug Use Questionnaire

1. How old were you the first time you used or tried any drug? _____
2. Have you used drugs in the last 30 days? ☐ Yes ☐ No
3. What drugs do you use?

	Age of First Use	Age of Last Use
Marijuana		
Cocaine		
Crack Cocaine		
Amphetamines		
Methamphetamines		
Heroin		
Other Opiates		
Hallucinogens		
Non-Prescription Methadone		
Barbiturates		
Other sedatives or hypnotics		
Inhalants		
Over-the-counter		
Tranquilizers		
Other Drugs		
PCP (Angel Dust)		

For each drug used, please answer the following questions:

4. Which drugs do you use daily? _____

   Weekly? _____

   Monthly? _____

   When did you last use? _____

   How many days in the past 30 days have you used drugs? _____

   Which drugs? _____

   Do you need more of the drug to get the same effect? ☐ Yes ☐ No

   Which drugs? _____

   Which drug do you like to use the most? _____

Client Name: _____

5. Has there been a time when you used drugs in larger amounts and/or for longer than intended? (3D) ☐ Yes ☐ No

6. Have you been arrested for possession, manufacture, distribution, etc? ☐ Yes ☐ No

   Which drugs? _____

7. Have you cut down on your drug use since your arrest? ☐ Yes ☐ No

8. Are you able to stop using drugs when you want to? (4D) ☐ Yes ☐ No

9. Where do you do most of your drugging? ☐ At home ☐ Away from home

10. Can you stop using drugs without a struggle? (4D) ☐ Yes ☐ No

11. Has your drug use ever caused you to lose a job? (6D) ☐ Yes ☐ No

12. Have you gotten into trouble at work or school because of drug use? (6D) ☐ Yes ☐ No

13. Have you ever neglected your responsibilities to yourself or your family because of drug use? (6D) ☐ Yes ☐ No

14. Have you had withdrawal symptoms when stopping the drug and/or have you used to avoid withdrawal? (2D) ☐ Yes ☐ No

15. Have you continued to use a drug/drugs when you were physically ill? (7D) ☐ Yes ☐ No

    Have you, your physician, or someone else, thought you were having physical problems because of your drug use? ☐ Yes ☐ No

16. Would you like assistance with drug problems now? ☐ Yes ☐ No

Client Name: _____

Drinking and Other Drugs

1. People drink and/or use other drugs for different reasons. How important would you say that each of the following is to you as a reason for drinking or using? (Put a check mark for each item.)

	Very Important	Fairly Important	Not at all Important
A. To help me relax.	_____	_____	_____
B. To be sociable.	_____	_____	_____
C. I like the taste of alcohol.	_____	_____	_____
D. Because other people I know do it.	_____	_____	_____
E. When I get angry.	_____	_____	_____
F. When I want to forget everything.	_____	_____	_____
G. To celebrate special occasions.	_____	_____	_____
H. To forget my worries	_____	_____	_____
I. To improve my appetite.	_____	_____	_____
J. To be polite.	_____	_____	_____
K. To cheer myself up.	_____	_____	_____
L. When I am tense and nervous.	_____	_____	_____
M. To feel normal.	_____	_____	_____
N. Other (specify): _____	_____	_____	_____

2. Have you gotten into fights after drinking or using drugs? ☐ Yes ☐ No

3. Drinking and using other drugs affects people in different ways. Check those that apply to you.
   - ☐ I become physically abusive (hit or push or slap, etc. others).
   - ☐ I become undependable.
   - ☐ I become quarrelsome.
   - ☐ Other (specify):

4. Check any of the following if they apply to how your friends and family feel about your alcohol and other drug use.
   - ☐ My family and friends worry about me.
   - ☐ My family and friends complain about my drinking/using.
   - ☐ I have problems with my girl friend, boy friend, spouse.
   - ☐ My friends and family have gone to others for help about my drinking and/or using.
   - ☐ My drinking and/or using has damaged my relationship with family and/or friends.

5. Do you consider yourself to have a potential problem with alcohol? ☐ Yes ☐ No

6. Do you consider yourself to have a potential problem with drugs? ☐ Yes ☐ No

7. Do you consider yourself to be an alcoholic? ☐ Yes ☐ No

8. Do you consider yourself to be a drug addict? ☐ Yes ☐ No

Client Name: _____

9. Which is your main problem? ☐ Alcohol ☐ Drugs ☐ Both

Psychological History

1. Please check those that apply.

☐ Depression
☐ Suicidal Thoughts
☐ Self harm/suicide attempt(s)
☐ Withdrawn/isolated
☐ Crying spells
☐ Anger control
☐ Appetite/weight changes
☐ Sleep changes
☐ Loneliness
☐ Hallucinations
☐ Paranoia
☐ Anxiety

2. Do you have any history of mental illness or psychiatric hospitalization for yourself or any of your family members? ☐ Yes ☐ No

   If yes, who and when? _____

3. Have you had any mental health counseling? ☐ Yes ☐ No

   If yes where and when and what kind? _____

4. Have you ever been prescribed medicine for any emotional problem? ☐ Yes ☐ No

   If yes, what medicine? _____

   Who prescribed it?
   Did it help? ☐ Yes ☐ No

5. Have you ever been emotionally abused (yelled at, threatened, called names)? ☐ Yes ☐ No

   If yes, by whom? _____

6. Have you ever been physically abused (pushed, hit, slapped)? ☐ Yes ☐ No

   If yes, by whom? _____

7. Have you ever been sexually abused? ☐ Yes ☐ No

   If yes, by whom? _____

History of Previous Treatment

1. How many times have you been in residential treatment for alcohol/drugs? _____

2. How many times have you been in treatment as a result of a DUII? _____

3. How many times have you been in outpatient treatment for alcohol/drugs? _____

Client Name: _____

4. How many times have you been in detox? _____

5. What is the total number of times you have been in all types of treatment? _____

6. Have you ever attended AA (Alcoholics Anonymous), NA (Narcotics Anonymous) or other 12 step meetings? ☐ Yes ☐ No

   If yes, why did you go? _____

   Do you have a sponsor? ☐ Yes ☐ No

   Have you had a sponsor? ☐ Yes ☐ No

   Have you worked the 12 steps? ☐ Yes ☐ No

7. How many times have you overdosed on drugs? _____

   When was the last time? _____

8. What is the longest period of time you have stayed clean and sober? (months or years) _____

Gambling

1. Do you gamble? ☐ Yes ☐ No

2. How much do you spend each week on gambling? _____

3. Have you made repeated, unsuccessful efforts to control, cut back or stop gambling? ☐ Yes ☐ No

4. How many days in the past 30 have you gambled? _____

5. Have you been troubled or bothered by gambling problems in the past 30 days? ☐ Yes ☐ No

6. Would you like help with gambling problems? ☐ Yes ☐ No

Health Screen Inventory

1. How many times in your life have you been hospitalized for medical problems? (Do count overdoses and delerium tremens [Dts]. Don't count detox and births.) _____

2. How long ago was your last hospitalization for medical problem? Years _____ Months _____

3. Do you now have any chronic medical problems which continue to interfere with your life? ☐ Yes ☐ No

4. Are you taking any prescribed medication on a regular basis for a physical problem? ☐ Yes ☐ No

Client Name: _____

5. Do you have any kind of disability (mobility, learning, eyesight, hearing, developmental) or major limitation? ☐ Yes ☐ No

6. Have you ever had nerve problems (convulsions, epilepsy, shaking, migrains [exclude mental health problems])? ☐ Yes ☐ No

7. Have you ever had eating disorders (bulimia, anorexia, binging, or purging)? ☐ Yes ☐ No

8. Where do you usually receive health care?

☐ Physician (M.D.)
☐ Nurse practitioner
☐ Community health nurse
☐ Emergency room
☐ Indian Health Services
☐ Other (specify): _____
☐ None

9. Please check if you have any current medical problems:

☐ Liver
☐ Heart
☐ Kidneys
☐ Lungs
☐ Skin Infections
☐ Diabetes
☐ TB
☐ Head Trauma
☐ Epilepsy/Convulsions
☐ Other (specify) _____

10. How troubled or bothered have you been by these medical problems in the past 30 days?

☐ Not at all
☐ Slightly
☐ Moderately
☐ Considerably
☐ Extremely

11. How important to you now is additional treatment for these medical problems?

☐ Not at all
☐ Slightly
☐ Moderately
☐ Considerably
☐ Extremely

LOS 4

HOMELESS HEALTH CARE LOS ANGELES
MENTAL HEALTH QUESTIONNAI.

Name _____ DOB _____ Date _____

1. Are you depressed? Yes ____ No ____

   A. Are you sleeping or eating more or less than usual? Yes ____ No ____
   B. Do you feel optimistic about the future? Yes ____ No ____
   C. Do you feel hopeless about the future? Yes ____ No ____
   D. Do you have about the same amount of energy as usual? Yes ____ No ____

2. Do you feel like hurting yourself? Yes ____ No ____

   IF YES, ANSWER THE FOLLOWING QUESTIONS

   A. Do you have a plan? Yes____ No____ Not determined ____
      If yes, explain _____
   B. Do you have access to the means to harm yourself? Yes____ No____ Not determined ____
      If yes, explain _____
   C. Do you have a history of attempts to harm yourself? Yes____ No____ Not determined ____
      If yes, explain _____

   Assessment of suicidal lethality:
   ___ none ___ mild ___ moderate ___ severe ___ not determined

3. Do you feel like hurting someone else? Yes ____ No ____

   IF YES, ANSWER THE FOLLOWING QUESTIONS

   A. Do you have a plan? Yes____ No____ Not determined ____
      If yes, explain _____
   B. Do you have access to the means to harm someone else? Yes____ No____ Not determined ____
      If yes, explain _____
   C. Do you have a history of attempts to harm other people? Yes____ No____ Not determined ____
      If yes, explain _____

   Assessment of homicidal lethality:
   ___ none ___ mild ___ moderate ___ severe ___ not determined

4. Have you ever seen a mental health professional for counseling/therapy services? Yes ____ No ____
   If yes specify _____

5. In the last 6 months have you been hospitalized for a mental health problem ? Yes____ No ____
   If yes specify when, where, why, length _____
   _____

6. Are you currently on medication for any physical or mental health problems? Yes____ No ____

   If no, have you been prescribed a certain medication and choose not to take it? Yes ___ No ___

   Type of Medication Mg. Why? How long?

7. Have there been times when you or others have felt that you were too hyper, too restless, too charged up, too excited, or too talkative for several days at a time? Yes ____ No ____
   If yes, explain _____
   _____

8. Have there ever been times wi... you felt much too nervous, anxious or tense a' ordinary things? Yes ____ No ____ If yes, check symptoms:
___ heart racing ___ sweating ___ chest pains ___ shortness of breath
___ dizziness ___ tingling sensations ___other _____

9. Do you ever have sudden spells or attacks of nervousness for no particular reason? Yes ____ No ____
If yes, explain _____

10. Have you ever heard voices or seen things that no one else could hear or see? Yes ____ No ____
If yes, explain _____

11. Have you ever felt that your mind or body was being secretly controlled, or controlled somehow against your will? Yes ____ No ____
If yes, explain _____

12. Have you ever felt that others wanted to hurt you or really get you for some special reason, maybe because you had secrets or special powers of some sort? Yes ____ No ____
If yes, explain _____

13. Have you ever had any other very strange, odd, or really peculiar things happen to you?
Yes ____ No ____
If yes, explain _____

14. Have you ever experienced nightmares or flashbacks, in which you found yourself reliving some terrible experience over and over again? Yes ____ No ____
If yes, explain _____

15. Have you ever had to repeat an act over and over again even though it did not make sense or had thoughts that came into your mind over and over that you could not stop? Yes ____ No ____
If yes, explain _____

FOLLOW UP NEEDS

General Mental Health

____ Follow-up HHCLA Mental Health Specialist

____ Referral for further Evaluation/Testing

____ Follow-up Homicide

____ Follow-up Suicide

NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

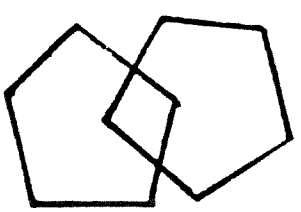
_____

Staff Signature

MINI MENTAL STATE EXAMINATION

DAL 4

Name _____ Date _____

Max	Score	
5		What is the (year) (season) (date) (day) (month) ?
5		Where are we: (state) (county) (town) (hospital) (floor) ?
3		Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each answer. Then repeat them until he learns all 3. Count trials and record. Trials
5		Serial 7's. 1 point for each correct. Stop after 5 answers. Alternatively spell "world" backwards.
3		Ask for 3 objects repeated above. Give 1 point for each correct.
9		Name a pencil, and watch (2 points) Repeat the following: "No ifs, ands or buts." (1 point) Follow a 3-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." (3 points) Read and obey the following: (1 point) Close your eyes Write a sentence. (1 point) Copy design (1 point)  ASSESS level of consciousness along a continuum. (No points) Alert Drowsy Stupor Coma
_____ Total Score	_____	

PROTOCOLS FOR EVALUATING AOD USING BATTERED WOMEN

ASSERTIVE COMMUNICATIONS COMMUNITY MENTAL HEALTH PROGRAMS

1) Current level of AOD use; none currently active last 24 hrs. last 48 hrs.

Type of AOD use_____

2) Current level of medical needs; none observable bruises no medical attention

immediate medical attention needed

3) Level of risk for continued abuse; none sporadic impending life threatening

4) Current mental status;

5) Interventions recommended;

6) Client's ability to follow up on recommended interventions; able to on own

moderate with no assistance moderate with some assistance

none with out some assistance none with out total assistance

7) Current medications;

8) Name of abuser; Age

Home address; Telephone;

Work address; Telephone;

BAL 47

UNIVERSITY OF MARYLAND MEDICAL CENTER /
HEALTHCARE FOR THE HOMELESS

PSYCHIATRIC EVALUATION

DATE:

ATTENDING PHYSICIAN: _____ THERAPIST: _____

ID / CC / HPI: _____

PAST PSYCH HISTORY: _____

SURG/MED HISTORY: _____

LEGAL HISTORY: _____

SUBSTANCE USE & TREATMENT:

ALCOHOL: _____

TOBACCO: _____

HEROIN: _____

COCAINE: _____

OTHER: _____

FAMILY PSYCH HISTORY: _____

SOCIAL HISTORY:

MARITAL STATUS: _____

OCCUPATION: _____

EDUCATION: _____

SUPPORT SYSTEM: _____

LIVING SITUATION: _____

MEDICATIONS: _____

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

ALLERGIES: _____

MSE

☐ ALERT ☐ SOMNOLENT ☐ STUPOROUS ☐ ORIENTED TO PERSON / PLACE / TIME

GENERAL APPERANCE

☐ WELL GROOMED ☐ DISHEVELED ☐ APPEARS STATED AGE / YOUNGER / OLDER

ATTITUDE

☐ COOPERATIVE ☐ GUARDED ☐ HOSTILE ☐ DEFENSIVE ☐ OTHER:

BEHAVIOR

☐ NORMAL ☐ PSYCHOMOTOR AGITATION / RETARDATION ☐ OTHER:

SPEECH

☐ RATE RAPID/ SLOW / PRESSURED ☐ TONE MONOTONOUS / NORMAL ☐ VOLUME LOUD / QUIET

MOOD

☐ EUTHYMIC ☐ DEPRESSED ☐ ANXIOUS ☐ ANGRY ☐ EUPHORIC

AFFECT

☐ FULL & APPROPRIATE ☐ BLUNTED FLAT ☐ LABILE ☐ BRIGHT ☐ SAD ☐ INAPPROPRIATE

THOUGHT PROCESS

☐ GOAL DIRECTED ☐ TANGENTIAL ☐ PERSEVERATIVE ☐ LOOSENING OF ASSOC ☐ PAUCITY OF IDEAS

☐ THOUGHT BLOCKING ☐ FLIGHT OF IDEAS ☐ ILLOGICAL ☐ CIRCUMSTANTIAL ☐ EVASIVE

THOUGHT CONTENT

SI: CURRENT INTENT? ○ YES ○ NO CURRENT PLAN? ○ YES ○ NO DESCRIBE: _____

HI: CURRENT INTENT? ○ YES ○ NO CURRENT PLAN? ○ YES ○ NO DESCRIBE: _____

DELUSIONS? ○ YES ○ NO DESCRIBE: _____

☐ PREOCCUPATIONS ☐ OBSESSIONS ☐ COMPULSIONS ☐ PHOBIAS

PERCEPTION: HALLUCINATIONS

☐ AUDITORY ☐ VISUAL ☐ TACTILE ☐ OTHER:

ATTN/CONC: ☐ INTACT ☐ IMPAIRED MEMORY: ☐ INTACT ☐ IMPAIRED MMSE: / 30

FUND OF KNOWLEDGE: ☐ APPROPRIATE / IMPAIRED ABSTRATION: ☐ INTACT ☐ CONCRETE ☐ ODD ☐ PERSONALIZED

INTELLIGENCE: ☐ AV ☐ <AV INSIGHT: ☐ FAIR ☐ GOOD ☐ POOR JUDGEMENT: ☐ FAIR ☐ GOOD ☐ POOR

CAPACITY TO WORK PSYCHOTHERAPEUTICALLY: ☐ FAIR ☐ GOOD ☐ POOR

ABILITY TO ESTABISH A THERAPEUTIC ALLIANCE: ☐ FAIR ☐ GOOD ☐ POOR

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

PLAN

MEDICATIONS: _____

RISKS AND BENEFITS DISCUSSED? ☐ YES ☐ NO

FOLLOW-UP APPOINTMENT: _____

OTHER REFERRALS / APPOINTMENTS

MEDICAL

LAB (NURSING): _____

HPE / MEDICAL CONCERN: _____

SOCIAL WORK

CASE MGMT. _____

ON-CALL TODAY: _____

ADDICTIONS: _____

DUAL DIAGNOSIS GROUP:

SIGNATURE: _____ PRINT NAME: _____

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UMMS / HEALTH CARE FOR THE HOMELESS
PSYCHIATRY FOLLOW-UP VISIT

DATE:

PROGRESS SINCE LAST VISIT: _____

MEDS COMPLIANT? ☐ YES ☐ NO

SLEEP: _____ APPETITE: _____

MSE

ORIENTATION: PERSON / PLACE / TIME CONSCIOUSNESS: O ALERT O SOMOLENT O STUPOROUS

ATTITUDE: O COOPERATIVE O UNCOOPERATIVE O GUARDED O HOSTILE O DEFENSIVE O OTHER: _____

GENERAL APPEARANCE: O APPROPRIATE O DISHELVED O WELL-GROOMED
O UNUSUAL/FLAMBOYANT O APPEARS STATED AGE/ YOUNGER / OLDER

SPEECH: *RATE* - O RAPID O SLOW O PRESSURED O NORMAL *TONE* - O MONOTONOUS O APPROPRIATE *VOLUME* - O LOUD O QUIET O APPROPRIATE MOOD: O EUTHYMIC O DEPRESSED O ANXIOUS O ANGRY O EUPHORIC

AFFECT: O FULL AND APPROPRIATE O BLUNTED / FLAT O BRIGHT O SAD O INAPPROPRIATE

THOUGHT PROCESS: O GOAL DIRECTED O PERSEVERATIVE O TANGENTIAL O ILLOGICAL O CIRCUMSTANCIAL O FLIGHT OF IDEAS/LOOSE ASSOC. O BLOCKING

THOUGHT CONTENT: O PREOCCUPATIONS O OBSESSIONS O COMPULSIONS O PHOBIAS O APPROPRIATE

DELUSIONS? ☐ NO ☐ YES DESCRIBE:

HALLUCINATIONS O AUDITORY O VISUAL O TACTILE O OTHER: _____

ATTENTION/CONCENTRATION O INTACT O IMPAIRED MEMORY: O INTACT O IMPAIRED

INSIGHT O FAIR O GOOD O POOR JUDGMENT: O FAIR O GOOD O POOR

RISK: SI: CURRENT INTENT? ☐ NO ☐ YES CURRENT PLAN? ☐ NO ☐ YES DESCRIBE: _____

HI: CURRENT INTENT? ☐ NO ☐ YES CURRENT PLAN? ☐ NO ☐ YES DESCRIBE:

ASSESSMENT

CHANGE SINCE LAST VISIT O SAME O WORSE O IMPROVED

ADDICTION O ACTIVE USE/SUBSTANCE _____ O MAINTAINING RECOVERY _____ DAYS/MOS. O RELAPSED O N/A

PROGRESS: _____

AXIS I: _____ AXIS II: _____

TREATMENT

MEDS: _____

_____

_____

RISKS AND BENEFITS DISCUSSED? ☐ YES ☐ NO

ALSO SCHEDULE WITH: ☐ THERAPIST ☐ SOCIAL WORKER ☐ MEDICAL ☐ ADDICTION ☐ NSG (LABS) ☐ DUAL DIAGNOSIS GROUP

OTHER INTERVENTIONS: _____

PHYSICIAN SIGNATURE: NEXT APPOINTMENT:

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

HCLA 13

PSYCHIATRIC STATUS Client ID #_____

1. How many times have you been treated for any psychological or emotional problems?
   In a hospital [ ][ ]
   As an outpatient or private patient [ ][ ]

2. Do you receive a pension for a psychiatric disability? [ ]
   0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes	Past 30 days	In your life
3. Experienced serious depression	[ ]	[ ]
4. Experienced serious anxiety or tension	[ ]	[ ]
5. Experienced hallucinations	[ ]	[ ]
6. Experienced trouble understanding, concentrating or remembering	[ ]	[ ]
7. Experienced trouble controlling violent behavior	[ ]	[ ]
8. Experienced serious thoughts of suicide	[ ]	[ ]
9. Attempted suicide	[ ]	[ ]
10. Been prescribed medication for any psychological/emotional problem	[ ]	[ ]

11. How many days in the past 30 have you experienced these psychological or motional problems? [ ][ ]

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? [ ]

13. How important to you now is treatment for these psychological problems? [ ]

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient:
0 - No 1 - Yes

14. Obviously depressed, withdrawn [ ]
15. Obviously hostile [ ]
16. Obviously anxious/nervous [ ]
17. Having trouble with reality testing, thought disorders, paranoid thinking [ ]
18. Having trouble comprehending, concentrating, remembering [ ]
19. Having suicidal thoughts [ ]

INTERVIEWER SEVERITY RATING

20. How would you rate the patient's need for psychiatric/psychological treatment? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

21. Patient's misrepresentation? 0 - No 1 - Yes [ ]
22. Patient's inability to understand? 0 - No 1 - Yes [ ]

Severity Profile

Problems	1	2	3	4	5	6	7	8
Medical								
Employment								
Alcohol								
Drug								
Illegal Activity								
Family/Social								
Psychiatric								

Comments:

HEALTH CARE FOR THE HOMELESS
PSYCHIATRIC/SOCIAL NEEDS ASSESSMENT

Date:

Identifying Characteristics:

Current Circumstances/Presenting Problem:

Psychiatric History (eg. hospitalizations, out-patient care, diagnoses, suicidal/homicidal behaviors, medications, family psychiatric history):

Physical Health History (eg. significant injuries/illnesses, current health problems, pregnancies, most recent physical exam, current health provider):

HIV Status/Risk Factors:

Allergies:

Current Medications:

NAME: SSN:

DOB: HMC #:

SEA2-2.

History of Alcohol/Substance Use (type of substance, age of onset, pattern of use, treatment history, medical/legal/social complications, family history of substance use):

Social History:
family of origin:

significant childhood events:

education:

employment:

military:

marriage/significant relationships/children:

legal problems:

emotional/physical/sexual abuse: (victim and/or perpetrator)

history of homelessness/current living situation:

income:

stresses:

strengths:

supports:

Mental Status:

appearance:

behavior:

mood/affect:

speech:

thought process:

thought content/perceptions:

suicidal or homicidal ideation:

orientation:

memory:

intellect:

insight:

judgement:

Assessment Summary (including diagnostic impression):

NAME:

SEA 2-4

Plan:

1) Survival services:

	offered/provided	no current need
shelter/housing	___	___
food	___	___
clothing	___	___

2) Crisis resource information: provided ___ not needed ___

3) Assessment for risk factors for HIV exposure:
yes ___ no ___ deferred ___
Education provided regarding HIV risk factors:
yes ___ no ___ already well-informed ___

Significant Contacts/Other Providers (address, phone):
Emergency contact:

Others:

NAME:

H.O.M.E.S., INC.
COMMUNITY LIVING SERVICES
PSYCHOLOGICAL EVALUATION

APPLICANT NAME: _____ DATE: _____

DATE OF BIRTH: _____ PSYCHIATRIST/PSYCHOLOGIST:

_____

CURRENT DIAGNOSIS:

AXIS I: _____

AXIS II: _____

AXIS III: _____

SUMMARY OF SUICIDAL IDEATION/GESTURE/ATTEMPT AND POTENTIAL FOR SAME:

SUMMARY/POTENTIAL OF ASSAULTIVE BEHAVIOR:

CURRENT MEDICATION:

HISTORY AND ATTITUDE TOWARD MEDICATION (INCLUDE ABILITY TO SELF-MEDICATE):

HISTORY AND LEVEL OF SEVERITY OF SUBSTANCE ABUSE:

LEVEL OF ABILITY TO LIVE COOPERATIVELY WITH OTHERS:

Strengths:

Needs:

PLEASE SUMMARIZE REASON FOR REFERRAL AND RECOMMEND WHAT SERVICES OF HOMES WOULD BE BENEFICIAL:

BAL 491

HEALTH CARE FOR THE HOMELESS, INC.

PSYCHOSOCIAL ASSESSMENT

DATE: _____

PRESENTING PROBLEM:

PSYCHIATRIC TREATMENT *(begin with most recent Treatment):*

Psychiatric In-Patient History	Psychiatric Out-Patient History

PSYCHOTROPIC MEDICATION HISTORY:

Past Psychotropics	Present Psychotropics

Medical Issues/Allergies to Medications (probe conditions r/t chronic pain):

Family Psychiatric and Substance Abuse History? ☐ No ☐ Yes **If yes, describe:**

If applicable, history of alcohol and/or drugs/substance (include last use):

SOCIAL/ FAMILY HISTORY:

Last Grade Completed: **Last Time Employed:** **Military History - Discharge Status:**

Support System:

Living Situation/History of Homelessness:

History of Physical/Sexual Abuse or Domestic Violence:

Legal History? ☐ No ☐ Yes **If yes:**

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

RISK ASSESSMENT:

Suicidal Ideation? ☐ No ☐ Yes Past history of suicide attempt? ☐ No ☐ Yes

Suicidal Plan? ☐ No ☐ Yes

Last suicide attempt (including means): _____

Homicidal Ideation? ☐ No ☐ Yes Prior history of homicidal attempt? ☐ No ☐ Yes

Homicidal Plan? ☐ No ☐ Yes

Last homicide attempt (including means): _____

MENTAL STATUS EXAM

Consciousness: ☐ Alert ☐ Confused ☐ Lethargic ☐ Stuporous

Orientation: ☐ Person ☐ Place ☐ Time (Year, Season, Date, Month)

Interview Behavior: ☐ Cooperative ☐ Angry ☐ Silly ☐ Negativistic ☐ Evasive
☐ Superficial ☐ Irritable ☐ Withdrawn ☐ Dependent ☐ Uncooperative

Memory:

☐ Immediate	☐ Recent	☐ Past
☐ Poor	☐ Poor	☐ Poor
☐ Fair	☐ Fair	☐ Fair
☐ Good	☐ Good	☐ Good

Mood:

☐ Depression	☐ Mania	☐ Other: _____
☐ Mild	☐ Mild	☐ Anxiety
☐ Moderate	☐ Moderate	☐ Mild
☐ Severe	☐ Severe	☐ Moderate
		☐ Severe

Agitation: ☐ Tense ☐ Restless ☐ Pacing ☐ Hostile ☐ NAD

Affect: ☐ Flat ☐ Blunted ☐ Full Ranged ☐ Labile ☐ Restricted ☐ Other: _____

Impulse Control: ☐ Poor ☐ Fair ☐ Good **Judgment/Insight:** ☐ Poor ☐ Fair ☐ Good

Speech: ☐ Normal ☐ Slurred ☐ Reduced ☐ Excessive ☐ Soft
☐ Loud ☐ Mute ☐ Pressured ☐ Stutters ☐ Rapid

Sleep: _____

Appetite: _____

Flow of Thought: ☐ Normal ☐ Circumstantial ☐ Tangential ☐ Blocking
☐ Perseveration ☐ Loose ☐ Flight of Ideas ☐ Indecisive

Thought Content: ☐ Rational ☐ Depressive ☐ Suspicious ☐ Poverty of ideas ☐ Phobias
☐ Obsessions ☐ Somatic Preoccupation ☐ Religiosity ☐ Referential ☐ Worthless ☐ Hopeless

Delusions Present? ☐ No ☐ Yes If yes, content:

Hallucinations present? ☐ No ☐ Yes If yes, describe:

Are they command hallucinations? ☐ No ☐ Yes If yes, describe:

General Cognitive Assessment: Overall estimate of IQ: ☐ Average ☐ Above Average ☐ Below Average

Potential barriers to learning/achieving treatment goals: ☐ Limited Education ☐ Cognitive deficits ☐ Poor motivation ☐ Cultural/religious
☐ Active substance use ☐ Psychosis ☐ Other: _____

Capacity to form therapeutic alliance: ☐ good ☐ fair ☐ poor

BAL 49-2

PSYCHOSOCIAL ASSESSMENT

Working Diagnosis/Diagnostic Impression:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Plan: (including referrals): _____

Individualized Treatment Plan (completed at time of Intake): **Date Initiated:**

Short Term Goals (reviewed at 6 months)	Date Reviewed	Achieved?
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No

Brief summary of adherence and prognosis (6 month review): _____

Signature/Title: Date of 6 month review:

Long Term Goals (reviewed at 1 year)	Date Reviewed	Achieved?
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No

Brief summary of adherence and prognosis (12 month review): _____

Signature/Title: _____ Date of 1 year review: _____

Intake Provider's Signature: Date:

CLIENT LAST NAME: FIRST NAME: HCH#:

BAL 51

HEALTH CARE FOR THE HOMELESS, INC.

PSYCHOSOCIAL CASE MANAGEMENT ASSESSMENT

SOCIAL SECURITY #	AGE	DATE OF BIRTH	☐ MALE ☐ FEMALE	☐ AFRICAN-AMERICAN ☐ CAUCASIAN	☐ HISPANIC ☐ OTHER _____

☞CONFIDENTIALITY FORM SIGNED? ☐ YES ☐ NO

1

PRESENTING PROBLEM:

WHERE STAYED LAST NIGHT:

HOW LONG HOMELESS?

HOMELESS HISTORY:

FAMILY COMPOSITION:

NEXT OF KIN:

CONTACT INFORMATION:

WHERE DO YOU GET YOUR FOOD?

2

EMPLOYED? ☐ YES ☐ NO . . . IF NOT, LAST FULL-TIME JOB:

USUAL OCCUPATION:

EDUCATIONAL LEVEL: | JOB SKILL TRAINING:

MILITARY SERVICES? ☐ NO ☐ YES. . . IF YES, EXPLAIN:

3

INSURANCE? ☐ NO ☐ YES: | BENEFITS? ☐ NO ☐ YES:

INCOME? ☐ NO ☐ YES: | IS INCOME ADEQUATE TO MEET YOUR NEEDS? ☐ NO ☐ YES

4

HIV TEST IN THE PAST 6 MONTHS? ☐ NO ☐ YES. . . IF YES, WHERE:

WHAT WERE THE RESULTS? | TEST CONFIRMED IN CHART? ☐ YES ☐ NO

HOW IMPORTANT IS YOUR SEXUALITY TO YOU?:

ANY CONCERNS ABOUT SEXUALITY THAT YOU WANT TO DISCUSS? ☐ NO ☐ YES:

CONDOM USAGE? ☐ NO ☐ YES: | HOW MANY PARTNERS IN PAST SIX MONTHS:

TOBACCO USE? ☐ NO ☐ YES: | IV DRUG USE? ☐ NO ☐ YES:

COCAINE USE? ☐ NO ☐ YES . . .LAST USE: | HEROIN USE? ☐ NO ☐ YES. .LAST USE:

ETOH USE? ☐ NO ☐ YES. . .LAST USE: | OTHER: LAST USE:

5

CURRENT MEDICAL PROBLEMS:

CURRENT MEDS:

IF HIV+, CD4 COUNT: | VIRAL LOAD:

OPPORTUNISTIC INFECTIONS:

CURRENT MH PROBLEMS:

EVER TRAUMATIZED? ☐ NO ☐ YES

6

TB TEST? ☐ NO ☐ YES | DATE:

WHERE: | RESULTS:

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

PSYCHOSOCIAL CASE MANAGEMENT ASSESSMENT

HEP C TEST? ☐ NO ☐ YES | DATE:

WHERE: | RESULTS:

7 *MEDICAL CARE/ADHERENCE ASSESSMENT*

WHERE DID YOU RECEIVE CARE IN THE PAST?

WHY DID YOU CHANGE TO HCH?

HAVE YOU EVER BEEN ON HAART THERAPY? ☐ N/A ☐ NO ☐ YES. . . GIVE SPECIFICS:

WHAT HEALTH CARE CONCERNS DO YOU HAVE?	YES	NO
UNDERSTANDING AND TAKING MEDICINES		
KEEPING REGULAR APPOINTMENTS		
FEELING GOOD ABOUT MY TREATMENT OPTIONS		
HAVING ALL MY QUESTIONS ANSWERED		
SEXUALITY ISSUES		

OTHER:

WHAT GETS IN THE WAY OF MEETING YOUR HEALTH CARE GOALS?

8 *LEGAL HISTORY*

NUMBER OF ARRESTS IN PAST 2 YEARS: CURRENTLY ON PAROLE OR PROBATION? ☐ NO ☐ YES:

CHARGES PENDING? ☐ NO ☐ YES:

OTHER SIGNIFICANT HISTORY:

9

RELIGIOUS PREFERENCE: CHURCH HOME? ☐ NO ☐ YES:

DO YOU CONSIDER YOURSELF SPIRITUAL OR RELIGIOUS? ☐ NO ☐ YES

ANYTHING ABOUT YOUR BELIEFS YOU WANT ME TO KNOW IN TERMS OF YOUR TREATMENT? ☐ NO ☐ YES:

10

PERSONAL GOALS:

RECREATION GOALS:

11 *SOCIAL/COMMUNITY SUPPORTS:*

WHAT OTHER AGENCIES PROVIDE SERVICES TO YOU?

NAME: SERVICES PROVIDED:

AGENCY ADDRESS: CITY: STATE: ZIP:

ARE THERE FAMILY & FRIENDS THAT HELP YOU? ☐ NO ☐ YES

DO YOU WANT THEM INVOLVED IN WHAT WE ARE WORKING ON? ☐ NO ☐ YES IF YES, DESCRIBE:

12

REFERRAL DIAGNOSIS

HE/SHE NEEDS:
☐ HOUSING ☐ MENTAL HEALTH ☐ ADDICTION SERVICES ☐ INCOME
☐ JOB TRAINING ☐ EMPLOYMENT ☐ HEALTH INSURANCE ☐ MEDICAL CARE
☐ OTHER:

CASE MANAGER SIGNATURE DATE

NEXT APPT. DATE: →

COMMENTS SECTION:

CAM 1-1

Camillus Health Concern, Inc.
PSYCHOSOCIAL REPORT

I. Date _____ CHC Number _____

Client Name _____ _____ _____
Last First SSN

II. Name Children(s) Age Sex Birth Dates

a. _____ ____ ____ _____

b. _____ ____ ____ _____

c. _____ ____ ____ _____

d. _____ ____ ____ _____

III. Family/Friends/Agency Contacts
(name, relationship, address, telephone number)

a. _____

b. _____

c. _____

IV. Presenting Concern(s) _____

V. Living Situation _____

_____

VI. Income and Expenses _____

_____

VII. Family History _____

_____

_____

VIII. Homelessness History _____

_____

_____

IX. Employment History _____

_____

_____

CHC Number _____

Client Name _____ _____ _____
Last First SSN

X. Addiction History _____

XI. Mental Health History _____

XII. Medical History _____

XIII. Other Background Information _____

XIV. Impressions _____

CHC Number _____

Client Name _____ _____ _____
Last First SSN

XV. Problems

a. _____

b. _____

c. _____

d. _____

Community or Camillus House Referrals

a. _____

b. _____

c. _____

d. _____

XVI. Follow-up Plan _____

_____

_____

Signature: _____

Print Last Name: _____

Title: _____

Name _____
Date _____

ZUNG DEPRESSION SCALE

	None OR a Little of the Time	Some of the Time	Good Part of the Time	Most OR All of the Time	
1. I feel downhearted, blue, and sad					
2. Morning is when I feel the best					
3. I have crying spells or feel like it					
4. I have trouble sleeping through the night					
5. I eat as much as I used to					
6. I enjoy looking at, talking to, and being with attractive women/men					
7. I notice that I am losing weight					
8. I have trouble with constipation					
9. My heart beats faster than usual					
10. I get tired for no reason					
11. My mind is as clear as it used to be					
12. I find it easy to do the things I used to do					
13. I am restless and can't keep still					
14. I feel hopeful about the future					
15. I am more irritable than usual					
16. I find it easy to make decisions					
17. I feel that I am useful and needed					
18. My life is pretty full					
19. I feel that others would be better off if I were dead					
20. I still enjoy the things I used to do					
				SDS Raw Score	

BAL 10-1

DAL 10-2

The Measurement of Depression

William W. K. Zung, MD

A self-rating depression scale (SDS) for the quantitative measurement of depression as an emotional disorder based upon an operational definition was first published in 1965[1]. This was followed by a series of reports that described its validity and reliability on the basis of investigations performed in the United States as well as in other countries throughout the world[2-5]

Although devised for use in psychiatric research, the scale readily lends itself to use in the general practice of medicine in which most depressions are first encountered. The use of the SDS in a variety of patients with physical complaints with no apparent organic basis may uncover and measure depression in the so-called masked depressions. This saves valuable time for the doctor and the patient, since the unmasking of the patient's depression by the doctor is the first necessary step toward treatment.

How to Use the Self-Rating Depression Scale

Depression is defined operationally as a syndrome comprised of coexisting signs and symptoms that signify the presence of pathologic disturbances or changes in four areas: somatic, psychologic, psychomotor, and mood.

The SDS comprises a list of 20 items. Each item relates to a specific characteristic of depression. The 20 items together comprehensively delineate the depressive disorders as they are widely recognized. Opposite the statements are four columns headed: *None or A Little of the Time, Some of the Time, Good Part of the Time, and Most* or *all of the Time*.

For each item, the patient is asked to put a check mark in the box according to how it relates to his/her feelings within a specified time period: "during the past week." Although some depressed patients orally volunteer little information, most will readily cooperate when asked to check the scale if told that this will help the doctor know more about them.

The statements in the scale are worded in the everyday language of the patient. Questions about how to complete the scale usually indicate the patient's desire to

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[1] Zung WWK: A self-rating depression scale. *Arch Gen Psychiatry* 1965; 12:63-70.
[2] Zung WWK: Evaluating treatment methods for depressive disorders. *AM J Psychiatry* 1968; 124(suppl):40-48.
[3] Zung WWK: A cross-cultural survey of symptoms in depression. *Am J Psychiatry* 1969; 126:116-121.
[4] Zung WWK, Wonnacott TH: Treatment prediction in depression using a self-rating scale. *Biol Psychiatry* 1970; 2:321-329
[5] Zung WWK: A cross-cultural survey of depressive-symptomatology in normal adults. *J Cross-Cult Psychol* 1972; 3:177-183.

cooperate with the physician. For example, a patient may ask how to check Item 5 because he or she is on a diet and therefore should not be eating as much. In this case, the patient is asked to answer as if he or she were not on a diet.

After the patient has filled out the scale, take a moment to check that all statements have been answered.

Interpretation of SDS Ratings in Depression and Other Emotional Disorders

"Depression" as a word can be used to describe: (1) an affect that is a subjective feeling tone of short duration, (2) a mood that is a state sustained over a longer period of time, (3) an emotion that comprises feeling tones along with objective indications, and (4) a disorder that has characteristic symptom clusters and complexes of signs and symptoms. The SDS is intended to rate depression as a disorder. However, the SDS is not intended to differentiate the different types of depression. It serves rather to quantitatively measure the intensity of depression, regardless of the diagnostic label used.

The Total Score can be interpreted as follows:

Score	Equivalent Clinical Global Impressions
Below 40	Within Normal range, no psychopathology
40-49	Presence of minimal to mild depression
50-55	Presence of moderate to marked depression
56 and over	Presence of severe to extreme depression

The above interpretations are based on data that compares depressed versus non-depressed patients as well as depressed patients versus normal subjects in the 20- to 64-year-old range. High scores are not in themselves diagnostic but indicate the presence of symptoms that may be of clinical significance.

Results from several studies have shown that there is usually some depressive symptomatology present in almost all of the psychiatric disorders. Patients may have several diagnoses: headache AND depression, schizophrenia AND depression, diabetes AND depression. Thus, a primary diagnosis other than depression does not eliminate the possibility that the patient is also depressed. If the Score is above 40, the patient may need treatment for the depression in addition to treatment for the primary diagnosis.

SCORING

1. I feel downhearted, blue, and sad	1	2	3	4
2. Morning is when I feel the best*	4	3	2	1
3. I have crying spells or feel like it	1	2	3	4
4. I have trouble sleeping through the night	1	2	3	4
5. I eat as much as I used to*	4	3	2	1
6. I enjoy looking at, talking to, and being with attractive women/men*	4	3	2	1
7. I notice that I am losing weight	1	2	3	4
8. I have trouble with constipation	1	2	3	4
9. My heart beats faster than usual	1	2	3	4
10. I get tired for no reason	1	2	3	4
11. My mind is as clear as it used to be*	4	3	2	1
12. I find it easy to do the things I used to do*	4	3	2	1
13. I am restless and can't keep still	1	2	3	4
14. I feel hopeful about the future*	4	3	2	1
15. I am more irritable than usual	1	2	3	4
16. I find it easy to make decisions*	4	3	2	1
17. I feel that I am useful and needed*	4	3	2	1
18. My life is pretty full*	4	3	2	1
19. I feel that others would be better off if I were dead	1	2	3	4
20. I still enjoy the things I used to do*	4	3	2	1

VAL 10-1