Columbia Addictions Center

Eileen Dewey, L.C.S.W.-C
Director

Date: _____

Client Name: _____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____

E-mail: _____ Preferred contact (circle one): home # cell # e-mail

Emergency contact (name & phone #): _____

If under age 18, name of parent or guardian: _____

Reason for current evaluation (DUI, possession, etc.):_____

Citation Date: _____ Court Date: _____

Did you take a breathalyzer? Yes_____ No_____

If yes, what was your Blood Alcohol Content (BAC)? _____

Name of lawyer or probation officer (if applicable):_____

Phone #: _____ Fax #: _____

Have you had any prior citations or arrests? Yes No

Date:_____ Charge(s):_____

Date:_____ Charge(s):_____

Date:_____ Charge(s):_____

How did you hear about us? _____

Client Requirements

Following today's visit, an education or counseling program may be recommended for you. We need you to be aware of our program guidelines in the event you enroll in a program.

Attendance

- Attendance at all scheduled sessions is expected.
- If you arrive more than ten minutes late to a group session, you will not be admitted.
- If you are late to an individual session, you are still responsible for the full cost of the session.

Abstinence and Drug/Alcohol Testing

- *Every client* is subject to random urinalyses and breathalyzers.
- Refusal to submit to a urinalysis or breathalyzer is considered to be a positive test result.
- The fee for these tests is the financial responsibility of the client. Urine screens are $40 each.

Our center is a drug-free and alcohol-free program. You agree to remain abstinent from all mood-altering substances while in this program. If you test positive, you will be required to meet with your counselor or program director for a reassessment. A reassessment is $75-$120 depending on length of the session.

Cancellation Policy

- We require at least 24 hours advanced notice for cancellations of individual appointments, or the full fee of the appointment will be charged.
- If you are unable to attend a group session, you must call our office before the group begins, or the full group fee will be charged.

Fees

- All fees are due at the time of service.
- If payment is not current, we are under no obligation to deliver services.
- You will be charged for all missed sessions unless you give the proper advance notice.
- You will not receive a refund for missing a portion of any session, including Operation Breakthrough.

I attest that all of the information I have provided is truthful and complete. I understand that providing misinformation may make it necessary to redo the initial evaluation at my own expense.

I understand these expectations and, if enrolled into a program, I agree to this contract:

_____ _____

Client Signature **Date**

_____ _____

Parent or Guardian Signature **Date**

Assessment of Family

The counselors understand that family is often a private affair and is sometimes difficult to discuss. However, relationships with your significant others and families are an important factor in the success of your treatment. Substance abuse affects your relationships with family members and significant others. In addition, family issues often precede an individual's substance abuse problems and/or may become a barrier to recovery. Therefore you are asked to complete this questionnaire in order to assist us in determining your needs that they relate to family issues.

Check all that apply:

_____ My family is caring.
_____ My family argues often.
_____ My family is supportive.
How are they supportive? _____
_____
_____
_____ My family shows me affection.
_____ My family ignores me.
_____ My family is very critical.
_____ My family makes me proud.
_____ My family is strong.
_____ My family is weak.
_____ My family listens to my opinions.
_____ My family does not really know me.
_____ I have little/no contact with my child(ren).

I would like to make the following changes in the way my family relates to each other:
_____
_____

I understand that family involvement may be an integral part of my treatment at CAC. Family involvement may include, but not be limited to, family counseling, client education on family issues, and/or education groups for family members.

At this time, I am opting to:

_____ Involve my family and/or significant other in my treatment.
_____ **Not** involve my family and/or significant other in my treatment at this time, with the understanding that I can change my decision at a later time.

Client Signature:_____ Date:_____

CAC Staff Signature:_____ Date:_____

Infectious Disease Information

Tuberculosis Information – this is to provide with information; it is not asking you if you have TB

(TB) is a disease that is spread from person to person through the air, usually affecting the lungs. The germs (bacteria) can be put into the air when a person with TB coughs, sneezes, laughs, or talks. TB also affects other parts of the body, such as the brain, the kidney, or the spine.

A skin test can tell if you have TB infection. You can get a skin test from your doctor or local health department. A negative test usually means the person is not infected, but there is a chance that the test results can be a false-negative. The results may also be a false-negative if the person's immune system is not working properly. A positive result usually means that the person has been infected with the TB germ. It does not necessarily mean that the person as TB disease. Other tests, such as an x-ray or sputum sample, are needed to see if the person has TB disease.

Symptoms of TB may include:
Feeling weak or sick, weight loss, fever, and/or night sweats, cough, chest pain, and/or coughing up blood.

If you have TB infection or disease:

-Get required follow-up tests
-Follow your doctor's advice
-Take the prescribed medication

HIV Risk Assessment

Needle Usage

a. Intravenous drug use	( ) Yes	( ) No
b. Shared needles	( ) Yes	( ) No
c. Tattoos	( ) Yes	( ) No

Sexual History

a. Multiple sex partners (last 10 yrs)	( ) Yes	( ) No
b. A partner of the same sex	( ) Yes	( ) No
c. Unprotected sex (no condoms)	( ) Yes	( ) No
d. Sex with a known HIV+ person	( ) Yes	( ) No
e. Sex with a known drug-user	( ) Yes	( ) No
f. Victim of sexual assault	( ) Yes	( ) No

Other Risks

a. Blood transfusion in last 10 yrs	( ) Yes	( ) No
b. Diagnosed hemophiliac	( ) Yes	( ) No
c. Other known exposure to an HIV+ person	( ) Yes	( ) No

Explain: _____

Client Signature: _____ Date:_____

FOR COUNSELOR USE ONLY: _____ No Referral Needed _____Referral to HIV Program Given

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

	YES	NO
1. Do you feel that you are a normal drinker? (By normal we mean that you drink less or the same as most other people.)	_____	_____
2. Have you ever awakened the morning after drinking and found that you could not remember part of the previous evening?	_____	_____
3. Does a relative ever complain about or worry about your drinking?	_____	_____
4. Can you stop drinking after one or two drinks without a struggle?	_____	_____
5. Do you feel guilty about your drinking?	_____	_____
6. Do friends or relatives think you are a normal drinker?	_____	_____
7. Are you able to stop drinking when you want to?	_____	_____
8. Have you ever attended a meeting of Alcoholic Anonymous (AA)?	_____	_____
9. Have you gotten into physical fights while drinking?	_____	_____
10. Has your drinking ever created problems between you and your spouse, parents, or other relative?	_____	_____
11. Has any family member ever sought help regarding <u>your</u> drinking?	_____	_____
12. Have you ever lost friends because of your drinking?	_____	_____
13. Have you ever gotten into trouble at school or work because of drinking?	_____	_____
14. Have you ever lost a job because of drinking?	_____	_____
15. Have you ever neglected your obligations (such as family or work) for two or more days in a row because of your drinking?	_____	_____
16. Do you drink before noon fairly often?	_____	_____
17. Have you ever been told that you have liver trouble? Cirrhosis?	_____	_____
18. After heavy drinking, have you ever had Delirium Tremors (DTs), severe shaking, or hallucinations?	_____	_____
19. Have you ever gone to anyone for help about your drinking?	_____	_____
20. Have you ever been in a hospital because of your drinking?	_____	_____
21. Have you ever been in a psychiatric hospital as a result of drinking?	_____	_____
22. Have you ever been seen at a psychiatric or mental health clinic, or by a doctor, social worker, or clergyman for help with an emotional issue where drinking was part of the problem?	_____	_____
23. Have you ever been arrested for drunk or impaired driving? If YES, how many times?	_____	_____
24. Have you ever been arrested for any other alcohol or drug related offense?	_____	_____

Client Signature: _____ **Date:** _____

DAST – Thinking of the last 2 years, please answer the following questions

Can you get through the week without using drugs (other than medical reasons)?	YES	NO
Are you always able to stop using drugs when you want to?	YES	NO
Have you used drugs other than those required for medical reasons?	YES	NO
Have you abused prescription drugs?	YES	NO
Do you abuse more than one drug at a time?	YES	NO
Do you abuse drugs on a continuous basis?	YES	NO
Do you try to limit your drug use to certain situations?	YES	NO
Have you had “blackouts” or “flashbacks” as a result of drug use?	YES	NO
Do you ever feel bad about your drug abuse?	YES	NO
Does your spouse (or parents) ever complain about your involvement with drugs?	YES	NO
Do your friends or relatives know or suspect you abuse drugs?	YES	NO
Has drug abuse ever created problems between you and your spouse?	YES	NO
Has any family member ever sought help for problems related to your drug use?	YES	NO
Have you ever lost friends because of your use of drugs?	YES	NO
Have you ever neglected your family or missed work because of your use of drugs?	YES	NO
Have you ever been in trouble at work because of drug abuse?	YES	NO
Have you ever lost a job because of drug abuse?	YES	NO
Have you gotten into fights when under the influence of drugs?	YES	NO
Have you ever been arrested because of unusual behavior while under the influence of drugs?	YES	NO
Have you ever been arrested for driving while under the influence of drugs?	YES	NO
Have you engaged in illegal activities in order to obtain drug?	YES	NO
Have you ever been arrested for possession of illegal drugs?	YES	NO
Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	YES	NO
Have you had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, etc.)?	YES	NO
Have you ever gone to anyone for help for a drug problem?	YES	NO
Have you ever been in a hospital for medical problems related to your drug use?	YES	NO
Have you ever been in a treatment program specifically related to drug use?	YES	NO
Have you been treated as an outpatient for problems related to drug abuse?	YES	NO

Consent for the Release of Confidential Information

_____

(Your attorney, probation officer, physician, etc.)

☐ I authorize Columbia Addictions Center to release *any portion* of my client record to the person or organization I have written above; I further authorize Columbia Addictions Center to obtain information from the person or organization list above.

-OR-

☐ I authorize Columbia Addictions Center to release *only* the following information to the person or organization I have written above:

_____Initial Evaluation

_____Progress, Attendance and Discharge reports

_____Urinalysis or Breathalyzer results

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

This authorization will be valid for one year unless I otherwise specify

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

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