



CENTER FOR BEHAVIORIAL HEALTH, LLC  
COLUMBIA ADDICTIONS CENTER

5570 Sterrett Place, Suite 205, Columbia, MD 21044  
Tele: 410.730.1333 Fax: 410.730.1559 Email: cac@columbiaaddictions.com

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact (Name & Phone Number): \_\_\_\_\_

If under age 18, name of parent or guardian: \_\_\_\_\_

**Reason for Evaluation**

Citation Date: \_\_\_\_\_ Court Date: \_\_\_\_\_

Did you take a breathalyzer? Yes No If yes, what was your BAC? \_\_\_\_\_

Have you had any prior citations or arrests? Yes No

Date: \_\_\_\_\_ Charge: \_\_\_\_\_

Date: \_\_\_\_\_ Charge: \_\_\_\_\_

**Referral Source / How Did You Hear About Us?**

Name : \_\_\_\_\_

Relationship: \_\_\_ Lawyer \_\_\_ P.O. \_\_\_ Family Member \_\_\_ Friend \_\_\_ School \_\_\_

Therapist \_\_\_ Physician \_\_\_ Employer \_\_\_ Flyer \_\_\_ Other : \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## 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. Please explain: \_\_\_\_\_
- 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.

## Gambling Assessment

- |   | YES   | NO    |
|---|-------|-------|
| 1. <b>Loss of Control:</b> Have you ever tried to stop, cut down, or control your gambling?   | _____ | _____ |
| 2. <b>Lying:</b> Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling?  | _____ | _____ |
| 3. <b>Preoccupation:</b> Have there been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, or planning out future gambling ventures or bets? | _____ | _____ |

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CAC Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b><u>FOR COUNSELOR USE ONLY:</u></b> _____ No Referral Needed    _____ Referral Given to Gambling (call: 1-800-GAMBLER)
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## Michigan Alcoholism Screening Test (MAST)

	YES	NO
1. Do you feel that you are a normal drinker? (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 related offense? If YES, how many times?	_____	_____

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Drug Use Questionnaire / DAST**

*Thinking of this **PAST YEAR**, please answer the following questions.  
Do not include alcoholic beverages.*

1. Have you used drugs other than those required for medical reasons?	YES	NO
2. Have you abused prescription drugs?	YES	NO
3. Do you abuse more than one drug at a time?	YES	NO
4. Can you get through the week without using drugs (other than medical reasons)?	YES	NO
5. Are you always able to stop using drugs when you want to?	YES	NO
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	YES	NO
7. Do you ever feel bad or guilty about your drug abuse?	YES	NO
8. Does your spouse, partner or parents ever complain about your involvement with drugs?	YES	NO
9. Has drug abuse ever created problems between you and your spouse, partner or parents?	YES	NO
10. Have you ever lost friends because of your use of drugs?	YES	NO
11. Have you ever neglected your family or missed work because of your use of drugs?	YES	NO
12. Have you ever been in trouble at work or school because of drug abuse?	YES	NO
13. Have you ever lost a job because of drug abuse?	YES	NO
14. Have you gotten into fights when under the influence of drugs?	YES	NO
15. Have you engaged in illegal activities in order to obtain drugs?	YES	NO
16. Have you ever been arrested for possession of illegal drugs?	YES	NO
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
18. Have you had medical problems or been hospitalized as a result of your drug use (memory loss, hepatitis, convulsions, etc.)?	YES	NO
19. Have you ever gone to anyone for help for a drug problem?	YES	NO
20. Have you ever been in a treatment program specifically related to drug use or been in a hospital for medical	YES	NO

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## CLIENT CONSENT

**Your signature below indicates that you:**

- Have reviewed the Program Policies & Informed Consent (located in our office or by request, we can email you an electronic copy)
- Agree to abide by the terms outlined therein
- Acknowledge review of HIPAA, Client Grievance Procedure, and HIV/Infectious Disease Fact Sheet
- Consent to substance abuse or mental health treatment, and
- Attest all the information provided is truthful and complete; understanding that providing misinformation may make it necessary to redo the initial evaluation at my own expense.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
DATE

\*\* If you would like a physical copy, please print from our website [www.columbiaaddictions.com](http://www.columbiaaddictions.com) under Forms.

### Terms of treatment

**I understand that by signing, I agree to the following:**

- CAC expects weekly and on-time attendance from all clients enrolled in our treatment programs.
- There is a \$20 fee for all missed groups, which will be assessed to your account. There is no difference between a missed group and calling to cancel a group.
- You may make up a missed group by attending an open group. Please arrive 15 minutes prior to the start of group to be registered and processed.
- Punctuality: You must report on time to all groups and individual counseling sessions. We **do not** have a grace period, so plan accordingly. If you are late, you **will not** be permitted into group, and may need to reschedule your individual session.
- **All programs at CAC require abstinence from all non-prescribed drugs and alcohol.** We will ask for random urinalysis and breathalyzers during the course of your treatment, as indicated by your treatment plan. Each urinalysis has a \$40 fee that will be assessed to your account.
- You must complete a “Correspondence Needed” form every time you need a Progress or Completion letter. There is no charge unless you need it in less than 5 business days.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
DATE

# Consent for the Release of Confidential Information

NAME: \_\_\_\_\_

(Circle One: Spouse, Parent, Attorney, Probation Officer, Counselor, Physician, Other/Please State)

PLEASE ENTER ONLY ONE NAME ABOVE; A SEPARATE FORM MUST BE COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION TO BE RELEASED

## FULL RELEASE

I authorize Columbia Addictions Center to release information to, and to obtain information from, the person or organization I have written above.

-OR-

## LIMITED RELEASE

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

\_\_\_\_\_ Appointment Dates/Times

\_\_\_\_\_ Account Balance

\_\_\_\_\_ Initial Evaluation

\_\_\_\_\_ Progress, Attendance, Completion 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.