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: _____

Phone #: _____ Age: _____

Email address: _____

Emergency Contact (Name & Phone Number): _____

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

Reason for Evaluation

What is the primary purpose of your visit? _____

_____

Do you have another mental health or substance abuse provider at this time? _____

Name: _____ Phone #: _____

(please fill out the release of information in this packet so we may contact them)

Do you have any current substance related legal charges? _____

_____

Referral Source / How Did You Hear About Us?

Name :_____

Were you referred to a specific provider at CAC? _____

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. ***Loss of Control***: Have you ever tried to stop, cut down, or control your gambling?	_____	_____
2. *Lying:* Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling?	_____	_____
3. *Preoccupation:* 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:_____

FOR COUNSELOR USE ONLY: ____No Referral Needed _____ Referral Given to Gambling ***(call: 1-800-GAMBLER)***

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 and take the prescribed medication

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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:_____

CAC Staff Signature:_____ Date:_____

FOR COUNSELOR USE ONLY: _____ No Referral Needed _____Referral to HIV Program Given
(call Howard County Health Department at 410-313-7500)

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.
- Understand that you must report on time to all groups and individual counseling sessions. If you do not cancel your appointment within a 24 hour period, you may be charged for that appointment.

Client Name: _____

Client Signature: _____ ____/____/_____
DATE

** If you would like a physical copy of our policies and proceedures, please print from our website www.columbiaaddictions.com under Forms.

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

PHONE: _____

FAX: _____

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.