



CONSENT TO TREAT CONTRACT

- 1. I, _____, the undersigned, do hereby acknowledge that I have voluntarily consented to become a client of True North Recovery Inc and that this voluntary consent is true, regardless of the fact that I may be court ordered to the program.
- 2. I understand that all things spoken about in group are confidential and should not be shared with anyone outside of treatment. I will respect all participants confidentiality.
- 3. I am aware that True North Recovery Inc is a chemical dependency/mental health treatment program. The general outline, purpose, and methods of treatment offered by True North Recovery Inc have been explained to me and I am in agreement with these.
- 4. I further understand that part of my treatment at True North Recovery Inc may require me to submit urine samples for analysis of drug content. Further requirements may include psychological, psychiatric, or general health testing, disclosure, and monitoring of prescribed medications. I consent to undergo these procedures.
- 5. I acknowledge and understand that no promise or guarantees have been made to me regardless of the outcome of my treatment by True North Recovery Inc and do hereby absolve True North Recovery Inc from liability in the event my treatment is unsuccessful.
- 6. I hereby agree to comply with and abide by the policies, rules, and regulations of True North Recovery Inc in my treatment.
- 7. I have read each paragraph contained here and have had the opportunity to clarify questions I have regarding these. Accordingly, I acknowledge that I duly understand the provisions of the document and its legal consequences.

FEES FOR SERVICE:

- 1. I agree to pay the cost of my treatment. I will make arrangements with the Financial Office before starting my treatment program.
- 2. I acknowledge that all fees for services are due and payable at the time of service unless other arrangements have been made.

ATTENDANCE:

- 1. I agree to be on time for all scheduled groups and counseling sessions. I understand that if I am late I may not be admitted to the group session.
- 2. Subject to ongoing assessment and evaluation of my treatment progress, I may expect changes in the level and duration of services while I am enrolled. Further, I may expect these changes to be discussed by the treatment team and any modifications will be in the best interest of my treatment.
- 3. My attendance at other support groups such as Alcoholics Anonymous, Narcotics Anonymous, Adult Children of Alcoholics, etc. may be required of me as determined by the treatment team.

ABSTINENCE:

- 1. Abstinence from non-prescribed, mind/mood altering chemicals (including alcohol) is clearly the primary goal of this program, unless contraindicated by my assessed special needs. Therefore, I agree to maintain abstinence from these chemicals while in treatment. My failure to comply with this abstinence policy will result in an immediate re-evaluation of my treatment needs and may result in termination from this program.

I have read and agree to comply with the above contract for treatment.

Client Signature

Date

Counselor Signature

Date



Financial Responsibility Agreement

If you come in to sign up for a treatment program you must provide proof of your household gross income at your financial appointment. Your financial contract must be completed before you begin treatment.

Ultimately you, the client, are responsible for payment of all services.

- If you have **INSURANCE** please bring your insurance ID card, or insurance form with patient portion completed and signed. We will gladly bill your insurance. If your insurance does not cover any portion of your costs you will then become eligible for the sliding fee scale. You may want to call your insurance company or look in your policy to determine if your insurance covers the treatment you are about to begin.
- If you are covered by **MEDICAID OR DENALI KID CARE** please bring in your sticker, coupon, or card covering the current month. If Medicaid does not cover any portion of your costs you will then become eligible for the sliding fee scale. You will then become responsible for payment.

If you DO NOT have Insurance, Medicaid, or Denali Kid Care you must bring your most recent TAX RETURN, W-2, and 1099 (if applicable) And any of the following that apply:

- **LAST TWO CHECK STUBS (IF MARRIED SPOUSES ALSO)**
- **UNEMPLOYMENT**
- **WORKMANS COMPENSATION**
- **SOCIAL SECURITY INCOME**
- **RETIREMENT PENSION**
- **DISABILITY INCOME**
- **PUBLIC ASSISTANCE**
- **NATIVE CORPORATION DIVIDENDS**

If you do not provide adequate proof of income you will be charged at our customary full rate.

I acknowledge that I have received a copy of this form.

Client Name

Client Signature

Date

Guardian Signature

Date



CLIENT MEDICAL RELEASE/ EMERGENCY INFORMATION FORM

For Your Safety, the following information will be kept in a secure area, accessible only to staff members, while you are attending group.

All information must be current in case of emergency. Please complete the following:

I, _____, hereby give my consent to be given emergency medical treatment in the event of an accident, injury or illness.

I hereby release the True North Recovery Inc and its representatives from any liability rising from an emergency situation in which it is deemed necessary to pursue medical treatment.

In case of an emergency, True North Recovery Inc may contact:

1. _____
Name/Relationship Phone #

2. _____
Name/Relationship Phone #

Drug Allergies: _____

Medications: _____

Other medical conditions: _____

Insurance Information or Medicaid number: _____

By signing below I authorize disclosure of the above information to appropriate emergency personnel

Client Signature/Date

Guardian Signature/Date



Instructions: Please fill in the blanks/check the boxes for each question. Do not leave anything blank.
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION SUBSTANCE ABUSE PROGRAM, MEDICAID, FIRST HEALTH SERVICE CORPORATION, AND STATE OF ALASKA DHSS DIVISION OF BEHAVIORAL HEALTH

I, _____ authorize

True North Recovery Inc.
591 S Knik Goose Bay Rd
Wasilla, AK 99654
Phone (907) 313-1333 Fax (907) 357-8781

And

Medicaid

And

Optum Alaska
911 W. 8th Avenue, STE 101
Anchorage, AK 99501

And

State Of Alaska DHSS
Division Of Behavioral Health
PO Box 110607
Juneau, AK 99811-0607

To communicate with and disclose to one another via verbally, electronically, or in writing the following initialed information:

(initial each category that applies)

- ___ my name and other personal identifying information;
- ___ my status as a patient in alcohol and/or drug treatment;
- ___ initial evaluation;
- ___ date of admission;
- ___ assessment results and history;
- ___ summary of treatment plan, progress, and compliance;
- ___ attendance;
- ___ urinalysis results;
- ___ date of discharge and discharge status;
- ___ discharge plan;

Client Name:

DOB:

(Revised 01/2023

)



____ other: _____

The purpose of the disclosures authorized in this consent is to enable the agencies listed above to evaluate my claims for insurance coverage and reimbursement.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

The date on which my insurance claims for this course of alcohol or drug abuse treatment have been completely processed.

I understand that generally True North Recovery Inc. may not condition my treatment on whether I sign this consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: _____

Signature of Patient

Dated: _____

Signature of Parent or Guardian

Dated: _____

Signature of Program Representative



CLIENT NOTICE

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, True North Recovery Inc. (TNR) may not say to a person outside TNR that you attend the program, nor may TNR disclose any information identifying you as an alcohol or drug abuser or disclose any other protected information except as permitted by federal law.

True North Recovery Inc. must obtain your written consent before it can disclose information about you for payment purposes. For example, TNR must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before TNR can share information for treatment purposes or for health care operations. However, federal law permits TNR to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate;
2. For research, audit or evaluations;
3. To report a crime committed on TNR' premises or against TNR personnel;
4. To medical personnel in a medical emergency;
5. As allowed by an authorizing court order.
6. Physical or sexual abuse or neglect committed against a child or elderly person
7. Suicidal or homicidal threats or attempts
8. Internal Communications

For example, TNR can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before TNR can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

YOUR RIGHTS

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. TNR is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. TNR will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by TNR, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in TNR' records, and to request and receive an accounting of disclosures of your health-related information made by

Client Name:

DOB:

(Revised 01/2023

Page 6

)



TNR during the seven years prior to your request. You also have the right to receive a paper copy of this notice. TNR may deny a client request for amendment if it determines that the information or record:

- Was not created by an TNR employee
- Is not part of a designated record set
- Is accurate and complete

A client, whose request for amendment is denied, may pursue the next appropriate level of the client grievance procedure.

TNR' Duties

TNR is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. TNR is required by law to abide by the terms of this notice. TNR reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Any revisions to this policy will be distributed to you at your next scheduled session or appointment.

Complaints and Reporting Violations

You may complain to TNR and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You may file a complaint if you believe your privacy rights have been violated by completing a complaint form (available at the front desk) and following the steps of the Grievance Procedures. You will not be subject to retaliation for filing such a complaint.

A violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Contact

For further information, contact TNR by telephoning 9073131333.

Effective Date

7/2018

Acknowledgement

I hereby acknowledge that I received a copy of this notice.

Dated: _____

Patient Signature: _____

Dated: _____

Guardian Signature: _____



Intake Information

1. File Locate at (Where will client be admitted?): _____

2. Intake Staff: _____

3. Initial Contact: **Check one**

<input type="checkbox"/> Phone	<input type="checkbox"/> Community Service Patrol
<input type="checkbox"/> Drop In (Orientation)	<input type="checkbox"/> By appointment
<input type="checkbox"/> Hospital/On Call Intervention	<input type="checkbox"/> Mail or Fax
<input type="checkbox"/> Emergency Outreach Intervention	<input type="checkbox"/> Other

4. Where client currently lives (city): _____

5. Intake Date: _____

6. Source of Referral: _____

7. **Only required if FEMALE:** Pregnant : ___ yes ___ no ___ unknown

8. Injection Drug User (within the past 6 months): ___ yes ___ no

9. What do you consider your number one problem: ___ Alcohol & Drugs ___ Alcohol ___ Drugs **or**

(Specify from list below) _____

What do you consider to be your second problem: _____ **(specify from list below)**

What do you consider to be your third problem: _____ **(specify from list below)**

(Alcohol & Drugs Alcohol Only; Drugs Only; Suicide attempt/threat; Child abuse victim; Sexual abuse victim; Domestic violence victim; Eating disorder; Thought disorder; Depression; Social/interpersonal (not family); Coping with daily roles/activities; Marital; Family (non marital); Legal; Medical/somatic; Psychological/emotional; Financial; Poverty; Child abuse perpetrator; Sexual abuse perpetrator; DV perpetrator; None; Other; Unknown)

10. Presenting Problem(s) in your own words (Why are you seeking services?): _____

Special Initiative: check all that apply

<input type="checkbox"/> None	<input type="checkbox"/> Anchorage Felony Drug Court
<input type="checkbox"/> Anchorage Coordinated Resource Project	<input type="checkbox"/> Anchorage DUI Court
<input type="checkbox"/> Anchorage Family Dependency Court	<input type="checkbox"/> Fairbanks Juvenile Treatment Court
<input type="checkbox"/> Anchorage Municipal Wellness Court	<input type="checkbox"/> Fairbanks Wellness Court
<input type="checkbox"/> Anchorage Veteran’s Court	<input type="checkbox"/> Juneau Coordinated Resource Project
<input type="checkbox"/> APIC (Assess, Plan, Identify, & Coordinate)	<input type="checkbox"/> Juneau DUI Court
<input type="checkbox"/> Bethel Therapeutic Court	<input type="checkbox"/> Ketchikan Therapeutic Court
<input type="checkbox"/> BTKH – Parenting with Love and Limits	<input type="checkbox"/> Methadone
<input type="checkbox"/> BTKH – Transition to Independence Process	<input type="checkbox"/> Palmer Coordinated Resource Project
<input type="checkbox"/> CASII – Matrix	<input type="checkbox"/> Psychiatric Emergency Services
<input type="checkbox"/> CASII – PLL	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> CASII – TIP	<input type="checkbox"/> Therapeutic Courts
<input type="checkbox"/> Disasters	<input type="checkbox"/> Women w/Children

Client Name:

DOB:

(Revised 01/2023

Page 10



<input type="checkbox"/> DVSA – Victim Services	
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Collateral Contacts

1) First Name _____ Last Name _____ Relation _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Can we contact? Yes No Consent On File? Yes No

2) First Name _____ Last Name _____ Relation _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Can we contact? Yes No Consent On File? Yes No

Who referred you to our agency? (Specify Agency and Name of Person) _____

Why are you seeking services at our agency? _____

In your own words, what problem(s) would you like our agency to help you with?

Have you ever received services from our agency? Yes No If yes, when and what type of services did you receive?

Are you currently receiving mental health and/or substance abuse treatment services from any other agency? Yes No If yes, which agency and what type of services?

Client Name:

DOB:

(Revised 01/2023

)



Life Domains/Client Status

1. Date: ___ ___ / ___ ___ / ___ ___
2. Domains: ___ Substance Abuse ___ Mental Health (can select both)
3. Client Type: ___ Adult non-SMI no COD ___ Adult non-SMI with COD ___ Adult SMI no COD ___ Adult SMI with COD ___ Youth non-SED no COD ___ Youth non-SED with COD ___ Youth SED no COD ___ Youth SED with COD ___ Youth/Adult SUD no COD (COD = Co-occurring Disorders)
4. Medication Assisted TX: ___ Yes, or ___ No
5. # of Prior SA TX Episodes: _____
6. # Of Non-TX SA Related Hospitalizations in Past 6 Months: _____
7. # Of times the client has attended a self-help program in the 30 days preceding the date of admission to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence: **Check One**

<input type="checkbox"/> No attendance in the past month	<input type="checkbox"/> 16-30 times in past month
<input type="checkbox"/> 1-3 times in past month	<input type="checkbox"/> Some attendance in past month, but frequency unknown
<input type="checkbox"/> 4-7 times in past month	<input type="checkbox"/> Unknown
<input type="checkbox"/> 8-15 times in past month	<input type="checkbox"/> Not Collected

Life Domains/Education

<p><u>Education Status: Check one</u></p> <input type="checkbox"/> No Schooling <input type="checkbox"/> If K-11 how many years _____ <input type="checkbox"/> General Education Degree (GED) <input type="checkbox"/> High School Diploma (not GED) <input type="checkbox"/> Vocational Training beyond High School <input type="checkbox"/> Special Ed Ungraded Classes <input type="checkbox"/> Baccalaureate Degree (BA, BS) <input type="checkbox"/> Graduate work (no degree) <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate/Professional degree <input type="checkbox"/> Post-Secondary 1 yr <input type="checkbox"/> Post-Secondary 2 yrs. <input type="checkbox"/> Post-Secondary 3 yrs. <input type="checkbox"/> Post-Secondary 4+ yrs. (no degree) <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Collected	<p><u>School Attendance Status: Check one</u></p> <input type="checkbox"/> Unknown <input type="checkbox"/> Not Collected (SA Clients only) <input type="checkbox"/> Not applicable – MH client age less than 3 or greater than 17 (except for young adults 18-21 protected by IDEA) <input type="checkbox"/> Attending School <input type="checkbox"/> Not in School
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Life Domains/Financial/Household Information

<p>Employment Status: <u>Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Armed Forces <input type="checkbox"/> No Response <input type="checkbox"/> Not Collected <input type="checkbox"/> Not in Labor Force/Other <input type="checkbox"/> Not Seeking Work <input type="checkbox"/> Other <input type="checkbox"/> Resident/Inmate <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal Employee/in season <input type="checkbox"/> Seasonal Employee/out season <input type="checkbox"/> Student <input type="checkbox"/> Unemployed/Not seeking work <input type="checkbox"/> Unemployed/Subsistence <input type="checkbox"/> Unemployed/Looking for work <input type="checkbox"/> Unknown 	<p>Source of Income: <u>Check one</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Alaska Native Corp Dividends <input type="checkbox"/> Alimony <input type="checkbox"/> Alaska PFD <input type="checkbox"/> Child Support <input type="checkbox"/> Employment <input type="checkbox"/> Interest and Other <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Public Assistance/Welfare Pay <input type="checkbox"/> Parent's Income <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Retirement, Survivor, Disability Pension <input type="checkbox"/> Social Security Disability (SSDI) <input type="checkbox"/> Self-Employment <input type="checkbox"/> Supplemental Security Ins (SSI) <input type="checkbox"/> SSI/SSDI Never <input type="checkbox"/> SSI/SSDI Previous <input type="checkbox"/> Spouse's or Significant Other's Income <input type="checkbox"/> Social Security <input type="checkbox"/> Tribal Assistance Programs <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Unknown <input type="checkbox"/> Not Collected 	<p>Health Insurance Type: <u>Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Commercial <input type="checkbox"/> Group Policy <input type="checkbox"/> Health Maint. Org. (HMO) <input type="checkbox"/> Individual Policy <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Long Term Policy <input type="checkbox"/> Litigation <input type="checkbox"/> Medicare Primary <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Medigap Part B <input type="checkbox"/> None <input type="checkbox"/> Other Public Insurance <input type="checkbox"/> Other Private Insurance <input type="checkbox"/> Other <input type="checkbox"/> Personal payment (cash- no ins) <input type="checkbox"/> Supplemental Policy <input type="checkbox"/> VA insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Not Collected
<p>Primary Payment Source: <u>Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Aetna <input type="checkbox"/> AK Native Health Care <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> CIGNA <input type="checkbox"/> Client Self Pay <input type="checkbox"/> HMO <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> No Charge <input type="checkbox"/> Not Collected <input type="checkbox"/> Other Government Grant <input type="checkbox"/> Other Native Health Care <input type="checkbox"/> Other Private <input type="checkbox"/> Other Public <input type="checkbox"/> Sliding Scale; client partial payment <input type="checkbox"/> Sliding Scale, No Charge <input type="checkbox"/> Unknown 	<p>Annual Household Income:</p> <p><i>Approximate or exact numeric amount, and include Alaska PFDs if applicable</i></p> <p>_____</p> <p>Occupation (O-Net): <u>Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Accommodation & Food Services <input type="checkbox"/> Administrative & support Services <input type="checkbox"/> Agriculture, Forestry, Fishing, & Hunting <input type="checkbox"/> Arts, Entertainment, & Recreation <input type="checkbox"/> Construction <input type="checkbox"/> Educational Services <input type="checkbox"/> Finance & Insurance <input type="checkbox"/> Government <input type="checkbox"/> Health Care & Social Assistance <input type="checkbox"/> Information 	<p>Occupation (O-Net) Continued: <u>Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Management of Companies & Enterprises <input type="checkbox"/> Manufacturing <input type="checkbox"/> Mining, Quarrying, Oil & Gas Extraction <input type="checkbox"/> Other Services (Except Public Admin.) <input type="checkbox"/> Professional, Scientific, & Technical Svcs. <input type="checkbox"/> Real Estate & Rental & Leasing <input type="checkbox"/> Retail Trade <input type="checkbox"/> Self-Employed <input type="checkbox"/> Transportation & Warehousing <input type="checkbox"/> Utilities <input type="checkbox"/> Wholesale Trade <input type="checkbox"/> None <p>Not Applicable</p>

Client Name:

DOB:

(Revised 01/2023

)



Life Domains/Financial/Household Information (Continued)

Living Situation: Check One

- Assisted Living Facility
- Correction/Detention Facility
- Crisis Residence
- Foster Care
- Group Home
- Halfway House
- Homeless
- Hospital for Non-psychiatric purposes
- Hospital for psychiatric purposes
- Nursing home
- Private Residence w/o supportive services
- Private Residence with supportive services
- Residential Treatment
- Shelter
- Therapeutic Foster Care
- Transitional Housing
- No Response
- Other
- Unknown

Marital Status: Check one

- Never Married-single
- Married
- Cohabiting
- Separated
- Divorced
- Widowed
- No Response
- Not Collected
- Unknown

Living in Home: Answer all

Number of people living with client: # ____

Number of children in household: # ____

Number of children in Residential Setting: # ____

Number of children in Residential Setting receiving services: # ____

of Children Living with Client: _____

List all Medications:

Name:

Dosage:

Frequency:

List all Allergies:



Life Domains/Substance Abuse Information

When you can have anything you want what is your first drug of choice:

- Alcohol
- Barbiturates
- Benzodiazepines
- Cannabis
- Cocaine/Crack
- Designer Drugs
- Heroin
- Inhalants
- Marijuana/Hashish
- Methamphetamines
- Nicotine
- Non-beverage alcohol
- Non-prescription methadone
- Other Amphetamines
- Other Hallucinogens
- Other Opiates/Hypnotics
- Other Tranquillizers
- Other Stimulants
- Over the Counter Meds
- Oxycodone
- OxyContin
- PCP
- Steroids

Frequency of Use:

- More than 3 times daily
- 2-3 times daily
- Daily
- 3-6 times per week

Method of Use:

- Inhalation
- IV injection
- Nasal
- Non-IV Injection
- Oral
- Smoking
- N/A
- Unknown

Think about your first drug of choice:

- 1) Age of FIRST use? # _____
- 2) Number of days since LAST use? # _____

Severity of Use:

- Use
- Abuse
- Dependence
- Not Applicable

When you can have anything you want what is your second drug of choice:

- Alcohol
- Barbiturates
- Benzodiazepines
- Cannabis
- Cocaine/Crack
- Designer Drugs
- Heroin
- Inhalants
- Marijuana/Hashish
- Methamphetamines

Frequency of Use:

- More than 3 times daily
- 2-3 times daily
- Daily
- 3-6 times per week

Method of Use:

- Inhalation
- IV injection
- Nasal
- Non-IV Injection
- Oral
- Smoking
- N/A
- Unknown



<input type="checkbox"/> Nicotine <input type="checkbox"/> Non-beverage alcohol <input type="checkbox"/> Non-prescription methadone <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Other Opiates/Hypnotics <input type="checkbox"/> Other Tranquilizers <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Over the Counter Meds <input type="checkbox"/> Oxycodone <input type="checkbox"/> OxyContin <input type="checkbox"/> PCP <input type="checkbox"/> Steroids	<p><u>Think about your second drug of choice:</u></p> <p>1) Age of FIRST use? # _____</p> <p>2) Number of days since LAST use? # _____</p> <p><u>Severity of Use:</u></p> <input type="checkbox"/> Use <input type="checkbox"/> Abuse <input type="checkbox"/> Dependence <input type="checkbox"/> Not Applicable								
<p><u>When you can have anything you want what is your third drug of choice:</u></p> <input type="checkbox"/> Alcohol <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Cannabis <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Designer Drugs <input type="checkbox"/> Heroin <input type="checkbox"/> Inhalants <input type="checkbox"/> Marijuana/Hashish <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Nicotine <input type="checkbox"/> Non-beverage alcohol <input type="checkbox"/> Non-prescription methadone <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Hallucinogens <input type="checkbox"/> Other Opiates/Hypnotics <input type="checkbox"/> Other Tranquilizers <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Over the Counter Meds <input type="checkbox"/> Oxycodone <input type="checkbox"/> OxyContin <input type="checkbox"/> PCP <input type="checkbox"/> Steroids	<p><u>Frequency of Use:</u></p> <input type="checkbox"/> More than 3 times daily <input type="checkbox"/> 2-3 times daily <input type="checkbox"/> Daily <input type="checkbox"/> 3-6 times per week <hr/> <p><u>Method of Use:</u></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Inhalation</td> <td><input type="checkbox"/> Oral</td> </tr> <tr> <td><input type="checkbox"/> IV injection</td> <td><input type="checkbox"/> Smoking</td> </tr> <tr> <td><input type="checkbox"/> Nasal</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td><input type="checkbox"/> Non-IV Injection</td> <td><input type="checkbox"/> Unknown</td> </tr> </table> <hr/> <p><u>Think about your third drug of choice:</u></p> <p>1) Age of FIRST use? # _____</p> <p>2) Number of days since LAST use? # _____</p> <p><u>Severity of Use:</u></p> <input type="checkbox"/> Use <input type="checkbox"/> Abuse <input type="checkbox"/> Dependence <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Oral	<input type="checkbox"/> IV injection	<input type="checkbox"/> Smoking	<input type="checkbox"/> Nasal	<input type="checkbox"/> N/A	<input type="checkbox"/> Non-IV Injection	<input type="checkbox"/> Unknown
<input type="checkbox"/> Inhalation	<input type="checkbox"/> Oral								
<input type="checkbox"/> IV injection	<input type="checkbox"/> Smoking								
<input type="checkbox"/> Nasal	<input type="checkbox"/> N/A								
<input type="checkbox"/> Non-IV Injection	<input type="checkbox"/> Unknown								

of Days Abstinent in the last 30 days(no use of alcohol, Marijuana, or illegal drugs) _____

Current Use of Tobacco: Check one

___ Cigarettes ___ Cigars/Pipes ___ Combination ___ Smokeless Tobacco ___ Not Applicable/None

Life Domains/Legal Status

Number of Arrests in **past 30** days: # _____

Legal Status at time of Admission:



<input type="checkbox"/> Court ordered for alcohol treatment	<input type="checkbox"/> Deferred Prosecution
<input type="checkbox"/> Court ordered for mental health treatment	<input type="checkbox"/> Deferred Sentence
<input type="checkbox"/> Court order for observation and evaluation	<input type="checkbox"/> Community Sentencing
<input type="checkbox"/> Court ordered juveniles; DJJ custody	<input type="checkbox"/> Emergency Commitment
<input type="checkbox"/> Court ordered juveniles; parents retain custody	<input type="checkbox"/> Title 12 – Not guilty by reason of insanity
<input type="checkbox"/> Furlough/Rehabilitative Leave	<input type="checkbox"/> Case pending
<input type="checkbox"/> Incarcerated	<input type="checkbox"/> 30-day commitment
<input type="checkbox"/> Probation/Parole	<input type="checkbox"/> 90-day commitment
<input type="checkbox"/> Informal Probation	<input type="checkbox"/> 180-day commitment
<input type="checkbox"/> Protective Custody	<input type="checkbox"/> None/no involvement
<input type="checkbox"/> Office of Children’s Services Custody	<input type="checkbox"/> Not Applicable

Anything else you would like to add at this time: _____
