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.

ATTENDENCE:

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

AUDIO – VIDEO/ AMBIENT LISTENING DISCLOSURE

This notice serves as disclosure of video and audio surveillance to clients at any True North Recovery location.

Purpose:

To disclose the nature of audio and video recording, as well as ambient listening throughout all True North Recovery Inc. properties and locations.

Policy:

True North Recovery Inc. has cameras installed throughout each of our locations as well as in staff vehicles. When you enter a True North Recovery location you are entering an area where audio and video recording may occur. Surveillance devices include security systems with audio recordings that capture conversations and activities on any prospective properties. Dylan's Place (Withdrawal Management) includes cameras within the bedrooms for added safety measures at this location. We do this with safety and quality of care in mind for our staff and clients.

Additionally, True North Recovery uses Blueprint AI Inc. to support service delivery through ambient listening. Ambient listening utilizes technology for note dictation to automate comprehensive progress notes and treatment plans. If this poses a barrier to your treatment, please inform an administrative staff so that we may explore possible accommodations.

Recordings utilized for these purposes are securely maintained but are not considered part of your medical record. They are destroyed on a regular basis and not stored long-term.

Your signature acknowledges that you are aware of this notice.

Client Name	Signature	Date

Employee Name	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;
____ 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 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: _____

Client Profile

1. Name (First and Last)_____ Today's Date:_____
2. Client Gender Female Male
   If female, maiden name required _____
3. Current Address: Street, Apartment _____
   City, State, Zip _____
4. Permanent Address: Street, Apartment _____
   City, State, Zip _____
5. Phone Number(s) _____
6. Email Address _____
7. What is your preferred form of Contact _____
8. Date of Birth (mm/dd/yyyy) _____
9. Where were you born? (COO) _____
10. Social Security Number __ __ __ -- __ __ -- __ __ __ __
11. Medicaid ID Number __ __ __ __ __ __ __ __ __ __
12. Religious Preference _____

Withdrawal Management Services

13. Are you interested in Withdrawal Management Services: Yes No
    If no, please skip 14-16 and continue with the demographics section
14. What substances are you currently using? _____
15. When was your last use? _____
16. How much are you using and how are you using? _____

Demographics

Ethnicity: ***Check one***
- ❒ Not Spanish/Hispanic/Latino
- ❒ Chicano
- ❒ Cuban
- ❒ Hispanic-not otherwise specified
- ❒ Mexican American
- ❒ Puerto Rican
- ❒ Spanish/Hispanic/Latino
- ❒ Not Collected
- ❒ Unknown

Race(s): ***Check all that apply***
- ❒ Aleut
- ❒ American Indian
- ❒ Asian
- ❒ Athabascan (Other than American Indian)
- ❒ Black/African American
- ❒ Caucasian
- ❒ Haida
- ❒ Inupiat
- ❒ Native Hawaiian
- ❒ Other
- ❒ Other Alaska Native
- ❒ Pacific Islander
- ❒ Refused
- ❒ Tlingit
- ❒ Tsimshian
- ❒ Yupik
- ❒ Not Collected
- ❒ Unknown

Veteran Status: ***Check one***
- ❒ Never in Military
- ❒ Vietnam Vet; combat
- ❒ Vietnam Vet; no combat
- ❒ Gulf War Vet; combat
- ❒ Iraq War Vet; combat
- ❒ Afghan War Vet; combat
- ❒ Active duty combat
- ❒ Active duty no combat
- ❒ Reserves/Nat. Guard; combat
- ❒ Reserves; no combat
- ❒ Retired from Military; combat
- ❒ Retired Military; non-combat
- ❒ Veteran other eras
- ❒ Military Dependent
- ❒ Not Applicable
- ❒ Not Collected
- ❒ Unknown

Sexual Orientation:
- ❒ asexual
- ❒ bisexual
- ❒ heterosexual
- ❒ homosexual

English Fluency:
- ❒ Excellent
- ❒ Good
- ❒ Moderate
- ❒ Poor
- ❒ Not At All

Interpreter needed? _____

Current U.S. Citizen?
- ❒ yes
- ❒ no

Dual Citizenship?
- ❒ yes
- ❒ no

If yes, where? _____

Special Needs:
- ❒ Acquired Brain Injury
- ❒ Autism
- ❒ Developmentally Disabled
- ❒ Fetal Alcohol Spectrum Disorder
- ❒ Major Difficulty in ambulating or nonambulation
- ❒ Moderate to severe medical problems
- ❒ New Immigrant
- ❒ Organically Based Problem
- ❒ Severe Hearing Loss or Deaf
- ❒ Traumatic Brain Injury
- ❒ Visual Impairment or Blind
- ❒ Alcoholism
- ❒ Drug Abuse
- ❒ Mental Health Issues
- ❒ HIV/AIDS
- ❒ Other
- ❒ Sex Offender Registry
- ❒ SO Priority Population
- ❒ Unknown

General Client Comments:

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Intake Information

1. File Locate at (Where will client be admitted?):_____
2. Intake Staff: _____
3. Initial Contact: ***Check one***

❒ Phone	❒ Community Service Patrol
❒ Drop In (Orientation)	❒ By appointment
❒ Hospital/On Call Intervention	❒ Mail or Fax
❒ Emergency Outreach Intervention	❒ 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***

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

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?

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***

❒ No attendance in the past month	❒ 16-30 times in past month
❒ 1-3 times in past month	❒ Some attendance in past month, but frequency unknown
❒ 4-7 times in past month	❒ Unknown
❒ 8-15 times in past month	❒ Not Collected

Life Domains/Education

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

Life Domains/Financial/Household Information

Employment Status: ***Check One***

- ❒ Disabled
- ❒ Employed Full Time
- ❒ Employed Part Time
- ❒ Homemaker
- ❒ Armed Forces
- ❒ No Response
- ❒ Not Collected
- ❒ Not in Labor Force/Other
- ❒ Not Seeking Work
- ❒ Other
- ❒ Resident/Inmate
- ❒ Retired
- ❒ Seasonal Employee/in season
- ❒ Seasonal Employee/out season
- ❒ Student
- ❒ Unemployed/Not seeking work
- ❒ Unemployed/Subsistence
- ❒ Unemployed/Looking for work
- ❒ Unknown

Source of Income: ***Check one***

- ❒ Alaska Native Corp Dividends
- ❒ Alimony
- ❒ Alaska PFD
- ❒ Child Support
- ❒ Employment
- ❒ Interest and Other
- ❒ None
- ❒ Other
- ❒ Public Assistance/Welfare Pay
- ❒ Parent's Income
- ❒ Railroad Retirement
- ❒ Retirement, Survivor, Disability Pension
- ❒ Social Security Disability (SSDI)
- ❒ Self-Employment
- ❒ Supplemental Security Ins (SSI)
- ❒ SSI/SSDI Never
- ❒ SSI/SSDI Previous
- ❒ Spouse's or Significant Other's Income
- ❒ Social Security
- ❒ Tribal Assistance Programs
- ❒ Unemployment Compensation
- ❒ Unknown
- ❒ Not Collected

Health Insurance Type: ***Check One***

- ❒ Commercial
- ❒ Group Policy
- ❒ Health Maint. Org. (HMO)
- ❒ Individual Policy
- ❒ Indian Health Service
- ❒ Long Term Policy
- ❒ Litigation
- ❒ Medicare Primary
- ❒ Medicare Part B
- ❒ Medicaid
- ❒ Medigap Part B
- ❒ None
- ❒ Other Public Insurance
- ❒ Other Private Insurance
- ❒ Other
- ❒ Personal payment (cash- no ins)
- ❒ Supplemental Policy
- ❒ VA insurance
- ❒ Unknown
- ❒ Not Collected

Primary Payment Source: ***Check One***

- ❒ Aetna
- ❒ AK Native Health Care
- ❒ Blue Cross/Blue Shield
- ❒ CIGNA
- ❒ Client Self Pay
- ❒ HMO
- ❒ Indian Health Services
- ❒ Medicaid
- ❒ Medicare
- ❒ No Charge
- ❒ Not Collected
- ❒ Other Government Grant
- ❒ Other Native Health Care
- ❒ Other Private
- ❒ Other Public
- ❒ Sliding Scale; client partial payment
- ❒ Sliding Scale, No Charge
- ❒ Unknown

Annual Household Income:

Approximate or exact numeric amount, and include Alaska PFDs if applicable

_____

Occupation (O-Net): **Check One**

- ❒ Accommodation & Food Services
- ❒ Administrative & support Services
- ❒ Agriculture, Forestry, Fishing, & Hunting
- ❒ Arts, Entertainment, & Recreation
- ❒ Construction
- ❒ Educational Services
- ❒ Finance & Insurance
- ❒ Government
- ❒ Health Care & Social Assistance
- ❒ Information

Occupation (O-Net) Continued: **Check One**

- ❒ Management of Companies & Enterprises
- ❒ Manufacturing
- ❒ Mining, Quarrying, Oil & Gas Extraction
- ❒ Other Services (Except Public Admin.)
- ❒ Professional, Scientific, & Technical Svcs.
- ❒ Real Estate & Rental & Leasing
- ❒ Retail Trade
- ❒ Self-Employed
- ❒ Transportation & Warehousing
- ❒ Utilities
- ❒ Wholesale Trade
- ❒ None

Not Applicable

Life Domains/Financial/Household Information (Continued)

Living Situation: Check One	Marital Status: Check one	Living in Home: **Answer all**
❒ 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	❒ Never Married-single ❒ Married ❒ Cohabitating ❒ Separated ❒ Divorced ❒ Widowed ❒ No Response ❒ Not Collected ❒ Unknown	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 Tranquilizers
- ❒ 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
- ❒ Nicotine
- ❒ Non-beverage alcohol
- ❒ Non-prescription methadone
- ❒ Other Amphetamines
- ❒ Other Hallucinogens
- ❒ Other Opiates/Hypnotics
- ❒ Other Tranquilizers
- ❒ 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 second 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 third 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 Tranquilizers
- ❒ 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 third drug of choice:

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

Severity of Use:

❒ Use
❒ Abuse
❒ Dependence
❒ Not Applicable

# 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: (one highlighted option below must be selected)

- ❒ Incarcerated in the past 90 days
- ❒ Probation/Parole
- ❒ None/no involvement

Other Legal Status at time of Admission

❒ Court ordered for alcohol treatment	❒ Deferred Prosecution
❒ Court ordered for mental health treatment	❒ Deferred Sentence
❒ Court order for observation and evaluation	❒ Community Sentencing
❒ Court ordered juveniles; DJJ custody	❒ Emergency Commitment
❒ Court ordered juveniles; parents retain custody	❒ Title 12 – Not guilty by reason of insanity
❒ Furlough/Rehabilitative Leave	❒ Case pending
❒ Incarcerated	❒ 30-day commitment
❒ Informal Probation	❒ 90-day commitment
❒ Protective Custody	❒ 180-day commitment
❒ Office of Children's Services Custody	❒ Not Applicable

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

_____

_____

_____