Instructions: Please fill in the blanks/check the boxes for each question. Do not leave anything blank.

## 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. Date of Birth (mm/dd/yyyy) _____________________________________________________
7. Social Security Number __ __ __ -- __ __ -- __ __ __ __
8. **Provider Client ID (Chart #)** ***Office Use*** _____________________________________________________
9. **Behavioral Health Provider** ***Office Use*** _____________________________________________________

## Demographics

| Race(s): ***Check all that apply*** | Alaska Native: | Ethnicity: ***Check one*** |
|---|---|---|
| ❒ American Indian<br>❒ Asian<br>❒ Black/African American<br>❒ Caucasian<br>❒ Native Hawaiian<br>❒ Pacific Islander<br>❒ Other | ❒ Aleut<br>❒ Athabascan<br>❒ Haida<br>❒ Inupiat<br>❒ Tlingit<br>❒ Tsimshian<br>❒ Yupik<br>❒ Other Alaska Native | ❒ Not Spanish/Hispanic/Latino<br>❒ Chicano/Other Hispanic<br>❒ Cuban<br>❒ Hispanic<br>❒ Mexican American<br>❒ Puerto Rican<br>❒ Spanish/Hispanic Latino |
| Special Needs: ***Check all that apply*** | Education: ***Check one response*** | English Fluency: ***Check one*** |
| ❒ None<br>❒ No Response<br>❒ FASD<br>❒ Autism<br>❒ Dev Disabled<br>❒ Major Difficulty in Ambulating or Nonambulation<br>❒ Moderate to Severe Medical Problems<br>❒ Severe Hearing Loss or Deaf<br>❒ Traumatic Brain Injury<br>❒ Visual Impairment or Blind<br>❒ Organically Based Problem<br>❒ Other | ❒ If K-11, how many years _______<br>❒ GED<br>❒ High School Diploma<br>❒ Vocational Training<br>❒ Special Ed Classes<br>❒ Baccalaureate degree (BA/BS)<br>❒ Graduate work (no degree)<br>❒ Master's degree<br>❒ Doctorate degree<br>❒ Post Secondary 1 yr<br>❒ Post Secondary 2 yrs<br>❒ Post Secondary 3 yr<br>❒ Post Secondary 4+ yrs (no degree)<br>❒ None<br>❒ Other | ❒ Excellent<br>❒ Good<br>❒ Moderate<br>❒ Poor<br>❒ Not at all<br><br>Veteran Status: ***Check one***<br><br>❒ Never in Military<br>❒ Reserves/Nat. Guard- combat<br>❒ Reserves/N.G.- no combat<br>❒ Military Dependent<br>❒ Active duty combat<br>❒ Active duty no combat<br>❒ Retired from military, non-comb<br>❒ Retired from military, combat<br>❒ Veteran other eras ______________<br>❒ Vietnam vet combat<br>❒ Vietnam vet no combat |

## Intake Information

1. Initial Contact: *Check one*

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

2. Village (where client currently lives): _______________________________________________

3. Source of Referral: ___________________________________________________________

4. *Only required if FEMALE*: Pregnant :___ yes ___no ___unknown If yes, due date: __ __/ __ __/ __ __

5. Injection Drug User (within the past 6 months): ___ yes ___no

6. 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)*

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

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

8. Special Initiative: ***Staff will complete this section - 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 | |

## Admission

1. Admission Type: ___First Admission ___Re-admission have you ever been a client here before?
2. # of Prior Substance Abuse ( SA) Treatment (TX) Admissions in the past: #______
3. # of Non-Treatment (TX) Substance Abuse (SA) Related Hospitalizations in Past 6 Months has there been other admissions to the hospital: #_______
4. # of Prior Mental Health (MH) Treatment (TX) Admissions: #_______
5. # of Prior Mental Health (MH) Hospitalizations: #_______
6. Your Health Status: ___ Poor ___ Fair ___Good ___Very Good ___Excellent
7. Mental Health problem: ___Yes or ___No
8. Opioid Replacement Therapy (Medication for Opioid Addiction): ___ Yes or ___No
9. On Psychotropic Medication: ___Yes or ___No
10. # of Times You Have Participated in a Self-help Group in the Last 30 Days: ____________________

## Financial/Household Information

| Employment Status: ***Check One*** | Primary Income Source: ***Check one*** | Expected Payment Source: ***Check One*** |
|---|---|---|
| ❒ Disabled | ❒ None | ❒ Indian Health Services |
| ❒ Employed Full Time | ❒ Tribal Assistance Program | ❒ AK Native Health Care |
| ❒ Employed Part Time | ❒ Alaska Native Corp Dividends | ❒ Aetna |
| ❒ Homemaker | ❒ Alimony | ❒ Blue Cross/Blue Shield |
| ❒ Armed Forces | ❒ Alaska PFD | ❒ CIGNA |
| ❒ Resident/Inmate | ❒ Child Support | ❒ United Health Care |
| ❒ Retired | ❒ Employment | ❒ Cigna Health Care |
| ❒ Seasonal Employee/in season | ❒ Interest and Other | ❒ Client Self Pay |
| ❒ Seasonal Employee/out of season | ❒ Public Assistance/Welfare | ❒ Other Private |
| ❒ Student | ❒ Parent's Income | ❒ Other Public |
| ❒ Unemployed/Not seeking work | ❒ Retirement/Survivor/Disability Pension | ❒ Other Govt Grant |
| ❒ Unemployed/Subsistence | ❒ Social Security Disability | ❒ Sliding Scale, Client Partial Pmt |
| ❒ Unemployed/Looking for work | ❒ Self-Employment | ❒ Sliding Scale, No Charge |
| ❒ Not in Labor Force/Other | ❒ Spouse/Significant Income | ❒ No Charge |
| ❒ Other __________ | ❒ Social Security | ❒ Other |
| | ❒ SSI | |
| | ❒ Unemployment Compensation | |
| | ❒ Other __________________ | |

11. What type of insurance do you have?: ________________________________________

Annual Household Income:

$______________________________

Occupation: ***Check One***

- ❒ Accommodation & food services
- ❒ Administrative & support services
- ❒ Agric, forestry, fishing, hunting
- ❒ Arts, entertainment, recreation
- ❒ Utilities
- ❒ Wholesale Trade
- ❒ Construction
- ❒ Education Services
- ❒ Finance & Insurance
- ❒ Government
- ❒ Health Care/Social Assistance
- ❒ Information Management
- ❒ Manufacturing
- ❒ Mining, Quarry, Oil & Gas
- ❒ Other Services
- ❒ Professional/Managerial
- ❒ Real Estate
- ❒ Retail Trade
- ❒ Self-Employed
- ❒ Transportation & Warehousing
- ❒ None
- ❒ Not Applicable

Household Composition: ***Check One***

- ❒ Lives alone
- ❒ Lives with adolescents
- ❒ Lives with children
- ❒ Lives with non-relatives
- ❒ Lives with relatives
- ❒ Lives with significant other
- ❒ Lives w/significant other & children
- ❒ Other ________

Living Arrangement: C***heck One***

- ❒ Homeless
- ❒ Correction/Detention Facility
- ❒ Crisis Residence
- ❒ Halfway House
- ❒ Hospital for Non-psychiatric purposes
- ❒ Hospital for psychiatric purposes
- ❒ Shelter
- ❒ Residential Treatment
- ❒ Private Residence w/out supportive services
- ❒ Private residence w/supportive services
- ❒ Nursing home
- ❒ Other __________
- ❒ Assisted Living Facility
- ❒ Foster Care
- ❒ Therapeutic Foster Care
- ❒ Group Home
- ❒ Homeless
- ❒ Transitional Housing

Marital Status: ***Check one***

- ❒ Cohabitating
- ❒ Divorced
- ❒ Married
- ❒ Never Married-single
- ❒ Separated
- ❒ Widowed

Living in Home/Residence: ***Answer all***

Number of people living with client: #____

Number of children in household: #____

If living in Residential facility:

Number of children in Residential Setting: #____

Number of children in Residential Setting receiving services: #____

(Residential setting is a Residential Substance Use Treatment Facility)

***Youth Only***: Days absent from school in the last 30 days _____

## 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

Severity of Use:

- ❐ Use
- ❐ Abuse
- ❐ Dependence
- ❐ Not Applicable
- ❐ Unknown

Frequency of Use:

- ❐ More than 3 times daily
- ❐ 2-3 times daily
- ❐ Daily
- ❐ 3-6 times per week
- ❐ 1-2 times per week
- ❐ 1-3 times per month
- ❐ Sporadic
- ❐ No use in past month

Method of Use:

- ❐ Inhalation
- ❐ IV injection
- ❐ Nasal
- ❐ Non-IV Injection
- ❐ Oral
- ❐ Smoking
- ❐ Other

Think about your first drug of choice:

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

**When you can't get your first choice of drug what is your second 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 *(Continued Below)*
- ❐ Other Stimulants
- ❐ Over the Counter Meds
- ❐ Oxycodone
- ❐ OxyContin
- ❐ PCP
- ❐ Steroids

Severity of Use:

- ❐ Use
- ❐ Abuse
- ❐ Dependence
- ❐ Not Applicable
- ❐ Unknown

Frequency of Use:

- ❐ More than 3 times daily
- ❐ 2-3 times daily
- ❐ Daily
- ❐ 3-6 times per week
- ❐ 1-2 times per week
- ❐ 1-3 times per month
- ❐ Sporadic
- ❐ No use in past month

Method of Use:

- ❐ Inhalation
- ❐ IV injection
- ❐ Nasal
- ❐ Non-IV Injection

Think about your first drug of choice:

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

| **When you can't get your first or second drug of choice what is your third choice:** | Severity of Use: |
|---|---|
| ❒ Alcohol<br>❒ Barbiturates<br>❒ Benzodiazepines<br>❒ Cannabis<br>❒ Cocaine/Crack<br>❒ Designer Drugs<br>❒ Heroin<br>❒ Inhalants<br>❒ Marijuana/Hashish<br>❒ Methamphetamines<br>❒ Nicotine<br>❒ Non-beverage alcohol<br>❒ Non-prescription methadone<br>❒ Other Amphetamines<br>❒ Other Hallucinogens<br>❒ Other Opiates/Hypnotics<br>❒ Other Tranquilizers<br>❒ Other Stimulants<br>❒ Over the Counter Meds<br>❒ Oxycodone<br>❒ OxyContin<br>❒ PCP<br>❒ Steroids | ❒ Use<br>❒ Abuse<br>❒ Dependence<br>❒ Not Applicable<br>❒ Unknown<br><br>Frequency of Use:<br>❒ More than 3 times daily<br>❒ 2-3 times daily<br>❒ Daily<br>❒ 3-6 times per week<br>❒ 1-2 times per week<br>❒ 1-3 times per month<br>❒ Sporadic<br>❒ No use in past month<br><br>Method of Use:<br>❒ Inhalation<br>❒ IV injection<br>❒ Nasal<br>❒ Non-IV Injection<br>❒ Oral<br>❒ Smoking<br>❒ Other<br><br>Think about your third drug of choice:<br>1) Age of FIRST use? #________<br>2) Number of days since LAST use? #________ |

# of Days Abstinent in the last 30 days _____________

**Current Use of Tobacco: *Check one***

____ Cigarettes ___Cigars/Pipes ___Combination ___Smokeless Tobacco ___Not Applicable/None

## Legal Status

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 |
| ❒ Probation/Parole | ❒ 90 day commitment |
| ❒ Informal Probation | ❒ 180 day commitment |
| ❒ Protective Custody | ❒ None/no involvement |
| ❒ Office of Children's Services Custody | ❒ Not Applicable |

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

Anything else you would like to add at this time:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________

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DO NOT COMPLETE – Staff will complete this section after your screening is complete.

Reviewed by Admission Staff: ______________________________________________
Signature

Treating here for: ________SA ________MH ________MH/SA

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

Does the client have a Mental Health problem? _____Yes ________No

Is opioid replacement therapy planned? ____Yes ________No

ASAM:

# DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g, Valium, barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right.
You may choose to answer or not to answer any of the questions in this section.

| These questions refer to the past 12 months | No | Yes |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | 0 | 1 |
| 2. Do you abuse more than one drug at a time? | 0 | 1 |
| 3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes." | 1 | 0 |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use? | 0 | 1 |
| 5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No." | 0 | 1 |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | 0 | 1 |
| 7. Have you neglected your family because of your use of drugs? | 0 | 1 |
| 8. Have you engaged in illegal activities in order to obtain drugs? | 0 | 1 |
| 9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | 0 | 1 |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | 0 | 1 |

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date________________ Patient Name:__________________________________ Date of Birth: _______________

*Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.*

| *PHQ-9* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy. | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating. | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way. | 0 | 1 | 2 | 3 |
| *Add the score for each column* | | | | |

Total Score (add your column scores): __________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all    Somewhat difficult    Very Difficult    Extremely Difficult

---

*Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.*

| *GAD-7* | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge. | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things. | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing. | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still. | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable. | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen. | 0 | 1 | 2 | 3 |
| *Add the score for each column* | | | | |

Total Score (add your column scores): __________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all    Somewhat difficult    Very Difficult    Extremely Difficult

# Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**…

   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you feel afraid that you might be physically hurt?
   Yes No If yes enter 1 ____
2. Did a parent or other adult in the household **often**…
   Push, grab, slap or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ____
3. Did an adult or person at least 5 years older than you **ever…**
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ____
4. Did you **often** feel that…
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ____
5. Did you **often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No
   If yes enter 1 ____
6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 ____
7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes of often** kicked, bitten, hit with fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ____
8. Did you ever live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ____
10. Did a household member go to prison?
    Yes No If yes enter 1 ____

Now add up your "Yes" answers: _____ This is your ACE Score