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SUBSTANCE USE TREATMENT
CLIENT HEALTH HISTORY FORM

Today's Date			
Last Name:	First Name:	Middle Initial	Birthdate:

SUBSTANCE USE TREATMENT INFORMATION & DETOX STATUS

Have you ever taken any of the following Anti-Anxiety Medications (Benzodiazepines)?

☐ Ativan ☐ Dalmane ☐ Halcion ☐ Prosom ☐ Serax
☐ Xanax ☐ Doral ☐ Niravan ☐ Restoril ☐ Tranxene

If yes, date of last use: Is it a current prescription? ☐ Yes ☐ No Prescribed to you? ☐ Yes ☐ No

Do you have any past/present withdrawal symptoms from alcohol or anti-anxiety medication? ☐ Yes ☐ No
If yes, please list the symptoms:

Current Drug Used	Use in Last 7 Days	Use IV?	How Often/How Much?	How Long?

Tobacco use: ☐ Never ☐ Previous Use ☐ Current Use If using: ☐ Smoke ☐ Smokeless ☐ Vape

How much / How often do you use tobacco? Do you have a Medical Marijuana card? ☐ Yes ☐ No

Have you been in treatment before? ☐ Yes ☐ No If yes, please list program(s) and year:

How many self-help support groups (AA, NA, etc.) do you attend in a typical months?

MEDICAL INFORMATION

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe If yes, how far along are you?

Primary Care Physician Name: Phone:

Dental Provider Name: Phone:

Do you need assistance finding a Primary Care Physician or Dental Provider? ☐ Yes ☐ No

Do you have a history of:

☐ Liver Disease	☐ Vision Problem	☐ Dental Problem
☐ Heart Attack, Stroke, Heart Surgery	☐ High Blood Pressure	☐ Headaches (frequent/severe)
☐ Seizure	☐ Hallucinations	☐ Chronic Cough
☐ DT's	☐ Diabetes	☐ Back Injury/Pain
☐ Head Injuries	☐ Other Chronic Medical Condition	☐ Eating Disorder
		☐ Chronic Pain

If any conditions are checked, please explain:

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Any Allergies to: ☐ Medications ☐ Bee Stings ☐ Foods List allergies:

Have you been diagnosed with: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV

If yes, do you need treatment for Hepatitis C / HIV? ☐ Yes ☐ No

If no, do you want to be tested for Hepatitis C / HIV? ☐ Yes ☐ No

Have you been tested for TB? ☐ Yes ☐ No If yes: ☐ Positive ☐ Negative Current TB Card? ☐ Yes ☐ No

Current Medications? ☐ Yes ☐ No **Do you have a 30-day supply?** ☐ Yes ☐ No Need Refill? ☐ Yes ☐ No

List Medications and Amounts (if available):

Medication Name	Amount	Medication Name	Amount

BEHAVIORAL HEALTH STATUS

Are you currently experiencing any of the following symptoms?

☐ Depression ☐ Mood Swings ☐ Panic/Anxiety ☐ Paranoia ☐ Hallucinations

☐ Suicidal Thoughts or Plan If you checked suicidal thoughts or plan, please describe:

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No Diagnosis:

Current Mental Health Provider Name: Phone:

Have you ever had to lie to people important to you about how much you have gambled? ☐ Yes ☐ No

Have you ever felt the need to bet more and money? ☐ Yes ☐ No

LEGAL STATUS

☐ Parole ☐ Probation ☐ Mental Health Court ☐Drug Court ☐ Incarcerated ☐ None ☐ Other:

Do you have any Pending Court Cases? ☐ Yes ☐ No If yes, for what?

Do you have any current or previous charges for Violent Offense? ☐ Yes ☐ No Sexual Offense: ☐ Yes ☐ No

How many times have you been arrested for DUII? Other charges?

Check agencies you're involved with: ☐ Mental Health ☐ Voc Rehab ☐ Bay Cities ☐ Translink ☐ CWP

Child Welfare Case Worker: **Parole/Probation Officer:**

Do you have any Family or Friends who work for Adapt Integrated Health Care? ☐ Yes ☐ No

If yes, please list name(s) and department:

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HAD SCALE

Patient's Name:	**Date of Birth:**
Counselors are aware that emotions play an important part in most addictions. If your counselor knows about these feelings, he or she will be able to help you more. This questionnaire will help your counselor know how you feel. Read each item and **circle** the best answer to show how you have been feeling **in the past week**.	

I feel tense or "wound up" **3 Most of the time** **2 A lot of the time** **1 Time to time, occasionally** **0 Not at all**	**I feel as if I am slowed down** 3 Nearly all of the time 2 Very often 1 Sometimes 0 Not at all
I still enjoy the things I used to enjoy 0 Definitely 1 Not quite as much 2 Only a little 3 Not at all	**I get sort of frightened feeling like "butterflies in the stomach"** **0 Not at all** **1 Occasionally** **2 Quite often** **3 Very often**
I get a sort of frightened feeling like something awful is going to happen **3 Very definitely and quite badly** **2 Yes, but not too badly** **1 A little, but it doesn't worry me** **0 Not at all**	**I have lost interest in my appearance** 3 Definitely 2 I don't take as much care as I should 1 I may not take as much 0 I take just as much care
I can laugh and see the funny side of things 0 As much as I always could 1 Not quite so much now 2 Definitely not so much now 3 Not at all	**I feel restless as if I must be on the move** **3 Very much indeed** **2 Quite a lot** **1 Not very much** **0 Not at all**
Worrying thoughts go through my mind **3 A great deal of time** **2 A lot of the time** **1 From time to time but not too often** **0 Only occasionally**	**I look forward with enjoyment to things** 0 As much as I ever did 1 Rather less than I used to 2 Definitely less than I used to 3 Hardly at all
I feel cheerful 3 Not at all 2 Not often 1 Sometimes 0 Most of the time	**I get sudden feelings of panic** **3 Very often indeed** **2 Quite often** **1 Not very often** **0 Not at all**
I can sit at ease and feel relaxed **0 Definitely** **1 Usually** **2 Not often** **3 Not at all**	**I can enjoy a good book or radio or TV program** 0 Often 1 Sometimes 2 Not often 3 Very seldom

FOR OFFICE USE ONLY:

A Score (bold): _____ D Score: _____ <7 not present; 8-10 doubtful; ≥ 11 definite

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LIFE EVENTS CHECKLIST

Patient's Name:	**Date of Birth:**

Listed below are several difficult or stressful things that sometimes happen to people. For each event, **check one or more of the boxes** to the right to indicate that: (a) it ***happened to you*** personally, (b) you ***witnessed it*** happen to someone else, (c) it ***doesn't apply*** to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, or earthquake).			
2. Fire or explosion			
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash).			
4. Serious accident at work, home, or during recreational activity.			
5. Exposure to toxic substance (for example, dangerous chemicals, radiation).			
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)			
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)			
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)			
9. Other unwanted or uncomfortable sexual experience			
10. Combat or exposure to a warzone (in the military or as a civilian)			
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)			
12. Life-threatening illness or injury			
13. Severe human suffering			
14. Sudden, violent death (for example, homicide, suicide)			
15. Sudden, unexpected death of someone close to you			
16. Serious injury, harm, or death you caused to someone else			
17. Any other very stressful event or experience			

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995

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INFECTIOUS DISEASE RISK ASSESSMENT FORM

This form is used for educational and referral purposes only.
It is not included in the treatment file and shredded after initial assessment.

1. In the past 12 months have you had a tattoo, body piercing, acupuncture or have had contact with someone else's blood?	☐ Yes ☐ No
2. Within the last 30 days, have you had any of the following symptoms <u>lasting for more than 2 weeks</u>?	
☐ Nausea ☐ Shortness of Breath ☐ Night Sweats (so bad that you had to change your clothes/sheets) ☐ Fever ☐ Weight Loss (unintentional) ☐ Productive Cough ☐ Diarrhea (lasting more than 1 week) ☐ Women—Have you missed your last two periods ☐ Coughing Blood ☐ Lumps/swollen gland in neck or armpit	
3. Have you ever been told you have TB?	☐ Yes ☐ No
4. Has anybody you know or have lived with been diagnosed with TB in the past year?	☐ Yes ☐ No
5. Have you ever had a positive skin test for TB? (A test where they gave you a shot in your forearm, and a few days later a hard bump appeared.)	☐ Yes ☐ No
6. Have you ever been treated for TB?	☐ Yes ☐ No
7. Have you ever been told that you have: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C	
8. Do you use needles to shoot drugs or shared needles or syringes to inject drugs?	☐ Yes ☐ No
9. Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact?	☐ Yes ☐ No
10. Do you use stimulants (cocaine/methamphetamine)?	☐ Yes ☐ No
11. In the last 12 months, have you or anyone you have had sex with had (STDS), like syphilis, gonorrhea, herpes, chlamydia, nongonococcal urethritis, other sexually transmitted diseases, or hepatitis?	☐ Yes ☐ No
12. Did you have a blood transfusion before 1992 or received blood products produces before 1987 for clotting problems?	☐ Yes ☐ No
13. Was your birth mother infected with Hepatitis C virus during the time of your birth?	☐ Yes ☐ No
14. Have you been, or are you currently, on long term dialysis?	☐ Yes ☐ No
15. Have you had sex with someone who has the blood disease hemophilia?	☐ Yes ☐ No
16. Have you had unprotected sex with a person who injects drugs or with a man who has sex with other men?	☐ Yes ☐ No
17. Have you had sex in exchange for money or drugs, or to survive?	☐ Yes ☐ No
18. Have you had sex with more than one person in the past 6 months? Any types of vaginal, rectal or contact without protection (condom or other barrier) with or without your consent?	☐ Yes ☐ No
19. Have you had sex <u>or</u> shared needles to inject drugs with a person who has AIDS <u>or</u> who tested positive on the antibody test for AIDS/HIV disease or Hepatitis C?	☐ Yes ☐ No
20. Have you ever injected drugs, even once?	☐ Yes ☐ No
21. Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C Virus?	☐ Yes ☐ No
22. Have you ever had a drinking problem that required medical care or counseling, or have you ever been told or thought that you have a drinking problem?	☐ Yes ☐ No

The following questions are asked to help with treatment planning.
It is not required that you answer them to participate in assessment and/or treatment.

1. Have you ever had a blood test for the HIV antibody?	☐ Yes ☐ No
If No, would you like a blood test?	☐ Yes ☐ No
If Yes, have you been tested within the last 6 months?	☐ Yes ☐ No
2. Have you ever had a blood test for the Hepatitis C Virus?	☐ Yes ☐ No
If No, would you like a blood test?	☐ Yes ☐ No
If Yes, have you been tested within the last 6 months?	☐ Yes ☐ No

3. How would you judge your own risk for being infected with HIV (the AIDS virus)?

☐ I know I am infected.
☐ I think I am at high risk.
☐ I think I am at low risk.
☐ I think I am at NO risk.
☐ I am not sure what my risk is.

4. How would you judge your own risk for being infected with the Hepatitis C Virus?

☐ I know I am infected.
☐ I think I am at high risk.
☐ I think I am at low risk.
☐ I think I am at NO risk.
☐ I am not sure what my risk is.