

ADULT ASSESSMENT

DEMOGRAPHIC INFORMATION

Date _____

Client's Name _____ Age _____

Date of Birth _____

Address _____

How long have you lived at this address? _____

Type of residence (Apt. Home, Duplex, Etc.) _____

Rent? _____ Own? _____

With whom do you live? _____

What circumstances led to this assessment? _____

What is your behavior like when you are using alcohol or drugs? _____

Who referred you or how did you hear about me? _____

SOCIAL INFORMATION

Number of meaningful relationships _____

Marital Status:

Never married ___ Married ___ Unmarried couple ___ Separated ___ Divorced ___ Widowed ___

How long at present status? _____ Married how many times? _____

Spouse's name _____ Occupation _____

Employer _____

How many children do you have? (Please list) None ___

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

How has your chemical use affected the relationship with your children? _____

How has your relationship with family/significant other been affected by your chemical use?

Does anyone in your immediate family have a problem with chemicals? _____

Have concerned person(s) complained about your use of chemicals? _____

Explain _____

Where were you raised and by whom? _____

Father's name _____ Father's occupation _____

Is your Father living? ___ His age ___ If not, cause of death _____

Mother's name _____ Mother's occupation _____

Is your Mother living? ___ Her age ___ If not, cause of death _____

Parent's relationship: Married ___ Divorced ___ Never married ___

Number of children in your family (counting yourself)? _____

Which number child were you? _____

Are your brother(s) living? #Yes ___ #No ___ sister(s) living? #Yes ___ #No ___

Any history of alcoholism in your family? _____

PERSONAL

What are your interests/hobbies? _____

What do you normally do with your leisure time? _____

How many close friends do you have? ____ Do you socialize with people who use drugs and/or alcohol? ____ Are you a member of a racial or minority group? _____

Religious preference? _____

Affectional orientation: heterosexual _____ Bi-sexual ____ Gay ____ Other _____

Have you ever been physically or sexually abused? _____

What is your attitude toward the use of alcohol and/or drugs? _____

How do you feel about seeking this assessment? _____

What do you think of yourself? _____

What are some personal strengths? _____

What do you see as problem areas? _____

How has your chemical use affected your self esteem? _____

How has your chemical use affected you sexually? _____

GAMBLING

Have you ever bet on horses, dogs or sporting events? Yes ____ No ____

Do you enjoy dice games such as craps? Yes ____ No ____

Have you ever played the lottery? ____ Bingo ____ Pull tabs ____ Poker ____

Slot Machines ____ Stock market ____ Other _____

What is the largest amount of money you ever gambled on at one occasion ? _____

Have you ever gambled more than you intended? _____

EDUCATION /VOCA TION

What is your highest grade in school? Elementary 6 7 8 High school 9 10 11 12

Name and place of High School _____

College 1 2 3 4 5 6 7 8 Degree _____

Name and place of College _____

List any special training _____

Has your chemical use affected your education plans? ____ Explain _____

Do you have any reading or writing problems? _____

Current employer _____ How long? _____

Occupation _____

Do you like your job? _____ Do you feel suited to your job? _____

Is your job in jeopardy now? _____

Do you have an employee assistance counselor? _____

Name _____ Telephone Number _____

How has chemical use affected your occupational plans? _____

How has chemical use affected you financially? _____

Previous consistent employment _____

Does anyone contribute to your support? _____

MILITARY HISTORY

Were you in the Armed Forces? _____ Branch _____

Total time in service _____ Highest Rank _____

Were you in combat? _____ Wounded or injured? _____

Any disciplinary action? _____ Explain _____

Were they chemical- related? _____ Type of discharge _____

CHEMICAL USE HISTORY

Drug of choice _____

Substance	Age & year Date of first use	Pattern? How often?	How much?	Date of last use
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Mushrooms	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____
Steroids	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Diet pills	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Crack	_____	_____	_____	_____
Meth.	_____	_____	_____	_____
Ecstasy	_____	_____	_____	_____
Heroin	_____	_____	_____	_____
PCP	_____	_____	_____	_____
Pain Killers	_____	_____	_____	_____
Valium	_____	_____	_____	_____
Sleeping pills	_____	_____	_____	_____
I.V. use	_____	_____	_____	_____
Other	_____	_____	_____	_____

Percent of leisure time spent drinking/using? _____

Longest period of abstinence _____

How often have you tried to quit? _____ Result? _____

Withdrawal symptoms? _____

AA or self help group attendance? _____

NICOTINE USE HISTORY

Do you smoke? If yes, how much? _____

Have you stopped smoking? _____

Do you have a desire to stop smoking? _____

TREATMENT HISTORY

Month/Year service	Agency name	Location	# days	Reason for
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(Include DWI classes, detox, CD treatment, psychological/medical hospitalization in the last 6 months counseling/illness/accidents.)

LEGAL HISTORY

Month/year	Location	Offense/charge	Outcome	BAC	Chemical
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Court action pending: _____

Probation Officer/Social /worker:

Name _____ County _____

Address _____

Phone _____ Fax _____

MEDICAL/PSYCHOLOGICAL HISTORY

Health status _____

Date of last physical _____

Who is your personal physician? _____

Address: _____

Phone: _____

Do you have any history of eating disorders? _____

Anorexia/bulimia/compulsive overeating? _____

What medical problems, if any, are you currently having? _____

Are these problems being treated? _____

By whom? _____

What diseases run in your family? _____

Check any of the following diseases/symptoms you have had:

- | | |
|--|---|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Tachycardia (increased pulse over 100) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Weakness or limb numbness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Ulcer (stomach) |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> Nervous breakdown or disorder |
| <input type="checkbox"/> History of withdrawal symptoms or
blackouts | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Eating disorders/Obesity or cachectic
(wasted) state | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Kidney disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bleeding tendencies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> DT's, Agitation or Hallucinations |
| | <input type="checkbox"/> History of seizures |
| | <input type="checkbox"/> Epilepsy |

What medications are you currently using? _____

Do you have any allergies to medications? _____

Do you have any other allergies? _____

List past hospitalizations, operations or serious illnesses:

Type of illness/Operation

Year

Hospital/Doctor

Have you ever had psychiatric treatment? _____ When? _____

Have you ever attempted suicide? _____ When? _____

Have you ever overdosed from a drug? _____ When? _____

Do you have any vulnerable adult issues? _____

FOR FEMALES ONLY Menstrual period: Regular _____ Irregular _____ Painful _____

Date of last menstruation: _____ Are you or do you think you are pregnant? _____

Number of live births? _____ Number of abortions? _____

What type of birth control are you using? _____

Have you been treated for female disorders? _____

Please mark each of the following that you have experienced as it relates to drug/alcohol use:

- using 1 or more times a week to intoxication
- using drugs or alcohol to function in a social setting
- driving while impaired by drugs or alcohol
- loss of friends due to using behavior
- tolerance (needing more to get the same effect)
- mood swings
- frequently using larger amounts than planned
- inability to set or follow through with limits of use
- spending a good deal of money on drugs/alcohol
- using despite medical/medication issues
- continuing substance use despite knowledge of persistent or recurrent physical or psychological problem caused by use
- hangovers
- withdrawal (sweats, shaking)
- persistent desire to cut down use
- giving up/reducing activities in order to use
- failure to meet obligations at home, school or work
- using in the morning
- using to medicate thoughts, feelings or physical pain
- preoccupation (thinking about or planning to use)
- using rapidly to get a buzz
- people complaining about chemical use
- fights or conflicts with others while under the influence
- daily use
- family history of alcohol/drug use
- secretive use
- using alone
- repeated attempts to control use
- protecting one's supply
- IV use, injecting
- drug/alcohol related legal problems
- not remembering using events
- using chemicals despite medication instruction
- passing out from using

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND
FACTUAL.

CLIENT SIGNATURE: _____ DATE: _____

MICHIGAN ALCOHOLISM SCREENING TEST

Yes No

- | | | |
|-------|-------|--|
| _____ | _____ | 1. Do you feel you are a normal user/drinker? |
| _____ | _____ | 2. Have you ever awakened the morning after some heavy drinking/using the night before and found that you could not remember a part of the evening before? |
| _____ | _____ | 3. Does your spouse (or parents) ever worry or complain about your drinking/using? |
| _____ | _____ | 4. Can you stop drinking/using without a struggle after one of two? |
| _____ | _____ | 5. Do you ever feel bad about your drinking/using? |
| _____ | _____ | 6. Do friends or relatives think you are a normal user/drinker? |
| _____ | _____ | 7. Do you ever try to limit your using/drinking to certain times of day or to certain places? |
| _____ | _____ | 8. Are you always able to stop drinking/using when you want to? |
| _____ | _____ | 9. Have you ever attended a meeting of Alcoholics Anonymous (AA)? |
| _____ | _____ | 10. Have you ever gotten onto fights when drinking/using (physical/verbal)? |
| _____ | _____ | 11. Has drinking/using ever created problems with you and your spouse/family? |
| _____ | _____ | 12. Has your spouse (or family) ever gone to anyone for help about your drinking/using? |
| _____ | _____ | 13. Have you ever lost friends or girlfriends/boyfriends because of drinking/using? |
| _____ | _____ | 14. Have you ever gotten into trouble at work because of drinking/using? |
| _____ | _____ | 15. Have you ever lost a job because of drinking/using? |
| _____ | _____ | 16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking/using? |
| _____ | _____ | 17. Do you ever drink/use before noon? |
| _____ | _____ | 18. Have you ever been told you have liver trouble or health problems because of your drinking/using? |
| _____ | _____ | 19. Have you ever had delirium tremors (DT's), severe shaking, heard voices or seen things that weren't there after heavy drinking or using? |
| _____ | _____ | 20. Have you ever gone to anyone for help about your drinking/using? |
| _____ | _____ | 21. Have you ever been in a hospital because of your drinking/using? |
| _____ | _____ | 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward for a general hospital with a drinking/using related problem? |
| _____ | _____ | 23. Have you ever been a patient in a psychiatric or mental clinic, gone to a doctor, social worker or clergyman for help with an emotional problem in which drinking/using was related? |
| _____ | _____ | 24. Have you ever been arrested, even for a few hours, because of drinking/using behavior? |
| _____ | _____ | 25. Have you ever been arrested for drunk driving or driving after using? |

Client signature

Staff Signature

Date