Chrysalis Behavioral Health

Database Intake Packet

350 E 11th Ave. Eugene, OR. 97401

(541) 683-1641

**If you require assistance in completing this form, please call the front office to schedule a time with a Peer Support Specialist who will help

Date form completed:

Seeking services for:

Why are you seeking services now? What goals are you wishing to address while in services?

What do you believe are your strengths? What interests and/or hobbies do you have?

Name:

Previous names used:

Address:

City:

State:

Zip:

Phone:

Is it ok to identify ourselves when we call?

Yes

No

E-mail

Is it ok to contact you through e-mail?

Yes

No

Date of Birth:

Have you ever been a past Chrysalis client?

Yes

No

If yes, what was your client number?

Do you have any friends or family currently attending Chrysalis?

Is yes, what are their names?

Referred by:

If not referred: Where did you hear about us?

Race/Ethnicity:

Marital Status:

Living Situation:

Highest Grade of School Completed:

Gender Identity:

Sexual Orientation:

Household Gross monthly income: Source of Income:

Including yourself, list number & ages of people dependent on listed income:

Do you have OHP? ID #: Which CCO? Do you need assistance applying for OHP?

Do you have OHP?
- Yes
- No

Which CCO?
- Trillium
- Pacific Source

Do you need assistance applying for OHP?
- Yes
- No

Private Health Insurance, if any: ID #:

Do you have an OMMP Card?
- Yes
- No

If yes, do you plan on using it?
- Yes
- No

Are you in a Methadone/Suboxone Program?
- Yes
- No

If you have an **OPEN** case, your DHS Child Welfare Caseworker's name:

If under Parole and Probation, your Probation Officer's name:

Are DHS and/or Parole & Probation asking you to enter treatment?

Yes No

Total number of arrests in your life: Total number of DUII arrests in your life:

Have you ever been in the military
- Yes
- No

If yes, what branch?

If discharged, what type of discharge?

Dimension 1

Check any of the following that you experienced in the last year after you stopped using alcohol or other drugs:

- N/A (does not apply)
- Seizures
- Agitation
- Tremors/shakes
- Heard things that were not really there
- Nausea
- Vomiting
- Trouble sleeping or sleeping a lot
- Heavy sweating
- Anxiety
- Depression
- Thoughts of suicide
- Saw things that were not really there
- Itching pains
- Burning sensations on or under skin
- Numbness
- Felt bugs crawling on or under skin
- Fidgety
- Restless
- Dizziness
- Diarrhea
- Nervousness
- Headaches

ALCOHOL AND OTHER DRUG USE HISTORY

******For each of the following substances, please fill out completely. Include your present and past use over your entire lifetime.******

Frequency of use:	Method of use:	Age of 1st Use:	How long since last use:
Alcohol (liquor, beer, wine)	Method of use:	Age of 1st Use:	How long since last use:
Amphetamines (meth, MDMA, adderalll)	Method of use:	Age of 1st Use:	How long since last use:
Marijuana	Method of use:	Age of 1st Use:	How long since last use:
Nicotine (cigarettes, chew)	Method of use:	Age of 1st Use:	How long since last use:
Cocaine	Method of use:	Age of 1st Use:	How long since last use:
Heroin	Method of use:	Age of 1st Use:	How long since last use:
Opiates (opium, morphine)	Method of use:	Age of 1st Use:	How long since last use:
Synthetic Opiates/Opioid's (Percocet, codeine, vicodin etc)	Method of use:	Age of 1st Use:	How long since last use:

Methadone	Method of use:	Age of 1st Use:	How long since last use:
Hallucinogens (mushrooms, LSD, mescaline, DMT, peyote)	Method of use:	Age of 1st Use:	How long since last use:
Sedatives	Method of use:	Age of 1st Use:	How long since last use:
Tranquilizers (benzos, valium)	Method of use:	Age of 1st Use:	How long since last use:
Barbiturates (Phenobarbital etc)	Method of use:	Age of 1st Use:	How long since last use:
Inhalants (glue, nitrous, paint)	Method of use:	Age of 1st Use:	How long since last use:
PCP (angel dust)	Method of use:	Age of 1st Use:	How long since last use:
Caffeine (Coffee, cola, tea)	Method of use:	Age of 1st Use:	How long since last use:
Other (kratom, poppers etc)	Method of use:	Age of 1st Use:	How long since last use:

Please list **current prescriptions** and/or provide a copy to the front office:

DIMENSION 1

	Yes	No	N/A
Do you often take in larger amounts of substances and/or over a longer period than planned?			
Have you ever tried to limit your use to certain times or amounts and failed to do so?			
Do you spend a lot of time getting the substance, using it, and/or recovering from it?			
Have you ever switched doctors to get more prescriptions?			
Have you given up hobbies, or other activities because of your use of alcohol or other drugs?			
Have you lost contact with friends or family because of your use of alcohol or other drugs?			
Have you changed the kind of friends you have because of your drug use?			
Have you missed work or school because of your alcohol or other drug use?			
Has anyone ever complained about your drinking or using?			
Has the quality of your work (including schoolwork) gone down due to your use of alcohol or other drugs?			
Have you become less involved in your children's activities because of your use?			
Has a doctor ever told you to quit using alcohol, nicotine or other drugs because your use was causing or making other health problems worse?			
Have you ever gone to work, or school while you were hung over or intoxicated?			
Have you ever lost a job or had job problems due to your use of alcohol or other drugs?			
Have you ever stolen drugs/alcohol or money to buy alcohol or other drugs?			
Have you ever had legal problems due to your use of alcohol/drugs (DUII, assault, etc.)?			

DIMENSION 2: MEDICAL HISTORY

Are you under a doctor's care at this time?

Yes

No

If so, please give name and address:

When was the last time you saw a physician?

List any surgery you have had:

List all current medical problems (within the past year) requiring medical treatment:

Have you had any blood tests done since you last used?

Yes

No

If so, please explain:

Are you pregnant?

Yes

No

If yes, are you receiving prenatal care?

Yes

No

If yes, who is your health care provider?

If no, do you want referrals?

Yes

No

INFECTIOUS DISEASE RISK ASSESSMENT FORM

	Yes	No	Don't Know
Have you seen a doctor or other health care provider in the past 3 months?			
Do you live or have you lived on the street or in a shelter?			
Have you ever been in jail/prison/juvenile detention?			
Have you ever been in a long-term care facility (nursing home, mental health hospital, or other hospital)?			
In the past 3 years have you traveled/lived outside the U.S. (except Canada, Australia, New Zealand, Japan, Western Europe or Great Britain)?			
Are you a combat veteran?			
In the past 12 months have you had a tattoo, ear/body piercing, acupuncture or come into contact with someone else's blood?			

Have you ever had any of the following? Check the appropriate boxes.

	No	Yes
Hepatitis		
Heart problems		
Skin infections		
Diabetes		
Kidney problems		
Tuberculosis (TB)		
Epilepsy/Seizures		
Pancreatitis		
Cancer		
Asthma		
Internal bleeding		
Been in hospital (Other than childbirth)		
Surgeries done or recommended		
Other health problems		

Dates and comments of any marked "yes"

Where were you born?

Are you a combat veteran?

Yes No

Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks:

- Nausea
- Fever
- Drenching night sweats that were so bad you had to change your clothes or the sheets on the bed
- Productive cough
- Shortness of breath
- Lumps or swollen glands in the neck or armpits
- Losing weight without meaning to
- Diarrhea (runs) lasting more than a week
- Brown tinged urine
- Women: Have you missed your last two periods?
- Extreme fatigue
- Jaundice (yellow skin) or yellow eyes

Have you been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year?

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 lump appeared.)

Have you ever been treated for TB?

- Yes
- No
- Don't Know

Have you ever been told you have:

- Hepatitis A
- Hepatitis B
- Hepatitis C

Have you ever shared needles or syringes ("rigs") to inject drugs?

Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact?

In the past 12 months, have you, or anyone you have had sex with, had: syphilis, gonorrhea, herpes, chlamydia, nongonococcal urethritis, other sexually transmitted diseases or hepatitis?

The following 2 questions are asked to help with treatment planning. It is not required that you answer them to participate in assessment and/or treatment.

	Yes	No
1. Have you ever had a blood test for the HIV antibody?		
If "no", would you like a blood test?		
If "yes", have you been tested within the last six months?		
2. Have you ever had a blood test for Hepatitis C virus?		
If "no", would you like a blood test?		
If "yes", have you been tested within the last six months?		

To help find out if you are at increased risk for HIV, the virus known to cause AIDS, or Hepatitis C (HCV), please take a minute to answer the following questions.

	Yes	No	Don't Know
Did you receive a blood transfusion before 1992?			
Have you received blood products produced before 1987 for clotting problems?			
Was your birth mother infected with Hepatitis C virus during the time of your birth?			
Have you been, or are you currently, on long-term kidney dialysis?			
Have you had unprotected sex with someone who has the blood disease hemophilia?			
Have you had unprotected sex with a person who injects drugs?			
Have you had unprotected sex with a man who has sex with other men?			
Have you had sex in exchange for money or drugs, or in order to survive?			
Have you had sex with more than one person in the past 6 months? Any type of vaginal, rectal or oral contact without protection (condom or other barrier) with or without your consent?			
Have you had sex or shared needles to inject drugs with a person who has AIDS or who tested positive on the antibody test for AIDS/HIV disease or Hepatitis C?			
Have you ever injected drugs, even once?			
Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C?			
Have you ever had a drinking problem that required medical care or counseling?			
Have you ever been told or thought that you have a drinking problem?			

* *If you answered "no" to all the questions, you are not at increased risk for HIV/AIDS or Hepatitis C.*
* *If you answered "yes" or "don't know" to any question, you may be at risk for HIV/AIDS or Hepatitis C.*

****IF YOU WOULD LIKE INFORMATION ON HOW TO GET TESTED FOR TB, HIV OR HEPATITIS, PLEASE ASK ANY CHRYSALIS STAFF****

DIMENSION 3

Have you experienced any of the following within the last 12 months:

	Yes	No
Have you been hospitalized for mental or emotional problems?		
Have you had any outpatient visits for mental or emotional problems?		
Has anyone been trying to harm you or plot against you?		
Have you seen things in magazines, in movies or on TV that have special messages for you?		
Have you heard your thoughts out loud, as if you had a voice outside your head?		
Have you felt that your thoughts were being broadcast out loud so others could hear them?		
Have you felt that someone or something was putting thoughts into your head?		
Have you felt that your thoughts were being taken away by someone or something?		
Have you heard voices or sounds that no one else could hear?		
Have you had any strange feelings in your body that others do not seem to have?		
Have you seen things that other people didn't seem to see?		
Do you have any ideas that are uninvited and occur over and over again?		
Are there things you do over and over?		
Are there things you must do in a certain way, and if they are not done that way, you must repeat them?		
Have you ever borrowed money to gamble?		
Have you ever missed being somewhere because you were gambling?		
Do you have a history of head trauma?		
Binge eating		
Fasting, not eating		
Violent behavior		
Thoughts of suicide, harm to self		
Attempted suicide		
Thoughts about harming someone else		

If you answered yes to any of these questions, please explain

DIMENSION 3
Adverse Childhood Experience (ACE) Questionnaire

	Yes	No
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 afraid that you might be physically hurt?		
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?		
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?		
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?		
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?		
Were your parents ever separated or divorced?		
Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill or did a household member attempt suicide?		
Did a household member go to prison?		

Now add up your "Yes" answers. This is your ACE Score

Are you concerned about your safety?	If yes, are you currently in a safe place?	If no, do you have a safety plan?
Yes	Yes	Yes
No	No	No
Unsure	Unsure	Unsure

DIMENSION 4

	Very	A lot	Somewhat	A Little	Not at All
In the last year, how important have drugs/ alcohol been in your life?					
How troubled or bothered have you been in the past year by alcohol problems?					
How troubled or bothered have you been in the past year by other drug problems?					
How important to you now is treatment for alcohol problems?					
How important to you now is treatment for other drug problems?					
If substance abuse treatment is recommended for you, how open will you be to treatment?					

Are you seeking services here voluntarily?

Yes

Yes, but there is also legal, family or other pressure to seek services.

No, I am not seeking services willingly, I have legal, family, or other pressure to seek services.

LEGAL HISTORY:

Incident : Date : Court : Alcohol/Drug related? BAC: Disposition:

ARRESTS AND LEGAL ACTIVITIES:

Current involvement with Criminal Justice System (check all that apply):

Awaiting trial	Incarcerated, post conviction	In other supervised program
On trial	On probation/parole	Convicted, awaiting sentencing
Work release	Incarcerated, pre trial	DUII Diversion
Drug Court	None	Other

DIMENSION 5

Have you ever been in counseling/treatment (detox, out-patient, re-hab) before?

Yes

No

What programs/agencies?

How long ago?

Were you mandated?

Did you complete?

Length of clean time after treatment?

Were you involved in aftercare/continuation care?

If you were in counseling/treatment before but did not complete, why didn't you?

DIMENSION 5

	Always	A lot	Sometimes	Rarely	Never
How often do you try to stop using or drinking, but then use or drink anyway?					
How often do you find yourself thinking about the next time you can use or drink?					
How often do you crave alcohol and/or other drugs?					
How often do you have alcohol or drug using dreams?					
How often do you get impatient waiting to use alcohol/other drugs?					

What if any, of the following reasons cause you to use/drink:

Does not apply

Relationship problems

Bad memories

Boredom

Loneliness

Weight problems

Depression

Anger

Certain places

Certain people

Stress

Other

Dimension 6

Housing:

How would you rate your housing?

Stable

Unstable (risk eviction or having to move

Homeless

Religion/Spirituality

Do you belong to a spiritual or religious group?

Yes

No

If yes, please list:

EDUCATION-VOCATION

How well do you read and write?

Needs improving

OK

Well

Have you had any technical/trade training?

Yes

No

If yes, which field?

Do you have plans to further your education or to get more training?

Yes

No

If yes, what are your plans?

Family

In the past year, have you had problems with the following due to your use of alcohol or other drugs?

	Yes	No	No Contact	NA
Your spouse/partner				
Your children				
Your mother				
Your father				
Your siblings				
Others				

Do you live with anyone who uses alcohol or other drugs?

Do you live with anyone who currently has an alcohol or other drug problem?

If you have family or significant others who live with you, will they support you if treatment is advised?

In the last year, have you been afraid of being victimized or abused by someone in your household?

Yes

No

If yes, please explain:

Social-Recreation

What **DRUG FREE** support(s) do you have?

Immediate family	Extended family	Club	Support Group
Counselor	School	Hobbies	Friends
Church	Coworkers	Sports	Doctor
Pets	Exercise	None	
Other			

How often do you use self-help groups?

With whom do you drink/use?

Where do you do most of your drinking/using?

How many of your friends use substances?

Financial

Rate your finances:

Cultural Identification

In terms of culture, how do you define yourself? (Examples: Native American, African American, Mexican American, Asian, European, etc.)

Did you identify with that background? If so, how? If not, why not?

Congratulations. You have completed the intake datapacket. A Chrysalis staff will contact you shortly.

For Office Use Only

Intake Fee Pd:

Monthly Fee/Funding Source:

Intake Date:

Intake Counselor:

If appointment not given, please indicate why:

Other notes, including reason why referral was given:

TB Screening (page 5, Q2-13, 4 or more YES or Symptoms):

No, referral needed   Yes, referral given   Yes, referral declined

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MD Review, Date, PE REQ, Labs Req:

MD Comments:

Medical Records Requested of:	Date of Request:	Received: