KEEP THIS PAGE FOR YOUR REFERENCE

# *** PLEASE DOUBLE CHECK THAT YOUR PACKET IS COMPLETE BEFORE RETURNING IT. ***

## Welcome to Chrysalis!

We offer programs for substance use treatment (drug and alcohol), including DUII & DMV requirements, and mental health counseling.

**Step 1**: Fill out this packet and we will schedule your intake appt when you return it to the front desk staff with:

- Intake fee, if you are paying for treatment either at the full or discounted rate.

- Proof of your gross (before taxes) monthly income of your entire household if you are using the sliding scale or funding discounts. Your household consist of you and your dependents that you would claim on taxes, such as a spouse or children. This could be 2 employment pay stubs, the first page of your latest tax return, your most recent bank statement, or proof of other benefits such as unemployment, social security or food stamps.

- We also have fully funded slots available for income qualified individuals.

**Step 2**: Show up 20 minutes prior to your scheduled intake/assessment appointment, it will last approximately 2 hours. This is day 1 of your treatment or mental health program. **DUII clients, your 90 day clean time starts with your first clean UA**

**Please call 541-683-1641 if you need to reschedule so that we can fill the spot with someone else waiting for services. Our appointments fill up fast and reschedules will be approximately three weeks out.**

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Chrysalis is located at **350 E. 11th Ave** between Mill and High St.

Parking is limited – so please plan accordingly. There is coin/ card metered parking available in front of our building on 11th, or free 2 hour parking on Mill and High St. After 6pm, metered parking is also free. If you are taking the bus, the downtown bus depot is about 5 blocks away on 11th and Willamette.

**Chrysalis Business Office Hours:**

Monday-Wed 9:00 to 6:00 pm

Thursday 9:00-11:30pm and 2:30pm to 6:00 pm

Friday and Saturday by appt.

PH# 541-683-1641

Class updates/cancellations and other important announcements are put on our Facebook page and website.

www.facebook.com/whitebird.11th

www.whitebirdclinic.org

## Low income? You may be eligible for Oregon Health Plan (OHP)

Contact the SHOP program at White Bird at 323 E. 12th Ave (Just behind Chrysalis).

**Tues-Fri :** Walk-ins: 10-4 pm

Appointments outside of walk-in hours are available by request. Call 541-342-4357 for an appointment.

RETURN THE FOLLOWING PAGES

**Chrysalis Behavioral Health**
# DUII Intake Packet
**350 E. 11th Eugene, OR 97401**
**(541) 683-1641**

***FOR OFFICE USE ONLY***

*Intake Fee Pd* ____/____/____
*Monthly Fee* $_____
Intake Date ___/____/____
*Intake Counselor* _____

Date form completed: ____/____/____

Name:_____Previous Names: _____DL#:_____
Address: _____ City: _____State: _____ Zip: _____
Phone: _____ Is it ok to identify ourselves if we call you: **Yes** **No**
Email:_____ Is it ok to contact you through email: **Yes** **No**

Date of Birth: _____/_____/_____ Race/Ethnicity: _____
Have you ever been a previous Chrysalis Client? □ Yes □ No If yes: Chrysalis File #_____
Referred by: _____ If not referred: Where did you hear about us?_____

Do you have any friends or family currently attending Chrysalis? _____

**Marital Status** (**circle one**): Never Married / Married / Widowed/ Divorced / Separated / Living as Married
**Living Situation** (**circle one**): Own Home/ Rent / Spouse or Partner's home / Relatives home/ Foster Home /Adult Children's home /Institution or Group Home / Friends home / Homeless-street/Homeless Shelter

Gender Identity: _____ Sexual Orientation: _____ Preferred Pronouns: _____
Highest Grade of School Completed: _____ Currently enrolled in school or training? _____

Occupation: _____ Hours _____per week $_____ per hour
If unemployed, seeking work? **Yes** **No** If no, why not? _____

**Household (you and any dependents) Gross (before taxes) monthly income: $**_____
**Source**(circle): Employment /Social Security/ SSI-Federal/ TANF/ Unemployment/ Other_____

Including yourself, list number & ages of people dependent (spouse, children, etc) on listed income: _____
_____

Do you have **OHP (Medicaid**)? **NO** **YES** **ID#** _____ **Trillium or PacificSource**
If no, have you applied? NO, I am ineligible YES, date: _____
Private health insurance, if any: _____ ID# _____

Do you receive Food Stamps? **Yes** **No**

Do you have an OMMP Card? YES NO If yes, do you plan on using it while in treatment? YES NO
Are you in a Methadone/Suboxone program? YES NO
Are you at Sponsors? YES NO
If you have an **open** case, your DHS Child Welfare Caseworker's name: _____
If under Parole & Probation, your Probation Officer's name: _____
Are DHS and/ or Parole & Probation asking you to enter treatment? _____

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

1/23/2020

**DIMENSION 1 (A)**

**ALCOHOL AND OTHER DRUG USE HISTORY**

*****Please fill out completely. Include your entire life history of use*****

| ***TYPE OF DRUG*** **Non Prescribed use** | **HOW OFTEN USED?** | No Use | Less than 1x per week | Once per week | Several times per week | Once daily | 2 or 3 times daily | **AGE OF FIRST USE?** | **HOW LONG SINCE LAST USE?** | **HOW USED** | Oral (eat, drink) | Smoke | Inhale (snort) | Inject in muscle | Inject in vein |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol (liquor, beer, wine) | | | | | | | | | | | | | | | |
| Amphetamines (meth, MDMA, adderall) | | | | | | | | | | | | | | | |
| Marijuana (pot, hash, grass, weed, dabs, hash oil) | | | | | | | | | | | | | | | |
| Nicotine (cigarettes, chew) | | | | | | | | | | | | | | | |
| Cocaine (rock, yayo, crack) | | | | | | | | | | | | | | | |
| Heroin (smack, chiva, horse) | | | | | | | | | | | | | | | |
| Opiates (opium, morphine) | | | | | | | | | | | | | | | |
| Methadone | | | | | | | | | | | | | | | |
| Synthetic Opiates/Opioid (Percocet, codeine, vicodin, dilaudid) | | | | | | | | | | | | | | | |
| Hallucinogens (mushrooms, LSD, mescaline, DMT, peyote) | | | | | | | | | | | | | | | |
| Sedatives (Quaaludes, soapers) | | | | | | | | | | | | | | | |
| Tranquilizers (benzos, valium) | | | | | | | | | | | | | | | |
| Barbiturates (Phenobarbital, etc) | | | | | | | | | | | | | | | |
| Inhalants (glue, nitrous, paint) | | | | | | | | | | | | | | | |
| PCP (angel dust) | | | | | | | | | | | | | | | |
| Caffeine (coffee, cola, tea) | | | | | | | | | | | | | | | |
| Other (Kratom, poppers, etc) | | | | | | | | | | | | | | | |
| **Prescribed Medications List:** | | | | | | | | | | | | | | | |

## DIMENSION 1 (B)

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

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

2. How many times have you been referred to or admitted for detoxification (detox) during the past year? ____ Times

## DIMENSION 1 (C) DSM-IV CRITERIA

| | | **(circle one)** | | |
|---|---|---|---|---|
| 1. | Does it take <u>more</u> to get you loaded, drunk, high than it used to? | Yes | No | NA |
| 2. | Have you ever drunk or used <u>more</u> than you had planned to? | Yes | No | NA |
| 3. | Have you ever drunk or used for <u>longer</u> periods of time than you had planned to? | Yes | No | NA |
| 4. | Have you ever tried to quit using just to prove that you could? | Yes | No | NA |
| 5. | Have you ever used alcohol or other drugs to relieve or keep from getting sick? | Yes | No | NA |
| 6. | Have you ever tried to limit your use to certain times or amounts and failed to do so? | Yes | No | NA |
| 7. | Have you ever switched doctors to get more prescriptions? | Yes | No | NA |
| 8. | Have you given up hobbies, or other activities because of your use of alcohol or other drugs? | Yes | No | NA |
| 9. | Have you lost contact with friends or family because of your use of alcohol or other drugs? | Yes | No | NA |
| 10. | Have you changed the kind of friends you have because of your drug use? | Yes | No | NA |
| 11. | Have you missed work or school because of your alcohol or other drug use? | Yes | No | NA |
| 12. | Has anyone ever complained about your drinking or using? | Yes | No | NA |
| 13. | Has the quality of your work gone down due to your use of alcohol or other drugs? | Yes | No | NA |
| 14. | Has the quality of your schoolwork gone down due to your use of alcohol or other drugs? | Yes | No | NA |
| 15. | Have you become less involved in your children's activities because of your use? | Yes | No | NA |
| 16. | 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? | Yes | No | NA |
| 17. | Have you ever gone to work, or school while you were hung over or intoxicated? | Yes | No | NA |
| 18. | Have you ever used alcohol or other drugs on the job or at school? | Yes | No | NA |
| 19. | Have you ever lost a job or had job problems due to your use of alcohol or other drugs? | Yes | No | NA |
| 20. | Have you driven a vehicle or used machinery after you have been using drugs/alcohol? | Yes | No | NA |
| 21. | Have you ever stolen drugs/alcohol or money to buy alcohol or other drugs? | Yes | No | NA |
| 22. | Have you ever had legal problems due to your use of alcohol/drugs (DUII, assault, etc.)? | Yes | No | NA |

## DIMENSION 2: MEDICAL HISTORY

Are you under a doctor's care at this time? **Yes** **No**

If so, give name and address: _____

_____

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

_____

_____

List any surgery you have had: _____

List all current medications, including non-prescription drugs: _____

Have you had a tetanus shot within the past 10 years? _____

Have you ever injected drugs? _____ When was the last time? _____

When was the last time you used drugs, including alcohol? _____

What did you use? _____

Since that time have you been seen by a physician? _____

If so, explain: _____

_____

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

Have you been incarcerated or in an inpatient drug treatment program since you last used? _____

If so, explain: _____

Have you ever had any of the following:

| Check Appropriate Boxes: | NO | YES | Date | Comments |
|---|---|---|---|---|
| Hepatitis | | | | |
| Other liver problems | | | | |
| Heart problems | | | | |
| Skin infections | | | | |
| Diabetes | | | | |
| Kidney problems | | | | |
| Tuberculosis (TB) | | | | |
| Other lung problems | | | | |
| Epilepsy/seizures | | | | |
| Pancreatitis | | | | |
| Cancer | | | | |
| Asthma | | | | |
| Internal bleeding | | | | |
| Been in hospital (other than for childbirth) | | | | |
| Surgeries done or recommended | | | | |
| Bad injuries | | | | |
| Bad illness | | | | |
| Other health problems | | | | |

**Female Bodied:**

**Are you pregnant? Yes No**

If you are pregnant, are you receiving prenatal care? **Yes No**

If yes, who is your healthcare provider: _____

If no, do you want referrals? _____

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## INFECTIOUS DISEASE RISK ASSESSMENT FORM

Circle the answer for each question:

1. Have you seen a doctor or other healthcare provider in the past 3 months? **Yes No Don't Know**
2. Do you live or have you lived on the street or in a shelter? **Yes No Don't Know**
3. Have you ever been in jail/prison/juvenile detention? **Yes No Don't Know**
4. Have you ever been in a long-term care facility (nursing home, mental health hospital, or other hospital)? **Yes No Don't Know**
5. Where were you born: _____
6. In the past 3 years have you traveled/lived outside the U.S. (except Canada, Australia New Zealand, Japan, Western Europe or Great Britain)? **Yes No Don't Know**
7. How long have you been in the U.S.? Years/Months _____
8. Are you a combat veteran? **Yes No Don't Know**
9. In the past 12 months have you had a tattoo, ear/body piercing, acupuncture or come into contact with someone else's blood? **Yes No Don't Know**
10. 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
    - ❑ Coughing up blood
    - ❑ 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
11. Have you been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year? **Yes No Don't Know**
12. 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.) **Yes No Don't Know**

13. Have you ever been treated for TB? **Yes** **No** **Don't Know**

14. Have you ever been told you have:
    - A. Hepatitis A **Yes** **No** **Don't Know**
    - B. Hepatitis B **Yes** **No** **Don't Know**
    - C. Hepatitis C **Yes** **No** **Don't Know**

15. Have you ever used needles to shoot drugs? **Yes** **No** **Don't Know**

16. Have you ever shared needles or syringes ("rigs") to inject drugs? **Yes** **No** **Don't Know**

17. Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact? **Yes** **No** **Don't Know**

18. Do you use stimulants (cocaine/methamphetamine)? **Yes** **No** **Don't Know**

19. 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? **Yes** **No** **Don't Know**

**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.**

20. Did you receive a blood transfusion before 1992? **Yes** **No** **Don't Know**

21. Have you received blood products produced before 1987 for clotting problems? **Yes** **No** **Don't Know**

22. Was your birth mother infected with Hepatitis C virus during the time of your birth? **Yes** **No** **Don't Know**

23. Have you been, or are you currently, on long-term kidney dialysis? **Yes** **No** **Don't Know**

24. Have you had unprotected sex with someone who has the blood disease hemophilia? **Yes** **No** **Don't Know**

25. Have you had unprotected sex with a person who injects drugs? **Yes** **No** **Don't Know**

26. Have you had unprotected sex with a man who has sex with other men? **Yes** **No** **Don't Know**

27. Have you had sex in exchange for money or drugs, or in order to survive? **Yes** **No** **Don't Know**

28. 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? **Yes** **No** **Don't Know**

29. 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? **Yes** **No** **Don't Know**

30. Have you ever injected drugs, even once? **Yes** **No** **Don't Know**

31. Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C? **Yes** **No** **Don't Know**

32. Have you ever had a drinking problem that required medical care or counseling? **Yes** **No** **Don't Know**

33. Have you ever been told or thought that you have a drinking problem? **Yes No Don't Know**

* 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.

**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 six months? **Yes No**

2. Have you ever had a blood test for Hepatitis C virus? **Yes No**

   If "no", would you like a blood test? **Yes No**

   If "yes", have you been tested within the last six months? **Yes No**

3. How would you judge your risk for being exposed to HIV (the AIDS virus)?

   I know I have HIV/AIDS ___
   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 risk for being exposed to Hepatitis C?

   I know I have Hepatitis C ___
   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. ___

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

FOR OFFICE USE ONLY

MD REVIEW _____ DATE _____ PE REQ. _____ LAB REQ: _____
MD COMMENTS: _____
_____
MEDICAL RECORDS REQUESTED OF: _____
DATE OF REQUEST: _____ RECEIVED: _____

COUNSELOR REVIEW: _____ DATE: _____
COMMENTS: _____

**DIMENSION 3 (A)**

**Circle the answer for each question:**

1. Have you been hospitalized for mental or emotional problems during the last year? **Yes No**
   If yes, how many times? _____

2. Have you had any outpatient visits for mental or emotional problems during the last year? **Yes No**
   If yes, how many times? _____

3. In the past year, have you been prescribed drugs for any mental or emotional problems? **Yes No**
   If yes, list the drug(s): _____

   If yes, who prescribed them?: _____

4. Has anyone been trying to harm you or plot against you? **Yes No**

5. Have you seen things in magazines, in movies or on TV that have special messages for you? **Yes No**

6. Have you heard your thoughts out loud, as if you had a voice outside your head? **Yes No**

7. Have you felt that your thoughts were being broadcast out loud so others could hear them? **Yes No**

8. Have you felt that someone or something was putting thoughts into your head? **Yes No**

9. Have you felt that your thoughts were being taken away by someone or something? **Yes No**

10. Have you heard voices or sounds that no one else could hear? **Yes No**

11. Have you had any strange feelings in your body that others do not seem to have? **Yes No**

12. Have you seen things that other people didn't seem to see? **Yes No**

13. Do you have any ideas that are uninvited and occur over and over again? **Yes No**

14. Are there things you do over and over? **Yes No**

15. Are there things you must do in a certain way, and if they are not done that way, you must repeat them? **Yes No**

16. Have you ever borrowed money to gamble? **Yes No**

17. Have you ever missed being somewhere because you were gambling? **Yes No**

18. Do you have a history of head trauma? **Yes No**
    **If "yes" explain:** _____
    _____
    _____

## DIMENSION 3 (B)

1. In the past six months, have you experienced:

| | | |
|---|---|---|
| Binge eating | **Yes** | **No** |
| Fasting, not eating | **Yes** | **No** |
| Violent behavior | **Yes** | **No** |
| Thoughts of suicide, harm to self | **Yes** | **No** |
| Attempted suicide | **Yes** | **No** |
| Thoughts about harming someone else | **Yes** | **No** |

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

_____

_____

## DIMENSION 3 (C)

1. Have you ever been emotionally abused? **Yes No Unsure**
   If yes, by whom? _____
   If yes, do you feel you have any unresolved issues regarding the above? **Yes No Unsure**

2. Have you ever been physically abused? **Yes No Unsure**
   If yes, by whom? _____
   If yes, do you feel you have any unresolved issues regarding the above? **Yes No Unsure**

3. Have you ever been sexually abused? **Yes No Unsure**
   If yes, by whom? _____
   If yes, do you feel you have any unresolved issues regarding the above? **Yes No Unsure**

4. Have you ever been exposed to severe trauma? **Yes No Unsure**
   If yes, please explain _____
   _____

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

## DIMENSION 3 (D)

1. Has anyone in your family ever had mental or emotional problems? **Yes No Unsure**
   If yes, who? _____
   What were the problems? _____

2. Is your natural mother: **Living Deceased Unknown Status**
   Is your natural father: **Living Deceased Unknown Status**

3. If you are enrolled in school or training, have you had any mental or emotional problems that cause trouble for you at school **Yes No** If yes, explain _____

## DIMENSION 3 (E)

1. Have you ever been in the Military? **Yes No**
2. If yes, what branch? _____
3. How long? _____
4. Job Specialty (please do not use number/letter codes) _____
5. Type of discharge? _____
6. Did you have a history of alcohol/drug abuse in the service? **Yes No**

**DIMENSION 4 (A)**

1. Why are you seeking services now? _____

_____

_____

**DIMENSION 4 (B)**

Circle the answer for each question:

1. In the last year, how important have drugs/alcohol been in your life?

   **Very A lot Somewhat A little Not at all**

2. How troubled or bothered have you been in the past year by:

   Alcohol problems **Very A lot Somewhat A little Not at all**

   Other drug problems **Very A lot Somewhat A little Not at all**

3. Do you think you have an alcohol/drug abuse problem now? **Yes No Maybe**
4. Have you ever had an alcohol/drug abuse problem? **Yes No Maybe**

   If yes, when? _____

5. How important to you now is treatment for:

   Alcohol problems **Very A lot Somewhat A little Not at all**

   Other drug problems **Very A lot Somewhat A little Not at all**

6. If substance abuse treatment is recommended for you, how open will you be to treatment?

   **Very A lot Somewhat A little Not at all**

**DIMENSION 4 (C)**

1. Are you seeking services here voluntarily?

   ___ **Yes**

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

   Explain: _____

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

   Explain: _____

**LEGAL HISTORY**

| Incident | Date | Court | Alcohol/Drug Related? | B.A.L. | Disposition |
|---|---|---|---|---|---|
| | | | ___ **Yes** ___ **No** | | |
| | | | ___ **Yes** ___ **No** | | |
| | | | ___ **Yes** ___ **No** | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | ___ **Yes** ___ **No** | | |

*ARRESTS AND LEGAL ACTIVITIES:*

**Previous arrests (check all that apply):**

- ❑ Prior arrests for drug offenses
- ❑ Prior for driving under the influence
- ❑ Prior arrests for domestic violence
- ❑ Prior arrests for property crimes
- ❑ Prior arrests for violent crimes: ____ _____
- ❑ Prior arrests for other offense
- ❑ Crime unknown
- ❑ None

**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 status
- ❑ None
- ❑ Other _____
- ❑ Drug Court

**DIMENSION 5 (A)**

1. Have you ever been in counseling/treatment (detox, out-patient, re-hab) before? **Yes** **No**
   If yes, complete the following:

| What programs? | How long ago? | Were you mandated? | Did you complete? | Length of clean time after treatment? | Was your family involved in treatment? | Were you involved in aftercare? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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

**DIMENSION 5 (B)**

1. How often do you try to stop using or drinking, but then use or drink anyway?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

2. How often do you find yourself thinking about the next time you can use or drink?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

3. How often do you crave alcohol and/or other drugs?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

4. How often do you have alcohol or drug using dreams?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

5. How often do you get impatient waiting to use alcohol/other drugs?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

6. What if any, of the following reasons cause you to use/drink: (**check boxes**)

- ❑ Does not apply
- ❑ Relationship problems
- ❑ Bad memories
- ❑ Boredom
- ❑ Loneliness
- ❑ Weight problems
- ❑ Depression
- ❑ Anger
- ❑ Certain people
- ❑ Certain places
- ❑ Stress
- ❑ Other: _____

7. How often do you feel pressured to drink/use when you are with friends?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

8. How often do you feel pressured to drink/use when you are with members of your family?

   **Always** **A lot** **Sometimes** **Rarely** **Never**

9. How often do you feel pressured to drink/use when you are with co-workers?

   **Always** **A lot** **Sometimes** **Rarely** **Never** **Doesn't Apply**

**DIMENSION 6**

*A.) HOUSING*

1. How would you rate your housing?
   - ❑ Stable
   - ❑ Unstable (risk eviction or having to move)
   - ❑ Homeless

*B.) RELIGION/SPIRITUALITY*

1. Do you belong to a spiritual or religious group? **Yes** **No**
   If yes, list: _____
   If yes, do you attend services, meetings, etc. on a regular basis? **Yes** **No**
   If yes, what is the religion/group's belief about the use of alcohol or other drugs? _____
   _____

_____

2. Do you have any spiritual beliefs? **Yes** **No**
   If yes, explain: _____

*C.) EMPLOYMENT*

1. What is your occupation (includes homemaker): _____
2. If employed, are you satisfied with your current job? **Yes** **No**
3. How many of your co-workers use alcohol/other drugs?

   **All** **Most** **Some** **Few** **None** **Doesn't Apply**

4. How many of your co-workers will support your recovery if you enroll in treatment?

   **All** **Most** **Some** **Few** **None** **Doesn't Apply**

5. How much influence does your work place have on your choice to use or not to use alcohol and other drugs?

   **Not at All** **A little** **Somewhat** **A lot** **Very** **Doesn't Apply**

*D.) EDUCATION – VOCATION*

1. How well do you read and write? **Needs improving** **OK** **Well**
2. Have you had any technical/trade training **Yes** **No**
   If yes, which field? _____
3. Do you have plans to further your education or to get more training? **Yes** **No**
   If yes, what are your plans? _____

*E.) FAMILY*

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

| | | | | |
|---|---|---|---|---|
| Your spouse/partner | **YES** | **NO** | **No contact** | **NA** |
| Your children | **YES** | **NO** | **No contact** | **NA** |
| Your mother | **YES** | **NO** | **No contact** | **NA** |
| Your father | **YES** | **NO** | **No contact** | **NA** |
| Your brothers and sisters | **YES** | **NO** | **No contact** | **NA** |
| Others | **YES** | **NO** | **No contact** | **NA** |

2. How troubled or bothered have you been in the past 30 days by:

| | | | | | |
|---|---|---|---|---|---|
| Family conflicts | **Not at All** | **A little** | **Somewhat** | **A lot** | **Very** |
| Conflicts with other people | **Not at All** | **A little** | **Somewhat** | **A lot** | **Very** |

3. Do you live with anyone who uses alcohol or other drugs? **Yes** **No**
4. Do you live with anyone who currently has an alcohol or other drug problem? **Yes** **No**
5. If you have family or significant others who live with you, will they support you if treatment is advised?

   **Yes** **No** **Unsure**

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

**Yes** **No** If yes, explain: _____

7. How important to you is counseling for:

| | | | | | |
|---|---|---|---|---|---|
| Family Conflicts | **Not at All** | **A little** | **Somewhat** | **A lot** | **Very** |
| Conflicts with other people | **Not at All** | **A little** | **Somewhat** | **A lot** | **Very** |

8. Are there any counseling issues you want to work on while here? _____

_____

9. Do you have children in the home? **Yes** **No**

Do you have reliable childcare? **Yes** **No**

If no, are you interested in resources? **Yes** **No**

*F.) SOCIAL – RECREATION*

1. How many activities have you done in the last year that involve your or someone else's use of drugs/alcohol?

**All** **Most** **Some** **Few** **None**

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

| | | | |
|---|---|---|---|
| Immediate family | Counselor | Church | Doctor |
| Extended family | School | Co-workers | Pets |
| Club | Hobbies | Sports | Exercise |
| Support Group | Friends | None | |

Other _____

3. How often do you use self-help groups?

**1-3x's a month** **1-2x's per week** **3-4x's per week** **Daily** **Never**

4. With whom do you drink/use?

**Alone** **Friends** **People from Work** **Family** **Neighbors** **Partner/Spouse** **N/A**

5. Where do you do most of your drinking/using?

**At Home** **At bars** **At parties** **At work** **At friends' houses** **Other _____** **N/A**

6. How many of your friends use alcohol/other drugs?

**All** **Most** **Some** **Few** **None**

7. How troubled or bothered have you been in the past 30 days by loneliness or being alone?

**Not at All** **A little** **Somewhat** **A lot** **Very**

8. How willing are you to find drug-free supportive people and activities?

**Not at All** **A little** **Somewhat** **A lot** **Very**

*G.) FINANCIAL*

Rate your finances:

___ I have enough money to cover my expenses.
___ I have some money, but not enough to cover all of my expenses.
___ My individual or family household does not have any income at this time.

***H.) CULTURAL IDENTIFICATION***

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

2. Did you identify with that background? If so, how?

   If not, why not?

3. Where were you raised?

4. What was the attitude of the community in which you grew-up toward alcohol?

   Toward other drugs?

5. What is the cultural/ethnic background of the people who raised you?

   Was it similar to the rest of your community?

6. What religious or spiritual activities did your original family practice?

7. What is the cultural background of your closest friend(s)?

8. Do you participate in any of your culture's activities? **Yes** **No**
   If yes, what are the activities?

9. What group did you associate with in school? (i.e. "jock", "soc", scholastic, arts, "outsider", etc.)

   What sort of activities?

10. Have you ever been treated badly because of your culture? **Yes** **No**
    If yes, please explain:

11. What is your primary language? _____

12. Do you know more than one language? If so, which ones?

13. Can you read and write your primary language? **Yes** **No** **Read Only**

14. Can you read and write English? **Yes** **No** **Read Only**

FAGERSTROM NICOTINE DEPENDENCE SCALE*

**DO YOU USE TOBACCO? YES NO**

**If yes, please complete the following:**

For each question, circle the answer that best applies to you. Keep track of the points as you go.

1. How soon after you wake up do you smoke your first cigarette?
   a. Within 5 minutes (3 points)
   b. Within 6-30 minutes (2 points)
   c. Within 31-60 minutes (1 point)
   d. After 60 minutes (0 points)

2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, at the library, at the movies, etc.) ?
   a. Yes (1 point)
   b. No (0 points)

3. Which cigarette would you hate most to give up?
   a. The first one in the morning (1 point)
   b. Any other (0 points)

4. How many cigarettes per day do you smoke?
   a.10 or less (0 points)
   b. 11-20 (1 point)
   c. 21-30 (2 points)
   d. 31 or more (3 points)

5. Do you smoke more during the first hours after waking than during the rest of the day?
   a. Yes (1 point)
   b. No (0 point)

6. Do you smoke even when you are ill enough to be in bed most of the day?
   a. Yes (1 point)
   b. No (0 points)

Now add up your points. How did you score? _____points
A score of 5 or more indicates a significant dependence, while a score of 4 or less shows a low to moderate dependence.

Are you interested in quitting smoking? Yes_____ No_____

Are you interested in receiving information about quitting smoking? Yes_____ No_____

*Heatherton, Todd F. etal 1991 The Fagerstrom Test for Nicotine Dependence: A Revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addiction 86: 1119-1127