

MID-OHIO VALLEY FELLOWSHIP HOME

Client Assessment Form

Children _____ Last use _____ CPS _____

Date: _____ Time: _____ Assessment Taken By: _____

Caller's Name: _____ Agency (if applicable) _____

Address: _____

Relationship to Patient: _____ County _____ Phone# _____

Client's Name: _____ Age: _____ D.O.B.: _____

Client's Address: _____ Phone# (H) _____ (W) _____

Current Residence(if other than above) _____ Phone# _____

Sex: M F Marital Status: M S W D Sep. Employer: _____ Address: _____

SS #: _____ Client Pregnant? No Yes If Yes, how many months? _____

Are you a veteran? No Yes _____

SOURCE OF AWARENESS - HOW DID YOU HEAR ABOUT US?

- Phone Book Radio Word of Mouth _____
 Physician _____ Other _____

SUBSTANCE ABUSE HISTORY

1.) Information obtained from: Client Other _____

2.) Why do you want treatment now? (Why now? What is going on?) _____

3.) Are you currently using drugs? Yes No Are you currently using alcohol? Yes No

4.) Recent Drug History: In the last 6 months have you used?

Alcohol daily Amount _____ 3-5 x/wk wkends Last Use _____ 1-8 x/month less than 1x/month Drink(s) of Choice _____

Cocaine daily Amount _____ 3-5 x/wk wkends Last Use _____ 1-8 x/month less than 1x/month Route _____

Heroin daily Amount _____ 3-5 x/wk wkends Last Use _____ 1-8 x/month less than 1x/month Route _____

Marijuana daily Amount _____ 3-5 x/wk wkends Last Use _____ 1-8 x/month less than 1x/month

Client's Name: _____

Opiates

_____ daily 3-5 x/wk wkends 1-8 x/month 1-8 x/month
Amount _____ Last Use _____ Route _____

Benzos

_____ daily 3-5 x/wk wkends 1-8 x/month 1-8 x/month
Amount _____ Last Use _____ Route _____

_____ daily 3-5 x/wk wkends 1-8 x/month 1-8 x/month
Amount _____ Last Use _____ Route _____

_____ daily 3-5 x/wk wkends 1-8 x/month 1-8 x/month
Amount _____ Last Use _____ Route _____

5.)What is your drug of choice:_____

6.)How many years have you been using alcohol?_____ Drugs?_____

7.)How long have you been using at this level?_____

8.)Have you ever tried to quit in the past?_____ How many times?_____

Longest time you quit _____

9.)In the last 6 months what is the longest period of time you have gone without using drugs or alcohol?_____

10.)Previous inpatient treatment for drug/alcohol problems? Yes No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FOR HOW LONG?

11.)Have you ever had prior outpatient treatment for drug/alcohol problems? Yes No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FOR HOW LONG?

Client's Name: _____

12.)Have you attended AA or NA or other support group? Yes No

MEDICAL HISTORY

1.)When you stop drinking or using have you experienced any of the following?

- tremors hallucinations audio/visual/tactile seizures agitation nausea/vomiting blackouts
- delirium tremors insomnia sweats irritability mood swings muscle aches
- other _____

2.) Have you ever been diagnosed with any of the following conditions?

- high blood pressure cirrhosis hepatitis liver disease diabetes tuberculosis
- heart problems _____ coronary artery disease pancreatitis breathing problems _____
- difficulty walking GI bleeding renal failure inability to take oral meds
- other medical conditions _____

3.)Have you been hospitalized for any of these conditions? Which ones? _____

4.)Do you have any disabilities, limitations or special needs? Yes No If yes, explain them:

5.)Medical Doctor: _____ Ph# _____ Last Seen: _____

6.) What prescribed medicines are you currently taking ? None

NAME	DOSE	FREQUENCY	LAST TAKEN	REASON FOR

7.)Are you allergic to any medications? _____

Any Foods? _____ Other? _____

8.) Have you ever been diagnosed with a eating disorder? _____

If yes, please explain. _____

8a.) Do you feel your eating habits are healthy? _____

Client's Name: _____

PSYCHIATRIC HISTORY

1.)Have you ever seen a psychiatrist or currently under the care of one now? Yes No If yes, please identify the name and date of psychiatrist: _____

2.)Have you ever been treated or hospitalized for any psychiatric problems? Yes No If yes, when, where, what for and for how long? _____

3.)Are you currently depressed? Yes No If yes, do you have any of the following symptoms:
 recent wt loss or gain (how much _____) insomnia sleeping all the time fatigue loss of energy
 feelings or worthlessness excessive guilt diminished ability to think or concentrate
 other symptoms described _____

4.)Are you currently suicidal? Yes No If yes, do you have a plan? Yes No If yes, what is the plan? _____

5.)Have you ever had suicidal thoughts? Yes No If yes, when? _____
Any past attempts? Yes No If yes, when and how? _____

6.)Have you ever displayed violent behavior? Yes No If yes, describe _____

7.)Any homicidal thoughts? Yes No If yes, describe _____

LEGAL INFORMATION

1.)Have you ever had any legal problems related to use of alcohol or drugs? (i.e., DUI, assault, burglary, theft)
 Yes No If yes, describe _____

2.)Any current legal charges pending? Yes No If yes, explain _____

3.)Have you ever been charged or convicted of Domestic Violence or Assaults or violent behaviors?
 Yes No If yes, explain:

4.)Are you currently on Probation or Parole? Yes No If yes, list conviction(s) _____

5.)Any scheduled hearing dates? _____

OTHER

1.)What areas (other than remaining sober) would you like to work on while living here? _____

2.)Are you currently in a significant relationship? Yes No If yes, explain. _____

Client's Name: _____

3.) Do you have children? Yes No Do you claim them on your Federal Tax Return? Yes No

If yes, how many and what ages? _____

4.) Describe your family and your relationship with them: _____

5.) What is the last grade you completed in school? _____

6.) How long would you like to live here if accepted? _____

7.) Have you ever lived in or been interviewed for placement at another halfway house? Yes No

If yes, where and when? _____

8.) If accepted, how would you pay the \$300 a month residency fees required to stay here? _____

OFFICE USE ONLY

Recommended for Residency _____ Yes _____ No Anticipated Admission Date _____

By: _____

Staff Signature

Admission Date _____

Approved by _____

Patrice M. Pooler, Executive Director

