Follman Agency

A treatment and assessment agency, certified by the State of Washington,
will prepare an Alcohol and/or Drug Assessment.

Court Ordered SUD Assessment

1. I have had NO prior Assessment for this offense except as noted below:
   _____
2. I understand that failure to reveal prior evaluations and/or to give permission for exchange of information among evaluation agencies will prohibit the current agency from providing evaluative services necessary to prepare the Alcohol/Drug Assessment.
3. I voluntarily consent to receive services for treatment and I agree to fulfill my financial obligations.

Signed: _____ Date _____

Initials of evaluating counselor: _____ Date: _____

How did you hear about our agency? _____

Please Print

Name			**Date**
Street Address			**Suite/Apt #**
City	**State**		**Zip Code**
Phone	**Email address**	**Age**	**Date of birth (m/d/y)**
Name of person with whom you live			**Relationship**
Name of person to call in an emergency	**Phone**		**Relationship**
Street Address			**Suite/Apt #**
City	**State**		**Zip Code**
Name of person completing this form (if not client)			
Name of referring or responsible physician/clinician			
Street Address			**Suite/Apt #**
City	**State**		**Zip Code**
Phone			

Follman Agency

A treatment and assessment agency, certified by the State of Washington,
will prepare an Alcohol and/or Drug Assessment.

Race		
☐ Caucasian	☐ African American	☐ Asian American
☐ Hispanic	☐ Native American	☐ Other

Residence		
☐ House	☐ Apartment	☐ Room
☐ Dormitory	☐ Hotel	☐ Other

Gender		
☐ Female	☐ Male	☐ Fluid
☐ Transgender	☐ Two-Spirit	☐ Other

Education (please specify highest level completed)	
High School Diploma ☐Yes ☐No	If No, highest year completed: ☐6th ☐7th ☐8th ☐9th ☐10th ☐11th
College Diploma ☐Yes ☐No	If Yes, Degree completed: ☐Associates ☐Bachelors ☐Masters ☐ Doctorate
If No, How many years completed: ☐less than 1 year ☐1 year ☐2 years ☐3 years ☐4 years	

Marital Status		
☐ Never married	☐ Married	☐ Living cooperatively
☐ Divorced	☐ Separated	☐ Marriage annulled
☐ Widow/Widower	☐ Other	
If married how many times:	☐1 ☐2 ☐3 ☐4 or more	
If divorced how many times:	☐1 ☐2 ☐3 ☐4 or more	

Occupation		
Occupation:		Length of Employment:
Employer:		

Follman Agency

A treatment and assessment agency, certified by the State of Washington,
will prepare an Alcohol and/or Drug Assessment.

Religion/ Spirituality		
☐ Protestant	☐ Catholic	☐ Jewish
☐ Muslim	☐ Buddhists	☐ Other

Family of Origin's Relgion:_____

Are you a spiritual individual? ☐Yes ☐ No

What do you draw faith from_____

Primary Language		
☐ English	☐ Spanish	☐ Russian
☐ French	☐ Mandarin	☐ Other

Veteran Status		
Military Service ☐Yes ☐No	Combat Service ☐Yes ☐No	Honorable Discharge ☐Yes ☐No
Branch:	Serve: From to	Highest Rank:
Combat Location:		Demotions ☐Yes ☐No
PTSD Diagnosis: ☐Yes ☐No	Prior PTSD Treatment: ☐Yes ☐No	Eligible for VA Benefits: ☐Yes ☐No
If yes, When and Where:		

Follman Agency

A treatment and assessment agency, certified by the State of Washington,
will prepare an Alcohol and/or Drug Assessment.

Legal
It this assessment suggested by anyone connected to the legal system: ☐Yes ☐No
If yes, Whom
Court ordered Mental Health or Chemical Dependency treatment: ☐Yes ☐No
Currently under supervision of the Department of Corrections: ☐Yes ☐No
If yes, CCO Name:
There is a court order exempting the individual participant from reporting requirements: ☐Yes ☐No
If yes, a copy of the court order must be included in the record if the participant claims exemption from reporting requirements.

Legal			
Current Legal Charge:			
Court:			Case #
BAC:	Offense:		Date of Offense:
Probation Officer:			Contact:
Outstanding Warrants: ☐Yes ☐No If yes, what and when:			
Past Convictions: ☐Yes ☐No			
Charge	**Date of Charge**	**Court**	**Final Outcome**
Name of Attorney:		**Attorney's Contact:**	
Attorney's Address:			

Self and Family Illness History

Indicate S=self, F=family, or B=both if there is any history in your family of:

	Diabetes		Obesity		Allergies		
	Gout		High blood fats		Stroke		
	Cancer of _____		Heart trouble		Alcoholism		
	Sleep disorder		Fatty liver		Anemia		
	Chronic depression		Ulcers		Recurrent trauma		
	Digestive illness		Peripheral neuropathy		Seizures		
	Esophageal reflux		cirrhosis		Fainting		
	Head ache or Migraine		Heartburn or gastritis		Hepatitis		
	Night sweats		Numbness in fingers or toes		Recurrent diarrhea		
	Shaking		Weight loss or gain		TB		

Statement of Present Health

Your statement of present health: **Excellent** **Good** **Fair/Poor** (explain)
Please explain: _____

Are you experiencing any sleep difficulties? **No** **Yes** (specify) Mild Moderate Severe
Please explain: _____

Do you take nonprescription drugs routinely? **No** **Yes** (specify)
Please specify: _____

Do you take prescription drugs routinely? **No** **Yes** (specify)
Please specify: _____

Do you exercise regularly? **No** **Yes** If so, how often?

When was the last time you visited a physician? **Date**

Is there any likelihood of a current pregnancy? **No** **Yes**

Are you under the care of a physician now? **No** **Yes** (specify)
Please specify: _____

What is your: Height _____ Weight _____ Usual blood pressure high low normal (circle one)

History of surgery:
Type(s)_____Date(s)_____

Name_____ Date_____ public (\\fs1) (P) SUD revised 4-20-17

MENTAL HEALTH

Are you currently receiving services as a mental health center or seeing a private practitioner? Y N
If Yes, where and when? _____

Have you ever received mental health counseling or psychiatric treatment? Y N
If yes, where and when? _____

Are you currently using medications for mental health reasons? Y N
If yes, What? _____

Is there a family history of mental illness? Y N
If yes, Please explain: _____

Have you had a significant period (not the direct result of alcohol/drug use) where you experienced any of the following? (check all boxes that apply)

	Anxiousness		Sleep Disturbances		Phobias/paranoia/ delusions		Anorexia
	Bulimia		Hallucinations		Serious depression		Hostility/Violence
	Referral to Mental Health		Grief and Loss Issues		Inability to comprehend		Loss of Appetite
	Hopelessness		Moodiness		Feeling Withdrawn		Decreased Energy
	Self-destructive Thoughts/or Self Harm		Giving Away Valuable Possessions		Sleeplessness		Taking Unnecessary Risks

Have you ever attempted suicide? Y N
If yes, when and where?

Do you have suicidal thoughts? Y N
If yes, explain most recent thoughts. _____

Is there any kind of physical, emotional or sexual abuse where you live? Y N
If yes, please explain. _____

Are you at risk of being abused? Y N
If yes, please explain.

Have you ever been abused physically, emotionally, or sexually? Y N
If yes, please explain. _____

Do you have a history of violence toward others? Y N
If yes, please explain. _____

ALCOHOL AND DRUG USE HISTORY

Check All Drugs Used	Age at First Use	Age When Regular Use Began	Average Number of Times Used Each Week	Average Amount Used Each Time	Usual Way Used (Oral, Smoked, IV, Snorted or IM)	Date of Last Use	Period of Heaviest Use
Caffeine							
Nicotine							
Beer							
Wine							
Liquor							
Marijuana							
Cocaine							
Amphetamines							
Tranquilizers							
Opiates							
Hallucinogens							
Inhalants							
Steroids							
OTC							
Other Substances							

Name_____ **Date**_____

ALCOHOL USE HISTORY

Have you ever used alcohol ? No Yes If no, leave the next three pages blank.

1. Have you ever tried to stop using alcohol? No Yes If yes, explain why you tried to stop.

   _____

2. If yes, how many times have you attempted to stop using alcohol? _____(number)

3. Have you ever tried to limit or reduce your alcohol intake? No Yes If yes, how did you limit your use?

   _____

4. How often do you feel an urge or craving to use alcohol? (circle one): Never Weekly Monthly Dai

5. If urges to use alcohol occur, rate the severity of the urge/craving. (circle one): Mild Moderate Severe

6. When do the urges occur? (circle all that pertain): Morning Afternoon Evening

7. When does the urge to use alcohol occur? _____

8. Do you feel a need to use alcohol when you are: (circle any descriptor that applies):
   Angry Depressed Lonely Happy Anxious With friends At a party Other All descriptors

9. How difficult is it to resist an urge to use alcohol? (circle one): Easy to resist, Difficult to resist, Impossible to resist

10. Has your alcohol use pattern interfered with your ability to perform at any of the following?
    (circle all that apply): Work, School, My responsibilities at home, Other _____

11. How many days per week do you use alcohol? ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4-5 ☐ 5-6 ☐ daily

12. When using alcohol, how many hours per week do you spend using?_____ hours

13. When using alcohol, how much time passes between your first drink to your last? _____

14. How often do you drink more than you originally intended? ☐ never ☐ seldom ☐ often ☐ most often

15. How many hours per week or month do you spend recovering from using alcohol? ___per week ___per month

16. Has your use of alcohol interfered with your personal life? ☐ yes ☐ no Professional life? ☐ yes ☐ no
    If yes to either, please explain: _____

17. Why are you using alcohol?

- ☐ relief from a painful memory
- ☐ relief from anxiety
- ☐ enjoyment
- ☐ like the taste
- ☐ to escape
- ☐ relief from self-consciousness
- ☐ relief from stress from _____
- ☐ while socializing
- ☐ while celebrating
- ☐ to relax
- ☐ other, please explain: _____

_____

18. Have you ever felt helpless or hopeless about your consumption? ☐ yes ☐ no

19. Do you still have the same interests/hobbies or have these changed over the years? No Yes

20. What is your idea of fun activities _____

21. Do you still participate in these activities? No Yes If no, explain

_____

22. Have you ever avoided or opted out of situations where alcohol is not encouraged? No Yes

If yes, explain _____

23. Have you ever missed work or school due to alcohol use? No Yes

24. How often have you used alcohol and driven an automobile or some other activity that is potentially dangerous?

(circle one): Never Rarely Once a year Often Weekly Monthly Repeatedly

25. How often do you feel guilty about your alcohol use? Never Rarely Frequently Daily

26. Have you ever used alcohol even though you told yourself you would not use alcohol? No Yes

27. Have you ever felt frustration about your alcohol use pattern? No Yes

28. Have you continued to use alcohol even though it has caused problems with your health? No Yes

29. Have you continued to use alcohol despite problems with work? No Yes

30. Have you continued to use alcohol despite problems with your relationships? No Yes

31. Have you continued to use alcohol despite promises to others not to use alcohol? No Yes

32. Have you lied to others about how much alcohol you consume? No Yes If yes, explain _____

33. Do you regret your decision to use alcohol (wished you had never used alcohol)? No Yes If yes, explain _____

34. Have you continued to use alcohol despite legal problems associated to alcohol? No Yes

Do you believe you would be healthier if you stopped using alcohol? No Yes If yes, explain _____

35. Has your alcohol use pattern affected your reputation? No Yes If yes, explain _____

36. How has alcohol use interfered with your ambitions/goals? _____

37. If you continue to use alcohol, do you believe you will fulfill your life goals? No Yes If no, explain _____

38. How many drinks did it take to become intoxicated when you were just beginning to use alcohol? _____

39. Over your lifetime, has your tolerance to alcohol: (circle one): Increased Decreased Remained Stable

40. Do you believe your ability to function normally (physically or psychologically) after using alcohol is: (circle one) Impaired Not Impaired

41. Currently, how many drinks does it take to become intoxicated? _____ (number)

42. Have you noticed you can drink more or less alcohol than you used to? (circle one) More Less

43. After using alcohol, a few hours later up to a few days later, have you experienced any of the following: (circle all that pertain) Sweating Insomnia High Pulse Hand Tremor Nausea Vomiting Anxiety Tension Seizures

44. Do you think your alcohol use is a problem? No Yes Unsure

DRUG USE HISTORY

Have you ever used drugs ? No Yes If no, leave the next four pages blank.

1. What drug do you prefer?

   _____

2. How old were you the first time you used?_____

3. Where do you typically use the drug?
   (circle all that pertain) My Home Private Residence Bar Tavern Restaurant

4. Who do you use the drug with?
   (circle all that pertain) Spouse Friends Acquaintances Family Members

5. What is the date of your last drug use?_____

6. When you use the drug, how many doses do you plan to use? _____(number)

7. How often do you use less of the drug than you intended?
   (circle one) Never Often Rarely Routinely

8. How often do you consume more of the drug than you intended?
   (circle one) Never Often Rarely Routinely

9. What percentage of the time do you use the drug without becoming intoxicated?
   %_____

10. What percentage of the time when you use the drug, do you become intoxicated?
    %_____

11. How much time elapses when you use the drug? Hours_____

12. How often do you use the drug for a longer period of time than you intended?
    %_____of the time

13. Have you ever used the drug over an eight hour period? No Yes

Name_____ Date _____ public (\\fs1) (P) SUD revised 4-20-17

DRUG USE HISTORY (CONT)

14. When you use this drug do you? (circle one) Intend to become intoxicated
    Not intend to become intoxicated Become intoxicated without thinking about it
    Have no plans to become intoxicated

15. Do you have rules for using the drug? No Yes
    If yes, why did you develop these rules? (circle all that apply) Limit my intake Avoid a DUI Reduce problems associated with the drug
    Other_____
    _____

16. When using the drug, do you have a preset limit? No Yes

17. When using the drug, how often do you exceed the preset limit? %_____of the time

18. Have you ever tried to stop using the drug? No Yes
    If yes, explain why you tried to stop
    _____
    _____

19. If yes, how many times have attempted to stop using this drug?
    _____(number)

20. Have you ever tried to limit or reduce your drug use? No Yes
    If yes, how did you limit the
    use?_____
    _____

21. How many days per week or month do you use the drug?
    Number of times per week_____ Number of times per month_____

22. How many hours per week or month do you spend using the drug?
    Number of hours per week_____ Number of hours per month_____

23. How many hours per week are spent recovering from using the drug? _____(number)

24. How often do you feel an urge or craving to use the drug?
    (circle one) Never Weekly Monthly Daily

DRUG USE HISTORY (CONT)

25. If urges to use the drug occur, rate the severity of the urge/craving:
    (circle one) Mild Moderate Severe

26. When do the urges occur? (circle all that pertain) Morning Afternoon Evening

27. Do you feel a need to use the drug when you are (circle any descriptor that applies):
    Angry Depressed Lonely Happy Anxious With friends At a party Other
    All of the above

28. How difficult is it to resist an urge to use this drug?
    (circle one) Easy to resist Difficult to resist Impossible to resist

29. Has your drug use pattern interfered with your ability to perform at any of the following?
    (circle all that pertain): Work School My responsibilities at home
    Other_____

30. Has your drug use pattern affected your relationship with others? (example: arguing with spouse or boss) No Yes
    If yes, explain _____
    _____

31. Do you still have the same interests/hobbies or have these changed over the years?
    No Yes

32. What is your idea of fun activities?
    _____

33. Can you still do these activities? No Yes
    If no, explain _____

34. Have you ever avoided or opted out of situations where drug use is not encouraged?

35. No Yes If yes, explain_____
    _____
    _____

36. Have you ever missed work or school due to drug use? No Yes

DRUG USE HISTORY (CONT)

37. How often have you used this drug and driven an automobile or some other activity that is potentially dangerous?
    (circle one): Never Rarely Once a year Often Weekly Monthly Repeatedly

38. How often do you feel guilty about your drug use?
    (circle one): Never Rarely Frequently Daily

39. Have you ever used the drug even though you told yourself you would not use it?
    No Yes

40. Have you ever felt frustration about your drug use pattern/history? No Yes

41. Have you continued to use drugs even though it has caused problems with your health?
    No Yes

42. Have you continued to use this drug despite problems with work? No Yes

43. Have you continued to use the drug despite problems with your relationships? No Yes

44. Have you continued to use the drug despite promises to others not to use it? No Yes

45. Have you ever had to apologize for your behavior when using the drug? No Yes

46. Do you regret your decision to use the drug (wished you had never used it)? No Yes
    If yes, explain _____
    _____
    _____
    _____

47. Have you continued to use the drug despite legal problems associated with it? No Yes

48. Do you believe you would be healthier if you stop using? No Yes
    If yes, explain _____
    _____
    _____
    _____

DRUG USE HISTORY (CONT)

49. Has your drug use pattern affected your reputation? No Yes
    If yes, explain _____
    _____

50. Have you lied to others about how much of the drug you use? No Yes

51. Has your drug use pattern interfered with your ambitions/goals? No Yes
    If yes, explain _____
    _____
    _____

52. If you continue to use this drug, do you believe you will fulfill your life goals? No Yes
    If no, explain _____
    _____
    _____

53. How many doses does it take to become intoxicated when you were just beginning to use the drug? _____(number)

54. Currently, how many doses of the drug does it take to become intoxicated?
    _____(number)

55. Have you noticed you can use more or less of the drug than you used to? More Less

56. After using the drug, a few hours later up to a few days later, have you experienced any of the following?
    (circle all that pertain) Sweating Insomnia High pulse Hand tremor Nausea Vomiting Anxiety Tension Seizures

57. How do you use the drug? (circle all that pertain) Smoke Inhale Inject Drink Eat Other_____

58. Any history of a drug overdose? No Yes If yes, how many overdoses?_____(number)

Gambling Supplemental Questions Form

Have you ever gambled? No Yes If no, leave this page blank

1. In the last twelve months:

   Have there been periods when you needed to gamble with increasing amount of money or with larger bets than before to get the same feeling of excitement?
   Yes _____ No _____

   Have you continued to gamble despite adverse consequences that have affected your finances, family relationships, work, or other parts of your life?
   Yes _____ No _____

   Have you lied to family members, friends, or others about how much you gamble?
   Yes _____ No _____

   Have there been periods lasting two weeks or longer when you spent a lot of time thinking about your gambling experiences or planning future gambling ventures or bets?
   Yes _____ No _____

   Have you tried but not succeeded in stopping, cutting down, or controlling your gambling behavior?
   Yes _____ No _____

2. In the last twelve months have you contemplated or attempted suicide?
   Yes _____ No _____

   Have you contemplated or attempted to do physical harm to another person?
   Yes _____ No _____

3. In the past 30 days, how many days have you played (enter quantity):

   Bingo _____
   Internet gambling _____
   Card Games (non-Casino) _____
   Casino table games _____
   Dice games, dominoes _____
   Horses, dogs _____
   Sports _____
   Gambling and substance use in the same day _____
   Bowl, pool, golf, or other games of skill _____
   Lottery, numbers, instant tickets (scratch-offs) ____
   Other forms of gambling _____
   Play slots, poker machines, video lottery terminals _
   Gambling more than you can afford _____
   Stock options, commodities _____

4. In the past 30 days:
   How much money would you say you spent per week on gambling? $_____
   Number of gambling episodes per week _____

Name_____ **Date**_____ **public (\\fs1) (P) SUD revised 4-20-17**

NOTICE OF PRIVACY PRACTICES

FOLLMAN AGENCY 910 S. ANACORTES STREET, BURLINGTON, WA, 98233

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

As part of our professional practice, we maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. **Protected Health Information (PHI)** is information about you, including demographic information, that may identify you or be used to identify you. PHI relates to your past, present, and future physical, mental or health or conditions, the provision of health care, services, or the past, present and future payment for the provision of health care.

Your Rights Regarding Your PHI

The following are your rights regarding PHI we maintain about you:

- **Right to Access to Inspect and Copy**. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies
- **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request a copy of the required accounting of disclosures we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restricting or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication**. You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not as why you are making the request.
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right of Complaint.** You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

Our Use and Disclosures of PHI for Treatment, Payment and Health Care Operations

- **Treatment.** We may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, we may disclose your PHI to other current providers, and to the extent you have not raised an objection in writing, to your prior providers or other persons, including family members, involved in your care.
- **Payment.** We may use your PHI in connection with billing statements we send you and our system for tracking charges and credits to your account. In addition, but with your authorization, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and to disclose PHI for medical necessity and quality assurance review.
- **Health Care Operations.** We may use and disclose your PHI for the Health Care Operations of our professional practice in support of the functions of treatment and payments. Such disclosures would be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal or financial services to assist us in our delivery of your health care.

Other Uses and Disclosures that Do Not Require Your Authorization or Opportunity to Object Required by Law

We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and

limited to the relevant requirements of the law. Examples are: public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigations of death. We also make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

- **Health Oversight.** We may disclose your PHI to a health oversight agency for activities authorized by law, such as our professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to us (such as third-party payers).

- **Threat to Health or Safety.** We may disclose your PHI when necessary to minimize an imminent danger to health or safety of you or any other individual.

- **Appointment Reminders**. We may disclose your PHI contact you to remind you of your appointment with us.

- **Business Associated.** We may disclose your PHI to Business Associates that are contracted by us to perform health care operations or payment activities on our behalf which may involve their collection, and use or disclosure of your PHI. Our contact with them must require them to safeguard the privacy of your PHI.

Compulsory Process

We will disclose your PHI if a court of competent jurisdiction issues an appropriate order. We will also disclose your PHI if:

- We and you have each been notified in writing at least 14 days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid our compliance.

- No qualified judicial or administrative proactive order has been obtained.

- We have received satisfactory assurances that your received notice of an opportunity to have limited or quashed the discovery demand, and such time has elapsed.

Use and Disclosures of PHI with Your Written Authorization

We will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we must submit subsequent claim(s) for payment.

This Notice

This notice of Privacy Practices informs you how we may use and disclose your PHI and your rights regarding PHI. We are required by law to maintain the privacy of your PHI and to provide you with notice of your legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of the Notice. We reserve the right to change the terms of our Notice at any time. Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice by providing a copy upon request, or at our next appointment. **If you have questions about this Notice of Privacy Practices, please contact our Privacy Officer. Kathy Follman, Follman Agency, 910 S. Anacortes Street, Burlington, WA 98233 (360) 755-1125.**

Complaints

If you believe we have violated your privacy rights, you may file a complaint in writing to us, as specified on the first page of this No tice. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

Acknowledgment

I hereby acknowledge reviewing and receiving a copy of this notice.

_____ _____

(Client Signature) Date)

The effective date of this notice is August 20, 2003.

READINESS TO CHANGE QUESTIONNAIRE IOP ONLY

Please read the sentences below carefully. For each one, please check the answer that best describes how you feel **at this time** about your **AOD (alcohol and other drugs)**. Your answers will be private and confidential.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. *My AOD use is okay as it is	☐	☐	☐	☐	☐
2. ^I am trying use AOD less than I used to	☐	☐	☐	☐	☐
3. #I enjoy my AOD use but sometimes I drink/drug too much	☐	☐	☐	☐	☐
4. #I should cut down on my AOD use	☐	☐	☐	☐	☐
5. *It's a waste of time thinking about my AOD use	☐	☐	☐	☐	☐
6. ^I have just recently changed my AOD habits	☐	☐	☐	☐	☐
7. ^Anyone can talk about wanting to do something about AOD use, but I am actually doing something about it	☐	☐	☐	☐	☐
8. #I am at the stage where I should think about less AOD use	☐	☐	☐	☐	☐
9. #My AOD use is a problem	☐	☐	☐	☐	☐
10. *It's alright for me to keep using AOD as I do now	☐	☐	☐	☐	☐
11. ^I am actually changing my AOD habits now	☐	☐	☐	☐	☐
12. *My life would still be the same, even if I used AOD less	☐	☐	☐	☐	☐

Scoring the readiness to change questionnaire

The precontemplation items are numbers 1,5,10 and 12. The contemplation items are numbers 3, 4, 8 and 9. The Action items are numbers 2, 6, 7 and 11. All items are to be scored on a 5-point rating scale ranging from:

-2 Strongly disagree
-1 Disagree
0 Unsure
+1 Agree
+2 Strongly agree

To calculate the score for each scale, simply add the item scores for the scale in question. The range of each scale is -8 through 0 to +8. A negative score reflects an overall disagreement with items measuring the stage of change, whereas a positive score represents overall agreement. The highest score represents the Stage of Change Designation.

Note: If two scale scores are equal, then the scale further along the continuum of change (precontemplation, contemplation, action) represents the subject's Stage of Change Designation. For example, if a subject scores 6 on the Precontemplation scale, 6 on the Contemplation scale and -2 on the Action scale, then the subject is assigned to the Contemplation stage.

Note that positive scores on the Precontemplation scale signify a lack of readiness to change. To obtain a score for Precontemplation that represents the subject's degree of readiness to change, comparable to scores on the Contemplation and Action scales simply reverse the sign of the Precontemplation score (see below)

If one of the four items on a scale is missing, the subject's score for that scale should be prorated (ie multiplied by 1.33). If two or more items are missing, the scale score cannot be calculated. In this case the Stage of Change Designation will be invalid.

Stage of Change designation

*Precontemplation score	_____	Precontemplation	_____	(reverse score)
#Contemplation score	_____	Contemplation	_____	(same score)
^Action score	_____	Action	_____	(same score)

Name _____ **Date** _____ **public (\\fs1) (P) SUD revised 4-20-17**

MICHIGAN ALCOHOL SCREENING TEST

Please answer each of the following questions:

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

Client Signature _____ **Date:** _____

Counselor Signature: _____ **Date:** _____

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

Stages of Change Readiness and Treatment Eagerness Scale (Socrates 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking and/or drugging. For each statement, place a check mark in the box that best describes your agreement with the statement **at this time.** Please check one and only one box for every statement.

Please Circle if you are here for alcohol, drugs, or both:

Alcohol Drugs Both

	NO! Strongly Disagree	NO Disagree	? Undecided or Unsure	Yes Agree	Yes! Strongly Agree
1. I really want to make, or have made changes in my drinking/drug use.					
2. Sometimes I wonder if, or I already know, I am addicted to alcohol/drugs.					
3. If I don't change, or if I hadn't changed, my drinking/drugging, problems are/were going to get worse.					
4. I have already started making some changes in my drinking/drugging.					
5. I was drinking/drugging too much at one time, but I've managed to change my drinking/drugging.					
6. Sometimes I wonder, or I already know, if my drinking/drugging is hurting people.					
7. I am, or used to be, a problem drinker/drug user.					
8. I'm not just thinking about changing my drinking/drugging, I'm already doing something about it.					
9. I have already changed my drinking/drugging, and I am looking for ways to keep from slipping back to my old pattern.					
10. I have, or have had, serious problems with drinking/drugging.					
11. Sometimes, I wonder, or have wondered, if I am in control of my drinking/drugging.					

Name_____ **Date** _____ **public (\\fs1) (P) SUD revised 9-6-17**

	NO! Strongly Disagree	NO Disagree	? Undecided or Unsure	Yes Agree	Yes! Strongly Agree
12. My drinking/drugging is causing, or has caused a lot of harm.					
13. I am actively doing things now to cut down, stop, or abstain from drinking/drugging.					
14. I want help to keep from going back to the drinking/drugging problems that I had before.					
15. I know that I have a drinking/drugging problem.					
16. There are, or have been times when I wonder if I drink or drug too much.					
17. I am an alcoholic/drug addict.					
18. I am working hard to change, or have changed, my drinking/drugging.					
19. I have made some changes in my drinking/drugging, and I want some help to keep from going back to the way I used to drink.					

SOCRATES SCORING FORM

Transfer the client's answers from questionnaire.

Recognition	Ambivalence	Taking Steps
1	2	4
3	6	5
7	11	8
10	16	9
12		13
15		14
17		18
		19
Totals		
Range 7-35	4-20	8-40

THE ALCOHOL USE DISORDER IDENTIFICATION TEST: INTERVIEW VERSION

1. How often do you have a drink containing alcohol?
   - (0) Never (Skip to questions 9-10)
   - (1) Monthly or less
   - (2) 2-4 times a month
   - (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - (0) (1 or 2)
   - (1) (3 or 4)
   - (2) (5 or 6)
   - (3) (7, 8, or 9)
   - (4) (10 or more)

3. How often do you have 6 or more drinks on one occasion?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

   Skip to questions 9 and 10 if Total Score or questions 2 and 3 =0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of your drinking?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - (0) Never
   - (1) Less than monthly
   - (2) Monthly
   - (3) Weekly
   - (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   - (0) No
   - (2) Yes, but not in the last year
   - (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health care worker been concerned about your drinking or suggested you cut down?
    - (0) No
    - (2) Yes, but not in the last year
    - (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

Name _____ Date _____ Public (\\fs1) (P) SUD created 4-27-17

If additional information arises where this Evaluation changes to a Child Custody Evaluation, additional charges will apply. Follman Agency's private pay rate for a Child Custody Evaluation is $750.00. Child Custody Evaluations are not billed to an Insurance Company. Payment is expected in full before the Evaluation is sent to the appropriate Courts/Attorney/Probation Officer/ Child Protection Services and/or Guardian Ad Litem. By signing below, I agree I have read this clause and understand payment will be due in full.

_____ _____

Patient Signature Date

_____

Patient Printed Name

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____

authorize the **FOLLMAN AGENCY**, 910 S. Anacortes Street, Burlington, WA 98233 to receive and/or disclose to:

_____

(Name) NAME OF ATTORNEY (Address) (Phone/Fax)

For the purpose of : **To Enable open communication and exchange of information**

I understand that my records are protected under Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160& 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it (e.g. probation, parole, etc) and that in any event this consent expires automatically as described:

Authorization expires after the following action takes place: 90 Days Post Discharge
(Specification of the date, event or condition upon which this expires)

I request the following information to be release: (Client's initials required next to check mark ☐)

☐ _____ Knowledge that I am a client at this agency (friends, relatives)
☐ _____ Diagnostic impression, symptomology, evaluation results, and recommendations
☐ _____ Drinking/drug use history and intake information
☐ _____ Copies of Court Ordered Treatment Plan and/or Probation Records
☐ _____ Abstinence status, progress reports, attendance records
☐ _____ Results of Urinalysis or Breathalyzer test(s)
☐ _____ Discharge Summary and Aftercare plans
☐ _____ Compliance with A/DIS requirements
☐ _____ Other (specify) _____

The information will be released in the following form(s):
☐ Written ☐ Verbal ☐ Audio ☐ Video ☐ Electronic (including Fax) ☐ Other _____

Notice: Prohibition or Re-Disclosure prohibits you from making further disclosure of information given above (42 CFR Part 2).
I understand that generally this agency may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Executed this _____ day of _____ 20____

_____ _____
Staff Signature Client Signature

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL

FOLLMAN AGENCY
910 South Anacortes Street
Burlington, WA 98233
(360) 755-1125 ♦ Fax (360) 757-1125

I, _____
(Name of Defendant)

hereby consent to communication between FOLLMAN AGENCY and

_____
Court. Prosecutor. Probation. Parole and/or Other Referring Agency

The purpose of, and need for, this disclosure is to:

To enable the treatment provider to communicate to the criminal justice system agency listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, continuing care plan referrals, and prognosis.

I understand that this consent will remain in effect and cannot be revoked by me until:

There has been a formal and effective termination or revocation of my release from confinement, probation, parole or other proceeding under which I was mandated into treatment.

The information will be released in the following form(s):
[X] Written [X] Verbal [X] Audio [ ] Video [X] Electronic (including fax) [ ] Other_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and recipients of this information may re-disclose it only in connection with their official duties.

_____ _____ _____
Defendant/Client Signature | Signature of parent. guardian or Authorized representative if required | Date

AUTHORIZATION TO RELEASE COURT RECORDS

1. DEFENDANT'S NAME: *(Please Print)*

_____

First Name Middle Name Last Name

authorizes

Follman Agency (Requestor) to obtain copies of defendant's court records and files in the state of Washington, whether in paper or electronic format, including any municipal court, district court, superior court and juvenile court records and files, and including a compilation of defendant's records and files, such as the defendant's criminal history record.

2. DEFENDANT'S DATE OF BIRTH: _____

3. DEFENDANT'S ADDRESS IS: _____

4. DEFENDANT'S DRIVER'S LICENSE # OR STATE ID#: _____

5. This authorization shall be valid for one (1) year from the date of the DEFENDANT'S signature herein. A photocopy of this authorization shall be as valid as the original.

6. REQUESTOR acknowledges that the court providing records pursuant to this authorization makes no representations as to the accuracy and completeness of the date except for court purposes.

7. REQUESTOR acknowledges that the court may request payment of costs prior to transmitting the requested records and files.

_____ _____

DEFENDANT'S SIGNATURE DATE SIGNED