FOLLMAN COUNSELING AGENCY

910 S. ANACORTES ST., BURLINGTON, WA 98233 TEL: 360-755-1125 FAX: 360-757-1125
EMAIL: FRONTDESK@FOLLMANAGENCY.COM

SUBSTANCE USE DISORDER ASSESSMENT

I have had NO prior Assessment except as notated here: _____

I understand failure to reveal prior Assessment and/or to give permission for exchange of information among evaluation agencies will prohibit the current agency from providing evaluation services necessary to prepare the Alcohol/Drug Assessment.

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.

I voluntarily consent to receive services for treatment and agree to fulfill my Financial Obligation

Signed: _____ **Date:** _____

Initials of Evaluating Counselor: _____ **Date:** _____

How did you hear about our agency? (Please Print) _____

Patient Name: _____	Patient Birthdate: _____
Patient Street Adress: _____	Patient Cell Phone: _____
City: _____ State: _____ Zip: _____	Patient Home Phone: _____
Patient Driver's License Number: _____ Patient Email Address: _____	Patient Last 4 of Social Security Number: _____
Name of person with whom you live: _____	Relationship (i.e., wife/parents/friend): _____
Name of person to call in an emergency and their address: Name: _____ Address: _____	Emergency Phone/Cell Number: Home Phone: _____ Cell Phone: _____
Patient Marital Status: _____	Name of person completing this form (if not patient): _____
Patient Occupation: _____	Patient Work Phone No: _____
Patient Work Address: _____	State: _____ Zip: _____
Name of referring or responsible Physician/Clinician: _____	Would you like Follman Agency to communicate to your referring Physician/Clinician: __ Yes __ No If yes, please sign Release of Information
Address of referring or responsible Physician/Clinician: City: _____ State: _____ Zip: _____	Phone: _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE USE DISORDER ASSESSMENT

Patient's Name: _____ **Date:** _____

Please check those that apply: RACE

Caucasian __	African American __	Asian American __
Hispanic __	Native American __	Other __

Please check those that apply: RELIGION

Protestant __	Catholic __	Jewish __
Muslim __	Hindu __	Other __

Please check those that apply: RESIDENCE

House __	Apartment __	Room __
Dormitory __	Hotel __	Hospital __
Other __	Friend __	Roommate __

Please check those that apply: EDUCATION (highest level completed)

High School	9th	10th	11th	Diploma	GED	Other
	__	__	__	__	__	__

College/University/Graduate School	AA	BA	BS	MA/MS	MBA	PhD	Other
	__	__	__	__	__	__	__

Veteran Status (Please check and complete)

Military Service	Yes __ No __	Branch: _____	Highest Rank: _____
Honorable Discharge	Yes __ No __	From: _____ To: _____	Demotions: Yes __ No __
Combat Service	Yes __ No __	Drink or Use in Military: Yes __ No __	
PTSD DX	Yes __ No __	Combat Location: _____	
Prior PTSD Treatment	Yes __ No __	Where: _____	When: _____
VA Eligibility	Yes __ No __	Where: _____	When: _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE USE DISORDER ASSESSMENT

Patient's Name: _____ **Date:** _____

Self and Family Illness History

Indicate: S = Self F = Family B = Both if there is any history in your family of:

S/F/B	SYMPTOM	S/F/B	SYMPTOM	S/F/B	SYMPTOM
__	Diabetes	__	Obesity	__	Allergies
__	Gout	__	High Blood Pressure	__	Stroke
__	Cancer of _____	__	Heart Trouble	__	Alcoholism
__	Sleep Disorder	__	Fatty Liver	__	Anemia
__	Chronic Depression	__	Ulcers	__	Recurrent Trauma
__	Digestive Illness	__	Cirrhosis	__	Seizures
__	Esophageal Reflux	__	Heartburn/Gastritis	__	Fainting
__	Headache/Migraines	__	Numbness in fingers/toes	__	Hepatitis
__	Night Sweats	__	Weight Loss/Gain	__	Recurrent Diarrhea

Statement of Present Health (Please check and Complete)

	Yes	No	
Your Statement of present health: Do you feel you are healthy?	__	__	How do you rate your current health? (Check One): __ Excellent __ Moderate __Mild __Fair __Poor __Severe Please Explain: _____
Are you experiencing any sleep difficulties?	__	__	If yes, please specify: _____
Do you take nonprescription drugs routinely?	__	__	If yes, please specify: _____
Do you take prescription drugs routinely?	__	__	If yes, please specify: _____
Do you exercise regularly?	__	__	If yes, how often: _____
Is there any likelihood of a current pregnancy?	__	__	If yes, expected due date: _____
Are you under the care of a Physician now?	__	__	If yes, please specify: _____

When was the last time you visited a Physician? _____ Usual blood pressure: ___ high ___ low ___ normal	Were there any concerns? _____
History of surgery(s): Type(s): _____	Date(s): _____
History of surgery(s): Type(s): Cont'd: _____	Date(s): _____

FOLLMAN COUNSELING AGENCY
SUBSTANCE USE DISORDER ASSESSMENT

Patient's Name: _____ **Date:** _____ **Page 4**

Legal Issues (If this section is not applicable, leave blank) ___ Check if you are Self-Referred

Please Check One. If yes, please explain:
Is this assessment prompted or suggested by anyone connected to the legal system? ___ No ___ Yes If yes, who? _____
Are you currently under the supervision of the Department of Corrections? ___ No ___ Yes If yes, CCO name: _____
Are you under civil or criminal court ordered mental health or chemical dependency treatment? ___ No ___ Yes If yes, please explain: _____
There is a court order exempting the individual participant from reporting requirements. ___ No ___ Yes If yes, a copy of the court order must be included in the record if the participant claims exemption from reporting requirements.
Current Legal Problem: _____ Date of Offense: _____
Court: _____ Judge: _____ Case #: _____ BAC: _____
Name of Attorney: _____ Phone No: _____ Fax No: _____
Attorney's Address: _____
Probation Officer: _____ Phone No: _____ Fax No: _____
Do you have your driving record with you today? ___ No ___ Yes ___ Not applicable: _____
Outstanding Warrants? ___ No ___ Yes If yes, what, and when? _____ _____ _____

Past Convictions? ___ No ___ Yes If yes, please list below:

CHARGE	DATE	COURT	FINAL OUTCOME	BAL

Patient's Name: _____ **Date:** _____ **Page 5**

READINESS TO CHANGE QUESTIONNAIRE

Please read the sentences carefully. For each one, please check the answer that best describes how you feel at the present time about your AOD (alcohol/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 to use AOD less than I use 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 is 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 doing something about it. #	—	—	—	—	—
8. I am at the stage where I should think about less about AOD use. %	—	—	—	—	—
9. My AOD use is a problem. %	—	—	—	—	—
10. It is alright for me to keep using AOD as I do now. *	—	—	—	—	—
11. I am changing my AOD habits now. #	—	—	—	—	—
12. My life would still be the same, even if I used AOD less. *	—	—	—	—	—

Key:

Precontemplation: 1,5,10,12
Contemplation: 3,4,8,9
Action: 2,6,7,11

Stage of Change Designation:

Precontemplation Score: _____ Precontemplation: _____ (reverse score)
Contemplation Score: _____ Contemplation: _____ (same score)
Action Score: _____ Action: _____ (same score)

Patient's Name: _____ **Date:** _____ **Page 6**

STAGES OF CHANGE READINESS AND TREATMENT EAGERNESS SCALE

(SOCRATES 8A) PAGE 1

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way you might (or might not) feel about your drinking and/or drug use. For each statement, check the box that indicates how much you agree or disagree **with the right now/present time**. Please check only one number for every statement (item).

Drug of Choice: Alcohol: ___ or Drugs: ___ or Both: ___

	NO. Strongly Disagree	NO Disagree	Undecided or Unsure	YES Agree	YES Strongly Agree
1. I really want to make changes in my drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
2. Sometimes I wonder if I am an alcoholic.	1 ___	2 ___	3 ___	4 ___	5 ___
3. If I do not change my drinking soon, my problems are going to get worse.	1 ___	2 ___	3 ___	4 ___	5 ___
4. I have already started making some changes in my drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
5. I was drinking too much at one time, but I have managed to change my drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
6. Sometimes I wonder if my drinking is hurting other people.	1 ___	2 ___	3 ___	4 ___	5 ___
7. I am a problem drinker.	1 ___	2 ___	3 ___	4 ___	5 ___
8. I am not just thinking about changing my drinking, I am already doing something about it.	1 ___	2 ___	3 ___	4 ___	5 ___
9. I have already changed my drinking and I am looking for ways to keep from slipping back to my old pattern.	1 ___	2 ___	3 ___	4 ___	5 ___
10. I have serious problems with drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
11. Sometimes I wonder if I am in control of my drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
12. My drinking is causing a lot of harm.	1 ___	2 ___	3 ___	4 ___	5 ___
13. I am actively doing things now to cut down or stop drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
14. I want help to keep from going back to drinking problems that I had before.	1 ___	2 ___	3 ___	4 ___	5 ___
15. I know that I have a drinking problem.	1 ___	2 ___	3 ___	4 ___	5 ___
16. There are times when I wonder if I drink too much.	1 ___	2 ___	3 ___	4 ___	5 ___
17. I am an alcoholic.	1 ___	2 ___	3 ___	4 ___	5 ___
18. I am working hard to change my drinking.	1 ___	2 ___	3 ___	4 ___	5 ___
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1 ___	2 ___	3 ___	4 ___	5 ___

Patient's Name: _____ **Date:** _____ **Page 7**

STAGES OF CHANGE READINESS AND TREATMENT EAGERNESS SCALE

(SOCRATES 8A) CONTINUED – PAGE 2

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:		
POSSIBLE RANGE:		
7-35	4-20	8-40

Patient's Name: _____ **Date:** _____ **Page 8**

Age: _____ Sex: ___ Male ___ Female

DSM – 5 SELF-RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE - ADULT

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____

In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, check the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0___	1___	2___	3___	4___	
	2. Feeling down, depressed, or hopeless?	0___	1___	2___	3___	4___	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0___	1___	2___	3___	4___	
III.	4. Sleeping less than usual, but still have a lot of energy?	0___	1___	2___	3___	4___	
	5. Starting lots more projects than usual or doing more risky things than usual?	0___	1___	2___	3___	4___	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0___	1___	2___	3___	4___	
	7. Feeling panic or being frightened?	0___	1___	2___	3___	4___	
	8. Avoiding situations that make you anxious?	0___	1___	2___	3___	4___	
V.	9. Unexplained aches and pains (e.g., back, joints, abdomen, legs)?	0___	1___	2___	3___	4___	
	10. Feeling that your illnesses are not being taken seriously enough?	0___	1___	2___	3___	4___	
VI.	11. Thoughts of hurting yourself?	0___	1___	2___	3___	4___	
VII.	12. Hearing things other people could not hear, such as voices even when no one was around?	0___	1___	2___	3___	4___	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0___	1___	2___	3___	4___	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0___	1___	2___	3___	4___	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0___	1___	2___	3___	4___	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0___	1___	2___	3___	4___	
	17. Feeling driven to perform certain behaviors or mental acts repeatedly?	0___	1___	2___	3___	4___	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0___	1___	2___	3___	4___	
XII.	19. Not knowing who you really are or what you want out of life?	0___	1___	2___	3___	4___	
	20. Not feeling close to other people or enjoying your relationships with them?	0___	1___	2___	3___	4___	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0___	1___	2___	3___	4___	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0___	1___	2___	3___	4___	
	23. Using any of the following medicines ON YOUR OWN, that is without a doctor's prescription, in the greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	0___	1___	2___	3___	4___	

Patient's Name: _____ **Date:** _____ **Page 9**

ALCOHOL USE HISTORY

Page 1

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 _____
2. If yes to question 1, 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? (Check One):
   ___ Never ___ Weekly ___ Monthly ___ Daily
5. If urges to use alcohol occur, rate the severity of the urge/craving. (Check One):
   ___ Mild ___ Moderate ___Severe
6. When do the urges occur? (Check One): ___ Morning ___ Afternoon ___ Evening
7. When does the urge to use alcohol occur? _____
8. Do you feel a need to use alcohol when you are: (Check all descriptors 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? (Check 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? (Check 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

ALCOHOL USE HISTORY
Page 2

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

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

17. Why are you using alcohol? ___ relief from a painful memory ___ relief from anxiety ____ enjoyment
    ___ relief from self-consciousness ___ relief from stress ___ like the taste ___ to escape
    ___ while socializing ___ while celebrating ___ to relax ___Other (please explain) _____

18. Have you ever felt helpless or hopeless about your consumption? ___ No ___ Yes

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, please explain:
    _____

22. Have you ever avoided or opted out of situations where alcohol is not encouraged? ___ No ___ Yes
    If yes, please 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? (Check 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 relationship? ___ No ___ Yes

ALCOHOL USE HISTORY
Page 3

31. Have you lied to others about how much alcohol you consume? ___ No ___ Yes If yes, please explain: _____

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

33. 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, please explain: _____

34. Has your alcohol use pattern affected your reputation? ___ No ___ Yes If yes, please explain: _____

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

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

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

38. Over your lifetime, has your tolerance to alcohol: (Check One): ___ Increased ___ Decreased ___ Remained ___ Stable

39. Do you believe your ability to function normally (physically and psychologically) after using alcohol is: (Check One): ___ Impaired ___ Not Impaired

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

41. Have you noticed you can drink more or less alcohol than you used to? (Check One): ___ More ___ Less

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

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

Patient's Name: _____ **Date:** _____

THE ALCOHOL USE DISORDER IDENTIFICATION TEST INTERVIEW

1. How often do you have a drink containing alcohol?	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 – Skip to questions 9-10	• (0) Never
• (1) Monthly or less	• (1) Less than monthly
• (2) 2-4 times a month	• (2) Monthly
• (4) 4 or more times a week	• (3) Weekly
TOTAL SCORE:	• (4) Daily or almost daily
	TOTAL SCORE
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	7. How often during the last year have you had a feeling of guilt or remorse after drinking?
• (0) 1 or 2	• (0) Never
• (1) 3 or 4	• (1) Less than monthly
• (2) 5 or 6	• (2) Monthly
• (3) 7, 8 or 9	• (3) Weekly
• (4) 10 or more	• (4) Daily or almost daily
TOTAL SCORE:	**TOTAL SCORE**
3. How often do you have 6 or more drinks on one occasion?	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	• (0) Never
• (1) Less than monthly	• (1) Less than monthly
• (2) Monthly	• (2) Monthly
• (3) Weekly	• (3) Weekly
• (4) Daily or almost daily	• (4) Daily or almost daily
Skip to question 9 and 10 if Total Score or questions 2 and 3 = 0	**TOTAL SCORE:**
TOTAL SCORE:	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	9. Have you or someone else been injured as a result of your drinking?
• (0) Never	• (0) No
• (1) Less than Monthly	• (2) Yes, but not in the last year
• (2) Monthly	• (4) Yes, during the last year
• (3) Weekly	**TOTAL SCORE:**
• (4) Daily or almost daily	
TOTAL SCORE:	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	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) Never	• (0) No
• (1) Less than Monthly	• (2) Yes, but not in the last year
• (2) Monthly	• (4) Yes, during the last year
• (3) Weekly	**TOTAL SCORE:**
• (4) Daily or almost daily	
TOTAL SCORE:	**RECORD TOTAL SCORE HERE:**

MICHIGAN ALCOHOL SCREENING TEST

Please check yes or no to each of the following questions. Your answers will be private and confidential.

	YES	NO
1. Do you feel like a normal drinker?	___	___
2. Have you ever awakened in the morning after drinking the night before and found that you could not remember part of the evening before?	___	___
3. Does your spouse, partner or parents ever worry or complain about your drinking?	___	___
4. Can you stop drinking without struggle, after one or two drinks?	___	___
5. Do you ever feel bad about your drinking?	___	___
6. Do friends or relatives think you are a normal drinker?	___	___
7. Do you ever try to limit your drinking to certain times a day or to certain places?	___	___
8. Are you always able to stop drinking when you want to?	___	___
9. Have you ever attended a meeting of AA?	___	___
10. Have you gotten into fights when drinking?	___	___
11. Has your drinking ever created problems between you and your spouse?	___	___
12. Has your wife, husband, family members ever gone to anyone for help about your drinking?	___	___
13. Have you ever lost friends, girlfriends/boyfriends because of your drinking?	___	___
14. Have you ever gotten into trouble at work because of your drinking?	___	___
15. Have you ever lost a job because of your drinking?	___	___
16. Have you ever neglected your obligations, your family, or your work for two or more days in row because of your drinking?	___	___
17. Do you ever drink before noon?	___	___
18. Have you ever been told you have liver trouble?	___	___
19. Have you ever had delirium tremors, severe shaking, heard voices or seen things that were not really there after heaving drinking?	___	___
20. Have you ever gone to anyone for help about your drinking?	___	___
21. Have you ever been hospitalized because of your drinking?	___	___
22. Have you ever been a patient in a psychiatric hospital or in a psychiatric ward of a general hospital where drinking was part of the problem?	___	___
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?	___	___
24. Have you ever been arrested, even for a few hours, because of drunken behavior?	___	___
25. Have you ever been arrested for drunk driving or driving after drinking?	___	___

Patient's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

ALCOHOL AND DRUG USE HISTORY

Check all Alcohol/Drug Use History and proceed with entering remaining information.

	Check	Age at First Use	Age When Regular Use Began	Avg No of Times Used Each Week	Avg Amount Used Each Time	Usual Way Used (Oral,Smoked,IV Snorted,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	___	___	___	___	_____	_____	_____	_____

Patient's Name: _____ **Date:** _____

DRUG SCREENING QUESTIONNAIRE (DAST)

Using drugs can affect your heath and some medications you may take. Please help us provide you with the best medical care by answering the questions below. Your answers will be private and confidential. Please **check** the following drugs you have recently used or used in the past:

	Check	How often: Monthly or less	How often: Weekly	How often: Daily or Almost Daily
Methamphetamine (speed, crystal)	__	_____	_____	_____
Cannabis (marijuana, pot)	__	_____	_____	_____
Inhalants (paint thinner, aerosol, glue	__	_____	_____	_____
Tranquilizers (valium)	__	_____	_____	_____
Cocaine	__	_____	_____	_____
Narcotics (heroin, oxycodone, methadone, etc.)	__	_____	_____	_____
Hallucinogens (LSD, mushrooms)	__	_____	_____	_____
Other: _____	__	_____	_____	_____

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

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

	Never	Currently	In the Past
Have you ever been in treatment for Substance Abuse? Please Check	__	__	__

Patient's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

DRUG USE HISTORY

Page 1

Have you ever used Drugs? _____ No _____ Yes. **If NO, leave the next four pages BLANK**. Your answers will be private and confidential.

1. What drug(s) do you prefer? _____

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

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

4. Who do you use the drug with? (Check 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 much do you plan to use? _____

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

8. How often do you consume more of the drug than you intended? (Check 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

14. When you use this drug do you? (Check all that apply)
    ___ 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? (Check 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

Patient's Name: _____ **Date:** _____

DRUG USE HISTORY

Page 2

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, please explain why you tried to stop _____

19. Also, if Yes to Question 18, how many times have you attempted to stop using the 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? (Check One)
___ Never ___ Weekly ___ Monthly ___ Daily

25. If urges to use the drug occur, rate the severity of the urge craving: (Check One)
___ Mild ___ Moderate ___ Severe

26. When do the urges occur: (Check all that pertain): ___ Morning ___ Afternoon ___ Night

27. Do you feel a need to use the drug when you are (Check 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? (Check 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: (Check 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):
___ Yes ___ No. If yes, please 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: _____

Patient's Name: _____ **Date:** _____ **Page 17**

DRUG USE HISTORY

Page 3

34. Have you ever avoided or opted out of situations where drug use is not encouraged? ___ No ___ Yes

35. Please explain your answer to question 34: _____

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

37. How often have you used this drug and driven an automobile or some other activity that is potentially Dangerous? (Check One) ___ Never ___ Rarely ___ Once a Year ___ ___ Often ___ Weekly ___ Monthly ___ Repeatedly

38. How often do you feel guilty about your drug use? (Check 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 promises to others not to use it? ___ No ___ Yes

44. Have you continued to use the drug despite problems with your relationships? ___ 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: _____
_____

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 _____

Patient's Name: _____ **Date:** _____ **Page 18**

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? ___

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?
(Check all that pertain) ___ Sweating ___ Insomnia ___ High Pulse ___ Nausea
___ Hand Tremor ___ Vomiting Anxiety ___ Tension ___ Seizures

57. How do you use the drug? (Check all that pertain) ___ Smoke ___ Inhale
___ Inject ___ Drink ___ Eat ___ Other

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

MENTAL HEALTH SURVEY

Are you currently receiving services at a Mental Health Center or seeing a Private Practitioner? ___ No ___ Yes

Have you ever received Mental Health Counseling or Psychiatric Treatment: ___ No ___ Yes

Is yes, where, and when? _____

_____

Are you currently using medications for mental health reasons? ___ No ___ Yes

If yes, What? _____

Is there a family history of mental illness? ___ No ___ Yes

If yes, please explain _____

_____

Have you ever attempted suicide? ___ No ___ Yes

If yes, When and Where? _____

Do you have suicidal thoughts? ___ No ___ Yes

If yes, explain most recent thoughts: _____

_____

Is there any kind of physical, emotional, or sexual abuse where you live? ___ No ___ Yes

If yes, please explain _____

_____

Are you at risk of being abused: ___ No ___ Yes

If yes, please explain _____

_____

Have you ever been abused physically, emotionally, or sexually? ___ No ___ Yes

If yes, please explain _____

_____

Do you have a history of violence toward others? ___ No ___ Yes

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 ___	Hopelessness ___	Sleep Disturbances ___	Phobias/Paranoia/Delusions ___	Inability to Comprehend ___
Bulimia ___	Moodiness ___	Hallucinations ___	Serious Depression ___	Feeling Withdrawn ___
Referral to Mental Health ___	Self-Destructive Thoughts of Self Harm ___	Giving away Valuable Possessions ___	Sleepiness ___	Anorexia ___
Hostility/Violence ___	Loss of Appetite ___	Decreased Energy ___	Taking Unnecessary Risks ___	Grief/Loss Issues ___

Patient's Name: _____ **Date:** _____

GAMBLING SUPPLEMENTAL QUESTINNAIRE FORM

	Check Box - Yes	Check Box - No
Have you ever gambled? If No, **LEAVE THIS PAGE BLANK**	___	___
	___	___
In the past twelve months:	___	___
Have there been periods when you needed to gamble with increasing amounts of money or with larger bets than before to get the same feeling of excitement?	___	___
	___	___
Have you continued to gamble despite adverse consequences that have affected your finances, family relationships, work, or other parts of your life?	___	___
	___	___
Have you lied to family members, friends, or others about how much you gamble?	___	___
	___	___
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?	___	___
	___	___
Have you tried but not succeeded in stopping, cutting down, or controlling your gambling behavior?	___	___
	___	___
In the last twelve months have you contemplated or attempted suicide?	___	___
	___	___
Have you contemplated or attempted to do physical harm to another person?	___	___

In the Past 30 days, how many days have you played (Enter Quantity)	
Bingo ___	Gambling and Substance Use in the Same Day ___
Internet Gambling ___	Bowl, Pool, Golf or Other Games of Skill ___
Card Games (non-Casino) ___	Lottery, Numbers, Instant Tickets (Scratch-Offs) ___
Casino Table Games ___	Other Forms of Gambling ___
Dice Games, Dominoes ___	Play Slots, Poker Machines, Video Lottery Terminals ___
Horses, Dogs ___	Gambling More than You Can Afford ___
Sports ___	Stock Options, Commodities ___

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

NOTICE OF PRIVACY PRACTICES (Page 1)

FOLLMAN COUNSELING 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 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. 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 ask 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 who 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 to contact you to remind you of your appointment with us.

NOTICE OF PRIVACY PRACTICES (Page 2)

FOLLMAN COUNSELING 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.

- **Business Associated.** We may disclose your PHI to Business Associates who 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:

- You and we 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 you 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 your next appointment.

CONTACT INFORMATION

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 Notice. 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.

Acknowledgement: I hereby acknowledge reviewing and receiving a copy of this Notice.

_____ _____

Patient's Signature **Date**

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) (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 released: (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
☒ _____ 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____

X _____ X _____

Staff Signature Client Signature

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

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