**Alcohol and Drug Services of Gallatin County BioPsychoSocial**

Thank you for completing this form. Please take your time and complete **all** questions/areas to the best of your ability. Incomplete, missing, unclear, false, or misleading information on the form will delay the assessment process. If you need assistance, please ask. (If a question does not apply to you, please write “N/A.”)

## DATE: INTERVIEW DATE:

**COUNSELOR:**

**NAME:**

**(Last) (First) (Middle) Maiden**

Birth Date: Age: Gender: Female Male Other Social Security Number: Montana Resident? Yes No

Race & Ethnic Background: Tribal Affiliation:

Referred to ADSGC by: Reason for Referral:

Offense Docket # Judge Court Offense Docket # Judge Court

Have you been in a controlled environment in the last 30 days?

No Jail Alcohol/Drug Treatment Medical Treatment Psychiatric Treatment Other

If “yes”, please explain:

## Alcohol and Drug History (ASAM D.1)

Have you used any alcohol/other drugs in the past two weeks? NO YES If "yes" please indicate the following:

## What? How Much? Last used?

Have you ever experienced any kind of withdrawal symptoms after stopping alcohol/other drug use? NO YES

If "yes", when:

Following the use of which chemicals did you experience withdrawal symptoms?

How long did the symptoms last?

Did you need or receive medical attention? NO YES If so, what kind?

Have you used alcohol/other drugs until you have passed out or had a “black out”?

NO

YES

If "yes", when:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are you currently feeling physically ill because of your alcohol/other drug use? | | | | NO | YES |
| If "yes", what are your symptoms now? | | | | | |
| Have you overdosed on alcohol/other drugs? | | NO | YES |  |  |
| If "yes", when: | | | | | |
| Were you hospitalized as a result? | NO | YES |  |  |  |
| If "yes", when and where: | | | | | |
| Have you been detoxified in a hospital or other setting from alcohol/other drugs? | | | | NO | YES |
| If "yes", when and where: |  |  | |  |  |
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|  |  | **Counselor Comments** | |  |  |

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| **Medical History (ASAM D2)** |  |  |  |  |  |  |  |  |  |
| Do you have a primary care provider? |  |  |  | NO |  | YES | | | |
| If no, do you need one? |  |  |  | NO |  | YES | | | |
| Provider’s Name and Phone Number: |  |  | | | | | | | |
| Date of your most recent physical exa |  | : | | | | | | | |
| Findings? | | | | | | | | | |
| Do you have any current medical/health issues? | | | | | | NO |  |  | YES |
| If "yes", please explain: |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Do you have any history of head injuries? NO YES  If "yes", please explain: | | | | | | | | | |
| Are you or do you suspect that you are pregnant? | | | | | | NO |  |  | YES |
| If "yes", when your due date? | | | | | | | | | |
| Name of provider overseeing pregnancy: | | | | | | | | | |
| Are you currently taking medications? |  |  |  | NO |  | YE | S |  |  |
| If "yes", please list all of the medications (and dose) that you are currently taking: | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| Do you have any allergies? NO YES | | | | | | | | | |
| If "yes", please explain: | | | | | | | | | |

Do you have a disability? NO YES

If "yes", please indicate by checking the following: Reading Learning Psychiatric

Physical Other

If Other, please explain:

Have you ever needed reasonable accommodation for the above? NO YES

If "yes", please explain:

|  |  |  |
| --- | --- | --- |
| Have you been hospitalized for any medical reasons in the past? | NO | YES |
| If "yes", please explain (when, where, condition?): |  |  |

|  |  |  |
| --- | --- | --- |
| Have you ever been tested for HIV or Hepatitis C? | NO | YES |
| If "yes", please explain (date, results?) |  |  |

**Counselor Comments**

## Mental Health (ASAM D3)

Have you ever been diagnosed with a mental health disorder?

NO YES

NO YES

If "yes", please explain:

Have you ever been referred for mental health counseling or seen a mental health therapist/counselor? NO YES

If "yes", please list when and where services were received (and providers):

Do you have any current mental health symptoms? NO YES

If "yes", please describe

Have you ever been hospitalized for psychiatric reasons? NO YES

If "yes", please explain:

Have you experienced any traumatic events? NO YES

If "yes", please describe:

Have you experienced any significant losses? NO YES

If "yes", please describe:

Have you ever been abused (physical, emotional, sexual)? NO YES

If "yes", please describe:

|  |  |  |
| --- | --- | --- |
| Have you ever experienced any emotional problems associated with your sexual interests, your  sexual activities, or your choice of sexual partner? | NO | YES |
| If "yes", please describe: |  |  |

Do you gamble? NO YES

|  |  |  |
| --- | --- | --- |
| Have you ever been treated for an eating disorder? | NO | YES |
| If "yes", please describe: |  |  |

If "yes", please describe:

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| --- | --- | --- | --- | --- |
| If “yes”, have you ever lost considerable sums of money through gambling or had problems at  work, in school, with your family and friends as a result of your gambling? | | | NO | YES |
| If "yes", please explain: |  |  |  |  |
| Have you ever attended counseling for gambling? | NO | YES |  |  |
| If "yes", when: |  |  |  |  |

Have you ever been a victim of a violent or non-violent crime? NO YES

If "yes", please explain:

Have you ever engaged in violent or combative behavior? NO YES

If "yes", please explain:

Have you ever had thoughts of harming someone else? NO YES

If "yes", please explain:

Have you caused harm to yourself (i.e., cutting, burning, oxygen deprivation, etc.)? NO YES

If "yes", please describe how and when this occurred:

Have you ever had suicidal thoughts? NO YES At any time, did those thoughts include a plan? NO YES

If "yes", please give specifics:

Have you made any suicide attempts? NO YES

If "yes", please list when and how:

Do you have a family history of mental illness? NO YES

If "yes", when:

**Counselor Comments**

## Treatment Readiness (ASAM D4)

Do you believe you have a problem with alcohol/other drugs? NO YES

How do you define alcoholism/other drug addiction?

Have you ever been diagnosed with a substance use disorder? NO YES

If "yes", by whom and when:

Have you received chemical dependency treatment (either outpatient or inpatient) in the past? NO YES If "yes", please list below:

## Approximate Dates Treatment Agency Outpatient/Inpatient Did You Complete?

Do family members or friends express concerns to you about your alcohol/other drug use? NO YES

If “Yes” what do you think about their concerns?

What negative life consequences or impact has your alcohol/other drugs use caused?

Do you believe you can recover on your own? NO YES

If "yes", please explain:

Are you willing to make changes in your life? NO YES

If "yes", please explain:

What problems/situations do you feel might affect your ability to fully participate in treatment?

Have you been court-ordered to complete treatment? NO YES

If "yes", what court?

Have you been ordered to not use alcohol/other drugs? NO YES

If "yes", by whom and when?

**Counselor Comments**

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| **Relapse Potential (ASAM D5)** |  |  |  |  |  |  |  |  |  |  |
| Have you ever stopped using all alcohol/other drugs before? |  |  |  |  | NO |  |  |  | YES |  |
| If "yes", when and for how long? |  |  |  |  |  |  |  |  |  |  |

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| hat was the longest period of time in which you have neither drank nor used any mood-altering chemicals? | | | | | | |
| n the past 30 days? | In the past six months? | |  | | | |
| f you stopped using alcohol/other drug, what caused you to drink or use again? | | | | | | |
| Do you often find yourself thinking about using alcohol/other drugs? | | | NO | YES |  |  |
| f "yes", please explain: | | | | | | |
| How often do you experience cravings (longing for, looking forward to) lcohol/other drugs? | | | Often | | Sometimes | Never |
| lease describe (what drugs?): |  | | | | | |
| Do you tend to use alcohol/other drugs impulsively (without planning)? | | | NO | YES |  |  |
| f "yes", please explain: | | | | | | |
| Are you able to refuse alcohol/other drugs when offered? | | NO | YES |  |  |  |
| ould you have to avoid certain friends or family members or situations to stay sober? | | | | NO | YES |  |
| f “Yes” how difficult would this be for you? (check one): | | | | | | |
| Not at all | A little bit | Pretty difficult | | I doubt I could do it | |  |
| Are you practicing other addictive behaviors? (i.e., gambling, spending, sexual acting out, masturbation,  pornography, overeating, problem relationships)? NO YES  If "yes", please explain: If you return and/or continue to use what consequences will occur?  **Counselor Comments** | | | | | | |

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## Recovery Environment (ASAM D6)

What are your current living arrangements?

Please describe:

Who do you live with?

Roommates Significant Parents Children Alone Other

Please describe their alcohol/other drug use:

Does your current living situation make it difficult to work on recovery from alcohol/other drugs? NO YES

If "yes", in what ways?

What is your current relationship status?

Married Remarried Widowed Separated Divorced Life Partner Never Married

Are you satisfied with your current relationship status? INDIFFERENT NO YES

If "no", please explain:

If you are in a relationship, how long have you been in the relationship? Has drinking or drugs ever caused issues in your current relationship?

Has drinking or drug use caused issues in ANY past relationships?

|  |
| --- |
| Where do they live? |
| Has DFS been involved? |

**FAMILY OF ORIGIN**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have any children? | NO | YES |  |
| If "yes", how old are they? |  |  |  |

Where did you grow up?

|  |  |  |
| --- | --- | --- |
| Do you have contact with family members? | NO | YES |
| If "yes", who? |  |  |

Describe your relationship with your family:

How would you describe your childhood?

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Did you ever witness any abuse in your household? | NO | YES |
| If "yes", please explain? |  |  |

What recreational activities/hobbies are you interested in?

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| --- | --- | --- |
| Are you aware of any genetic predisposition towards alcoholism or addiction in your family? | NO | YES |
| If "yes", who? |  |  |

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| --- | --- | --- |
| Does your family understand addiction/substance use disorders? | NO | YES |
| Do your important friends understand addiction/substance use disorders? | NO | YES |
| Do your family and friends encourage you to abstain from alcohol/other drugs? | NO | YES |
| Do you have contact with friends or family who do not use alcohol/other drugs? | NO | YES |
| If "yes", who: |  |  |

|  |  |  |
| --- | --- | --- |
| Have any of your recreational activities/hobbies been affected by your drinking and/or use? | NO | YES |
| If "yes", please explain: |  |  |

**LEGAL HISTORY**

## Past Legal Issues:

|  |  |  |
| --- | --- | --- |
| Have you ever been charged with DUI? | NO | YES |
| If "yes", please list location, dates, BAC? |  |  |

|  |  |  |
| --- | --- | --- |
| Have you ever been charged with MDD/PODP? | NO | YES |
| If "yes", please list location, dates? |  |  |

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| --- | --- | --- |
| Have you ever been charged with MIP? | NO | YES |
| If "yes", please list location, dates? |  |  |

|  |  |  |
| --- | --- | --- |
| Do you have ANY other past legal issues? | NO | YES |
| If "yes", please list location, dates? |  |  |

|  |  |  |
| --- | --- | --- |
| Are you presently awaiting charges, trial, or sentencing? | NO | YES |
| If "yes", please list location, dates? |  |  |

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| --- |
| Have you ever been on probation? NO YES  If "yes", please list location, dates? |
| Probation Officer name? |

**EDUCATION**

What is your highest level of education? Are you currently enrolled in college, technical school, or another training program? NO YES

If "yes", please explain:

Are you considering further education or vocational training? NO YES

If "yes", please explain:

Did you ever get suspended, drop out, get expelled or face any other disciplinary actions in school? NO YES

If "yes", please explain:

Did you have any problems, difficulties, or learning disabilities in school? NO YES

If "yes", please explain:

Did you have any issues with substance use while in school? NO YES

If "yes", please explain:

**EMPLOYMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you employed? | NO | YES | Not in Labor Force |
| If "yes", current occupation and Employer: | | |  |

|  |
| --- |
| For how long? |
| If you are unemployed or not in the labor force, why? For how long? |

What is the longest you have held a job in the past (type of job, duration)?

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| --- | --- | --- |
| Have you ever experienced any drug/alcohol related issues with work? | NO | YES |
| If "yes", please explain: |  |  |

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| --- | --- | --- |
| Are you experiencing any financial difficulties at this time? | NO | YES |
| If "yes", please explain: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Have you ever served in the military? | NO | YES |  |
| If “yes”, which branch? | | | |
| Did you ever serve in active combat? | NO | YES |  |
| Type of discharge? | | | |
| Did drug or alcohol use affect your service or discharge? NO YES  If "yes", please explain: | | | |
| Are you eligible for Veteran’s assistance? |  | NO | YES |

Do you have any spiritual/religious beliefs? NO YES

If "yes", please explain:

Has your spiritual practice/orientation been affected by your alcohol/other drug use? NO YES

If "yes", please explain:

|  |  |  |
| --- | --- | --- |
| Have you attended recovery support groups in the community in the past (i.e., AA/NA/GA)? | NO | YES |
| If "yes", please explain: |  |  |
| Are you willing to attend support groups? Please explain: |  |  |

**Counselor Comments**

# Client Signature Date

**Counselor Signature Date**