

NAME:



Client Orientation Packet

By my signature below, I consent to treatment at First Step, acknowledge receipt of this orientation packet, and understand the following policies outlined in the packet:

- **Confidentiality of First Step Clients**
- **Consent for Purposes of Treatment, Payment and Health Care Operations (HIPAA)**
- **Non-Discrimination and Client Rights**
 - **Grievance Procedure**
 - **Rules and Regulations**
 - **Fee Policies**

Patient or Legally Authorized Individual Signature

Date

First Step Witness Signature

Date

NAME:

CONFIDENTIALITY OF FIRST STEP CLIENTS

Your information is protected by Federal Law and regulations (42 CFR Part 2). Generally, we may not disclose to anyone outside our program that you attend the program, or disclose any information identifying you as a client of First Step (or drug or alcohol abuser) unless:

1. You consent in writing
2. The disclosure is allowed by a court order or
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulation do not protect any information about a crime committed by you either at the program or against any person who works for the programs or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected abuse or neglect from being reported under State law to appropriate State or local authorities. First Step is required by law to comply with reporting those who were abused or neglected as children. The purpose is to assist in identifying children who are in need of protection. This will be discussed first with you and a decision will be made if there is sufficient information to make a report.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by **First Step, Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **First Step, Inc.**

I understand that diagnosis or treatment of me by **First Step, Inc.** may be conditioned upon my consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **First Step, Inc.** is not required to agree to the restrictions that I may

NAME:

request. However, if **First Step, Inc.** agrees to a restriction that I request, the restriction is binding on **First Step, Inc.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **First Step, Inc.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my clinician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **First Step, Inc.**'s Notice of Privacy Practices prior to signing this document.

The **First Step, Inc.**'s Notice of Privacy Practices has been made available or provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **First Step, Inc.**

The Notice of Privacy Practices for **First Step, Inc.** is also provided as a posting at each office of **First Step Inc.** and on the **First Step, Inc.** web site at www.firststepmd.com.

This Notice of Privacy Practices also describes my rights and the duties of **First Step Inc.** with respect to my protected health information.

First Step, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

NAME:

NON-DISCRIMINATION & CLIENT RIGHTS

As a client of First Step, you have the right to:

1. Be treated with consideration, respect, and full recognition of your human dignity and individuality.
2. Receive treatment, care and services that are adequate, appropriate and in compliance with relevant state, local and federal laws and regulations without regard to race, color, religion, sex, national origin, age, disability or any other characteristic protected by law.
3. Not be physically or mentally abused by the program staff.
4. Be free from discrimination.
5. Be free from physical restraints.
6. Privacy and confidentiality.
7. Not participate in any experimental research unless fully informed and written consent.

First Step will provide you with a copy of the Client Grievance procedure upon admission. You will be informed, in a timely manner, when revisions are made to the Grievance Policy as to the nature and extent of those revisions. No retaliation will be taken if you present a grievance.

First Step will not discriminate in the provision of services on the basis of race, creed, color, age, gender, sexual orientation, national origin, marital status, disabilities, and any other classification prohibited under State or Federal law.

NAME:

GRIEVANCE PROCEDURE

All persons who receive services from First Step, Inc. have the right to seek resolution when it is believed that there is a grievance involving the staff, procedures or policies of the program. When a problem of this nature arises, you may seek resolution using the following procedures:

- STEP 1: The grievance is discussed with your assigned Counselor.
- STEP 2: If the problem cannot be resolved by the Counselor, you should submit a written appeal to the counselor's supervisor stating the nature of the grievance, the relief sought and the action taken by the Counselor. If you need assistance in preparing this written appeal, it is the Counselor's duty to assist.
- STEP 3: If relief is not found at that level, a written appeal will be forwarded to the Clinical Director.
- STEP 4: The final level of written appeal will be made to the Chief Executive Officer, representing the First Step Board to hear your appeal.

If a staff member is the object of the grievance, that individual will not be allowed to participate in any steps of the grievance procedure. A staff member may have decision making role in only one (1) of the first three (3) steps of the grievance process.

Flagrant violation of First Step's rules, i.e. attacking staff, selling drugs at program site or actions which represent a danger to program staff or other clients will be dealt with by your removal from the program and there will be no grievance.

The Alcohol and Drug Abuse Administration, Department of Juvenile Justice, or other First Step grantees will not be involved in the grievance process except to insure that all steps are followed.

NAME:

RULES AND REGULATIONS

- Strict confidentiality is observed at First Step. What happens at First Step – stays at First Step.
- Fees are payable at each session. Acceptable forms of payment are cash, check, money order and VISA or MasterCard.
- We expect you to attend all sessions and if you are going to miss a session, you must contact your Counselor and give at least 24 hours' notice by calling the office. Two (2) missed sessions in a row without explanation may be grounds for termination.
- Anyone arriving late for a session will not be allowed and if you are more than 10 minutes late for a group, individual or family session (30 minutes for an IOP session) you WILL NOT be allowed to participate and it will be counted as a missed unexcused session. Please arrive 15 minutes prior to the starting time of any session to allow time to check in, pay your fee, etc.
- beepers, cellular phones, and other type of telecommunications devices should be turned off when on the premises. No food or open drinks are to be brought in to the clinician's office or the group room.
- You are not permitted to participate in First Step activities under the influence of drugs and/or alcohol and are not permitted to bring any drugs and/or alcohol on the premises. If you arrive for a session under the influence, a clinician will meet with you and reschedule an appointment time. You may make arrangements for transportation. If you leave and drive while intoxicated, the agency will be required to call the police and report an unsafe driver.
- You may not bring any drugs or medication into the agency to trade or sell. If you are on medication and may need to take it while attending a session – please discuss how to handle this with a counselor.
- Clients are not permitted to smoke in the agency or on the agency premises.
- Physical and/or verbal abuse and/or violence directed at any person on the premises will result in you being asked to leave and an immediate discharge from services.
- Weapons of any kind may not be brought onto the premises.

NAME:

**FIRST STEP
URINE MONITORING CONTRACT**

Providing random urine samples for urinalysis is an important component of your treatment services here at First Step. The guidelines for urinalysis are listed below.

1. You may be asked to provide a random urine sample at any time. If you do not give the specimen when asked, it will be counted as a positive test result. There are no excuses for missed submission of a sample.
2. If you are unable to urinate, drink a glass of water and wait until you can urinate. You will have a one hour grace period.
3. Be sure that the specimen container is labeled with your name and date.
4. The frequency of urinalysis will be based on a clinical decision as determined by your progress in treatment.
5. This contract covers the use of any other alcohol and drug detection methodology that First Step may use at its discretion

I have read and understand the above guidelines and I agree to abide by them.

Signed _____ Date _____

Witnessed _____

NAME:

FEE POLICIES

Thank you for choosing First Step as your behavioral health care provider. We are committed to providing you the best care and service possible. In an environment of rising healthcare costs, we have attempted to contain our costs and fees but we need your assistance. The following is a statement of the policies in effect for our agency.

1. All fees, co-pays and deductibles are due at the time of your visit. If there are extenuating circumstances, please speak with the Office Manager about payment arrangements. First Step accepts cash, checks and Visa/MasterCard.
2. If your insurance changes, please notify us as soon as you know. Behavioral healthcare often requires pre-authorization for services and a delay in notifying us may jeopardize your ability to have insurance cover the cost of services. In the event you notify us after your insurance has changed, you will be responsible for all charges incurred up and until your current insurance allows coverage. We will not backdate or change dates of service.
3. If your insurance lapses or you do not have active coverage, you are responsible for all charges incurred while you are without insurance.
4. To cancel an appointment, you must give 24 hours notice. Your appointment time is reserved for you and we are unable to schedule other people without adequate notice.
5. If you miss two (2) appointments without providing advance notice, you may jeopardize your ability to stay in treatment with us.
6. First Step will not submit forms or paperwork if there is an outstanding balance. If you owe a balance, you may also be asked to make payments prior to being able to have future counseling sessions
7. There may be an administrative fee for completion of forms, letters and other communications regarding your health and treatment. Examples include disability forms, letters to schools/employers or the Courts. We ask that you allow 5-7 work days for form completion. Insurance does not cover these costs.
8. We do not currently charge a fee for telephone calls. Our clinical staff has varying schedules and has limited times to return calls. Please leave times and telephone numbers that you can be reached at. If it is a crisis, please let the person answering the phone know this.
9. **Prescription Refills-** No refill prescriptions will be given for clients who have missed their appointment with the psychiatrist. Please plan ahead. It is your responsibility to make sure you have enough of your prescription between appointments.

NAME:

First Step has a value added service to remind you of your upcoming appointments. We will need your permission to provide this service to you. You are automatically enrolled in this service which will provide you with a reminder call (generally 2 days prior to your appointment) - Please take a moment to make sure we have the correct information below and provide us with your preference for this reminder service below.

_____ Send reminders by telephone to this number _____

_____ Send reminder emails to this email address: _____

_____ Send reminder text message to this number: _____

_____ I would not like to receive any appointment reminders.

Client Signature

Date

NAME:

INFECTIOUS DISEASE INFORMATION

Hepatitis B

Hepatitis B is a liver disease. A virus called the Hepatitis B virus causes Hepatitis B disease.

The following are ways in which you can get Hepatitis B: Having sex with an infected person without using a condom, sharing drug needles, getting a tattoo or body piercing with dirty tools that were used on someone else, getting pricked with a needle that has infected blood on it, or sharing a toothbrush or razor with an infected person. An infected woman can give Hepatitis B to her baby at birth or through her breast milk.

Hepatitis B symptoms can make you feel like you have the flu. You might feel tired, sick to your stomach, have a fever, not want to eat or have stomach pain and have diarrhea. Some people have dark yellow urine, light-colored stools and yellowish eyes and skin. Some people don't have any symptoms.

A doctor can test your blood to see if you have Hepatitis B. You can protect yourself from Hepatitis B by getting a vaccine. You can also protect yourself by using a condom when having sex, not sharing drug needles with anyone, wearing gloves if you have to touch anyone's blood, not using an infected person's toothbrush, razor or anything else that could have blood on it.

AIDS

AIDS is *Acquired Immune Deficiency Syndrome*. Like Hepatitis, AIDS is caused by a virus called the *Human Immunodeficiency Virus or HIV*. HIV attacks a person's immune system and weakens it. The immune system fights against germs and viruses that cause sicknesses and diseases. The immune system eventually becomes so weak that it is unable to fight off infections. Serious illnesses and/or death are the result. There is no cure for AIDS and no way to prevent the destruction of the immune system once a person becomes infected with HIV. AIDS can infect both sexes, and people of all races and ages. The only way to prevent the disease is knowing how not to become infected with HIV.

The virus that causes AIDS or HIV is spread through unprotected sex, sharing needles used for drugs, or having contact with an infected person's blood or body fluids. Symptoms of HIV infection may appear as early as 6 months after being infected with the HIV virus or as late as 10 years. Symptoms of HIV infection include high fever, dry cough, sores and infections that don't go away, fatigue, weakness, unexplained weight loss, diarrhea, and night sweats. Many people who have AIDS do not have any symptoms and do not realize that they have the disease. These people do not realize that they could be infecting other people with the HIV virus.

NAME:

Latex condoms can greatly reduce the risk of contacting HIV infection if used correctly every time a person has sex. If you use drugs, don't share needles or syringes and do not have sex with someone who does share needles and syringes. Take precautions not to have contact with infected blood or other body fluids. Trained health counselors can be reached at 410-887-AIDs to answer questions about AIDS.

Tuberculosis (TB)

Tuberculosis (TB) is a disease that spreads from person to person by going through the air. While TB is primarily a lung disease, it can also affect other parts of the body such as the brain, the kidney, or the spine. The symptoms of TB may include: feeling weak or sick, weight loss, fever, and/or night sweats. Symptoms of TB of the lungs may include cough, chest pain, and/or coughing up blood. Other symptoms depend on the particular part of the body that is infected.

TB infection is different from TB disease. People with TB disease are sick from the germs that are active in their body. They usually have one or more of the symptoms of TB. These people are often capable of giving the infection to others. Permanent body damage and death can result this disease. Doctors can give medicines which can cure TB.

People with TB infection (without the disease) have the germ that causes TB in their body. They are not sick because the germ lies inactive in the body. They cannot spread the germ to others. However, these people may develop TB disease in the future. There are medicines that can be given to these persons that prevent them from getting TB disease.

A skin test can tell if you have the TB disease. You can get a skin test from your doctor or local health department. Other tests, such as x-ray or sputum sample may be needed to see if the person has TB disease. If a person has TB infection or TB disease it is important that they get required follow up tests, follow their doctor's advice, and take medicine as prescribed.

I have read the above information on infectious disease and discussed it with my counselor. I understand those activities which may put me at risk of getting Hepatitis B or HIV infections. I also understand how the TB germ is transmitted from person to person and the importance of getting the necessary treatment if TB infection or TB disease is contacted. I know that I may discuss any questions or concerns I may have about these diseases with my counselor.

Client signature

Date

NAME:

ADDICTIONS TREATMENT TB ASSESSMENT/REFERRAL FORM	
PROGRAM:	
COUNSELOR:	PHONE:
CLIENT NAME:	REFERRAL DATE:
BIRTH DATE:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS:	RACE:
	PHONE:

I. TB HISTORY (U= Unknown)	
1. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Previous history of tuberculosis – Where? _____ When? _____
2. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Previous positive TB skin test- Where? _____ When? _____ (obtain documentation of positive results)
3. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	History of INH preventive therapy Where? _____ When? _____
If answers to questions 1, 2, or 3 are Yes, TB skin test not needed. STOP	
4. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	History of negative TB skin test. Where? _____ When? _____ Retesting may be recommended 1 year following a negative test. Go to Section II.
II. TB RISK ASSESSMENT:	
1. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	HIV Infection
2. <input type="checkbox"/> Y <input type="checkbox"/> N	Injection drug history
3. <input type="checkbox"/> Y <input type="checkbox"/> N	Are you aware of any exposure in last 24 months to someone close to you with active TB?
4. <input type="checkbox"/> Y <input type="checkbox"/> N	Female with crack cocaine history
5. <input type="checkbox"/> Y <input type="checkbox"/> N	Client enrolled in Methadone, Intermediate Care Facility or Therapeutic Community Program
If answer is “No” to 1, 2, 3, and 4, referral is not needed. STOP (Do not complete rest of form). If answer is “Yes” to any of above, go on to Section III.	
III. REFERRAL INFORMATION FOR TB EVALUATION	
Name of TB Clinic: _____	Appt. Date: _____
Address: _____	Phone: _____
Reason for Referral: 1. _____ Client needs a TB skin test.	
2. _____ Client had a positive skin test _____ mm on ___/___/___ and is in need of follow up.	
3. _____ Client meets the criteria for a TB suspect (TB Symptom Checklist) and needs immediate evaluation.	
Comments: _____	

NAME:

<p>IV. FOLLOW-UP REPORT <i>(to be completed by TB Clinic or Program Nurse)</i></p> <ol style="list-style-type: none">1. _____ Client received skin test and had it read Result _____ mm <input type="checkbox"/> Pos <input type="checkbox"/> Neg Date ____/____/____.2. _____ Preventive therapy was initiated on ____/____/____. Next appointment is ____/____/____,3. _____ Treatment for active TB was initiated on ____/____/____. Next appointment is ____/____/____.4. _____ Client had skin test and did not return for reading.5. _____ Client never kept appointment for TB screening. <p>Comments: _____ _____ _____</p> <p>Contact Person: _____ Phone: _____ Date: _____ (TB Clinic: Please send form back to the above addictions program)</p>

Declination Statement: I have been assessed as needing a TB skin test but have chosen not to have one even though I realize that I am at risk of contracting this disease.

Client Signature _____

Date _____

NAME:

FIRST STEP
AIDS/STD RISK ASSESSMENT

Please circle one:

Have you ever participated in IV drug use? YES NO

Have you ever shared needles or works? YES NO

How many different sexual partners have you had? _____

Have you ever had unprotected sex (w/o condoms, gloves, dental dams, etc)? YES NO

Have you ever had sex with another person who is at “high risk” (multiple partners, IV drug users)? YES NO

Have you ever had a sexually transmitted disease? If yes, Please specify _____ . YES NO

Have you ever had a blackout? (A period of time where you Could not remember what you said or did) YES NO

Have you ever used alcohol or other drugs? YES NO

Do you have:

High Stress Level? YES NO

Poor Nutrition? YES NO

Poor Health? YES NO

A tattoo or tattoos? YES NO

A body piercing or piercings? YES NO

Are you pregnant? YES NO

NAME:

TOBACCO INFORMATION

Tobacco is a substance consisting of the dried leaves and stems of the plant *Nicotinia tabacum*, which contains the drug nicotine. This plant is native to North America but is now grown around the world. Nicotine is considered by many to be the most addictive drug in existence and is a powerful nerve stimulant and is extremely toxic. Two to three drops of pure nicotine, if taken all at once are enough to kill the average person.

The use of tobacco can occur in one of several forms but whether smoked, chewed, dipped or snuffed – there is no safe use that does not have severe health consequences.

Smoking has been identified as the single most preventable cause of death and disease in the United States. It has been identified as a leading cause of cancer of all kinds, emphysema, high blood pressure and heart disease as well as a host of other ailments. Environmental smoke (frequently referred to a “second hand smoke”) is also detrimental to health and it has been found that contact with second hand smoke causes a greater incidence of respiratory problems in non-smokers.

Even when not smoked – tobacco use has been linked to gum and oral cancer.

Here are some more quick facts about tobacco use and its consequences:

- Cigarette smoke contains over 4,800 chemicals, 69 of which are known to cause cancer. Smoking is directly responsible for approximately 90 percent of lung cancer deaths and approximately 80-90 percent of COPD (emphysema and chronic bronchitis) deaths.
- About 8.6 million people in the U.S. have at least one serious illness caused by smoking. That means that for every person who dies of a smoking-related disease, there are 20 more people who suffer from at least one serious illness associated with smoking.
- Among current smokers, chronic lung disease accounts for 73 percent of smoking-related conditions. Even among smokers who have quit chronic lung disease accounts for 50 percent of smoking-related conditions.
- The list of diseases caused by smoking includes chronic obstructive pulmonary disease (COPD, including chronic bronchitis and emphysema), coronary heart disease, stroke, abdominal aortic aneurysm, acute myeloid leukemia, cataract, pneumonia, periodontitis, and bladder, esophageal, laryngeal, lung, oral, throat, cervical, kidney, stomach, and pancreatic cancers. Smoking is also a major factor in a variety of other conditions and disorders, including slowed healing of wounds, infertility, and peptic ulcer disease.

NAME:

- Smokers die significantly earlier than nonsmokers: 13.2 years for men and 14.5 years for women.
- In 2009, an estimated 49.9 million adults were former smokers. Of the 46.6 million current adult smokers, 46.7 percent stopped smoking at least 1 day in the preceding year because they were trying to quit smoking completely.
- Nicotine is an addictive drug, which when inhaled in cigarette smoke reaches the brain faster than drugs that enter the body intravenously. Smokers not only become physically addicted to nicotine; they also link smoking with many social activities, making smoking a difficult habit to break.
- Quitting smoking often requires multiple attempts. Using counseling or medication alone increases the chance of a quit attempt being successful; the combination of both is even more effective.
- Nicotine replacement products can help relieve withdrawal symptoms people experience when they quit smoking.
- There are seven medications approved by the FDA to aid in quitting smoking. Nicotine patches, nicotine gum and nicotine lozenges are available over-the-counter, and a nicotine nasal spray and inhaler are currently available by prescription. Bupropion SR (Zyban) and varenicline tartrate (Chantix) are non-nicotine pills.
- Individual, group and telephone counseling are effective. Telephone quitline counseling is widely available and is effective for many different groups of smokers.

First Step encourages all clients to look at their use of tobacco products and to seriously consider ceasing their use of such products. Please talk to your counselor if you would like more information about or a referral to a Smoking Cessation Program.

NAME:

FIRST STEP TREATMENT PROGRAM – RECOMMENDATIONS

✓	Service	Beginning	Times	With
	Social Drinkers Program (2 ind. sessions & 6 weekly groups of 2 hrs) @ \$340			
	Education Group			
	Parent Group			
	Treatment Group			
	Individual Counseling			
	Family Counseling			
	Random Urinalysis			
	Intensive Outpatient Program			
	Buprenorphine			
	Psychiatric Evaluation			
	Medication Management			
	Referred Out			
	No services needed at this time			
	Services offered by refused			
	Undecided about services – will contact us			

Completed by _____ Date _____

For Office Use Only:

_____ Case #: _____

NAME: _____

Family Assessment & Involvement Plan

Do you live with someone who uses drugs or alcohol? _____

Are drugs and alcohol available to you in your home? _____

Who do you usually live with? _____

Are you happy with this? _____

Is there a history of drug use or alcohol abuse in your family? _____

Is there any abuse or neglect in your family? _____

Has your family ever been in treatment before? _____

How much does your sobriety depend on your family's support? Circle one:
0 = not at all, 1 = a little, 2 = somewhat, 3 = a lot

What do you need more from your family? Circle one: space support

Do you want your family involved in your treatment? Y/ N

<input type="checkbox"/> DEFER	Client needs to develop a stable recovery program. While they are doing this - the family will be referred to: Sheppard Pratt's Addictions Educational Series Wednesday 7 – 9 pm Sheppard Pratt Conference Center 410-938-3157
<input type="checkbox"/> REFER	Client is stable in recovery, and family is a significant relapse trigger. Client's family is referred to: _____ _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

NAME:

CRITERIA FOR SUBSTANCE DEPENDENCE

(Write the number of the drug for all that apply)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- _____ (1) tolerance, as defined by either of the following:
- (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - (b) markedly diminished effect with continued use of the same amount of the substance
- _____ (2) withdrawal, as manifested by either of the following:
- (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances).
 - (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
- _____ (3) The substance is often taken in larger amounts or over a longer period than was intended.
- _____ (4) There is a persistent desire or unsuccessful efforts to cut down or control substance use
- _____ (5) a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain smoking, or recover from its effects
- _____ (6) important social, occupational, or recreational activities are given up or reduced because of substance use
- _____ (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

NAME:

CRITERIA FOR SUBSTANCE ABUSE

(Write the number of the drug for all that apply)

- A) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:

_____ (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance related absences, suspensions, or expulsions from school; neglect of children or household).

_____ (2) recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use).

_____ (3) recurrent substance related legal problems (e.g. arrests for substance related disorderly conduct)

_____ (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused by exacerbated by the effects of the substance (e.g. arguments with spouse about consequences or intoxication, physical fights)

- B) The symptoms have never met the criteria for Substance Dependence for this class of substance.

CATEGORIES OF DRUGS

1. Alcohol
2. Amphetamine/Stimulant
3. Barbiturates
4. Benzodiazepines
5. Cannabis
6. Cocaine
7. Hallucinogen
8. Inhalant
9. Opiate
10. Phencyclidine
11. Sedative Hypnotic

NAME:

OTHER IMPORTANT HISTORY

Name of Primary Care Physician	
Date of Last Exam	
Is client pregnant?	
If so – due date	
Pre Natal Appointment Scheduled	
Pre Natal Appointment Completed	
OB/GYN knows of Pregnancy?	

Substance Abuse History

Drugs of Choice	Last Use	Route	Date Use Began	Frequency	Tx Screen Date	Results
Alcohol						
Barbiturates						
Cocaine						
Opiates						
Other						

History of	YES	NO	Last Date
DT's			
Blackouts			
Alcohol Related Seizures			

LIST ALL MEDICATIONS

Type	Dosage	Start Date	Response

If medications are being administered by someone other than client – please identify

Suicidal / Homicidal Behaviors? No_____ Yes_____ Clarify _____

NAME: _____

If yes, is client able to contract for safety? _____

List recent hospitalization or attempts _____

If client has a co-occurring psychiatric diagnosis, is client in treatment Yes ____ No ____

Client's mental health professional _____

Phone Number _____

Release of Information Signed? Yes ____ No ____

Psychosocial Functioning

Domestic Violence _____

Drugs in the Home _____

Education _____

Legal Problems _____

Primary Support System _____

Recovery Environment _____

Working _____

Other _____

Brief Mental Status _____

Statement of Problems

Goals Related to Presenting Problems (use finite / measurable / observable terms)

DIAGNOSIS (please complete ALL axes – use DSMIV codes)

AXIS I	
AXIS II	
AXIS III	
AXIS IV	
AXIS V (GAF)	

NAME:

ADULT TREATMENT PLAN

Successful completion of treatment requires achieving A/D Goals 1&2

Goal Codes	
P	- Psychological
L	- Legal
S/F	- Social/Family
A/D	- Alcohol/Drug
V/E	- Vocational/Educational
P/N	- Physical/Nutritional

Major Concerns (Problem Areas)	Goals/Objectives	Treatment Strategies	Person Responsible	Target Finish Date
A/D 1 Alcohol/drug use	To achieve/maintain abstinence/reduced use of non-medication substances in order to lessen the severity of the substances' impact on the client's physical, mental, emotional, or social dysfunction.	<ol style="list-style-type: none"> 1. Client must attend all scheduled clinical activities (individual, family, group sessions) unless previously excused or due to an emergency. Missed sessions will be documented in the clinical record. Client may make up missed session in order to successfully complete treatment. 2. Client must demonstrate participation in all clinical activities as evidenced by progress notes indicating at least two statements/comments made by the client in group treatment and active involvement in conversation during individual/family sessions. 3. Client must complete all group tasks. 4. Client will submit to random urinalyses. 5. Client must meet all goals related to her/his alcohol and drug problem(s) unless the goal is discontinued due to clinical reason(s). 	Client	
A/D 2 Relapse	To maintain a relapse prevention program	<ol style="list-style-type: none"> 1. Client will identify at least 3 triggers to relapse and report them to group/counselor. 2. Client will develop a social support system. 	Client	

NAME:

Initial Treatment Plan Contract Dates: _____ To: _____ Reviewed by Client: _____ Date: _____

Reviewed by Clinician: _____ Date: _____

Reviewed by Supervisor: _____ Date: _____

90-Day Review: _____ To: _____

Reviewed by Client: _____ Date: _____

Reviewed by Clinician: _____ Date: _____

Reviewed by Supervisor: _____ Date: _____