The Caring Center of Wichita LLC

PERSONAL & SUBSTANCE ABUSE HISTORY
Biological / Psychological / Social Assessment

Assessors Name:	**Date of Assessment:**

General Information

Client Name:_____ Maiden (If Applicable):_____	
Date of Birth:_____	Home Phone: _____ Cell Phone: _____
Address:_____ _____	

Referred by:	**Date Referred:**
Presenting Issue(s):	

Emergency Contact Person: Phone Number:	
Primary Physician: Phone Number:	
Education (Level Achieved):	
Vocational Experience (If Applicable):	
Military Experience (If Applicable):	
Religious/Spiritual Affiliation:	

Current Living Situation/Support System

Economic Resources: Gross Income:	Number in household:
Client Identified Support System Available:	

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Five Year Employment History

Employer Name	Dates of Employment	Reason for Leaving

Information on Immediate Family Members (Parents, Siblings, Other)

Name	Relationship	Age	Health	Substance Use Y / N

Children

Name	Bio/Step/Adopt	Age

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Social and Family History

Currently in a Relationship?	Length of Time:	
Married? Number of Marriages: Yes	Separated?	Divorced?

Significant Other Information (Parent/guardian/representative, if applicable):

Name:	Relationship:
Address:	Phone:
History of Alcohol and/or Drug Problems? Yes ☐ No ☐ If so, what?	

History of Abuse

History or pattern of abuse	Yes	No	Victim?	Perpetrator?	Alleged/Documented
Physical abuse					
Sexual abuse					
Emotional / Verbal abuse					

Risk of Suicidal or Homicidal Behavior

History of suicidal or homicidal behavior	Yes	No	Details
Suicidal thoughts / Plan?			
Attempts (last 10 years)?			
Homicidal thoughts / Plan?			
Attempts (last 10 years)			

Other Mental Health / Social Issues

Problem	Yes	No	Problem	Yes	No
Anger / Aggression			Depressed Mood		
Feeling Anxious			Difficulty Concentrating		
Lacks Trust in Others			Problems w/ Perfectionism		
Impulsive / Lacks Self-control			Difficulty w/ Decision Making		
Fears / Phobias			Problems w/ Socializing		
Unresolved Grief / Loss			Relationship Issues		
Racism / Sexism			Gambling Problems		
Discrimination Issues			Spiritual / Religious Issues		
Addictions (Sex, Food, Gambling)			Other:		

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Treatment History

Previous Alcohol and Drug Treatment: Yes ☐ No ☐ *If yes please see below*		Previous Mental Health Treatment: Yes ☐ No ☐ *If yes please see below*
Substance Abuse Provider	Dates of Service	Outcome
Mental Health Provider	Dates of Care	Outcome

Medical History

Have you or any of your immediate family ever been diagnosed or treated for any of the following?

Condition	Y	N	Who	Condition	Y	N	Who
Diabetes				Low blood sugar			
High Blood Pressure				Low Blood Pressure			
Heart Problems				Epilepsy			
Gastritis				Ulcers			
Pancreatitis				Cancer			
Other				Other			

Current Medications (include all medications prescribed or over-the-counter)

Medication	Route	Dosage	Prescribing Dr.	Reason

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Risk factors for infectious disease (i.e.- HIV, AIDS, HCV, and STD's)

TB Skin Test in Last 30 Days:	If Positive, date of last chest x-ray:

TB Risk Assessment Questions	**Yes**	**No**
1) Have you had contact with someone who has infectious TB disease?		
2) Were you born in an area of the world where TB is common (ex. Asia, Africa or Latin America)?		
3) Do you have inadequate access to health care, or have been homeless in the past two years?		
4) Have you lived or worked in residential facilities (for example nursing homes, correctional facilities or treatment facilities)?		
5) Have you worked in a facility where you may have been exposed to TB (health care workers who serve high risk symptoms)?		
If any of the above questions (TB Questions) were answered yes, the client should be evaluated for the following symptoms: 1) A cough lasting over three weeks? 2) Sputum production or blood in cough? 3) Unexplained loss of appetite or sudden weight loss? 4) Fever, chills, or night sweats for no reason? 5) Persistent shortness of breath? 6) Increase fatigue? 7) Chest pain?		
Other Risk-Related Questions	**Yes**	**No**
Have you participated in any of the following high risk behaviors: (unprotected sex, multiple sex partners, sex with prostitute, IV drug use, shared needles, anal sex, same-sex relationship)?		
Have you been tested for HIV/AIDS		
Have been tested for Hepatitis B and/or C		
Have you been tested for other sexually transmitted diseases?		
Would you like a referral to be tested for any of the above?		

Questions Related to Substance Use

	Yes	**No**
Have you ever experienced blackouts from substance use?		
Do you have a family history of substance use?		
If so, Who?		
Is there any family member currently using drugs / alcohol?		
If so, Who?		
Are you a Nicotine abuser?		
If so…. Do you use (circle) Cigarettes / Cigars or Smokeless Tobacco (Chew)		
How old were you when you first used Tobacco products?		
Have made any attempts to quit or cut down?		

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Alcohol and Drug Use History

Key for Frequency of Use: E = Experimented, used once or twice ever.
R = Regular, used at least weekly.
O = Occasional, used less than once a month.
D = Daily
RX = Abused a Prescription

Key for Route Used: O = Oral ; Sm = Smoked ; IV = Intravenous ; H = Huffed / Inhaled ; Sn = Snorted / Sniffed

Drug used?	Age of first use	Amount used	Frequency of use	Route	Longest and Last period of abstinence	Date / Time of Last Use	Behavior during use	Effects on Relationships

If additional space is needed, please advise the counselor.*

Common Drugs Used May Include: Marijuana, Hashish, Methamphetamines, Alcohol, Opiates, Inhalants, Steroids, Over-the-Counter (Coricidin, Robitussin, Dramamine), LSD, PCP, Club Drugs (Ecstasy, GHB, Ketamine), Heroin, Benzodiazepines (Xanax, Valium, Klonopin, Ativan), Tranquilizers (Thorazine, Haladol, Ativan), Barbituates/Sedatives (Nembutal, Seconal, Tuinal, Quaaludes), MDMA, Mushrooms, Peyote, Narcotics (Hydrocodone, Oxycotin, Codeine, Dilaudid, Demerol, Morphine)

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Legal History: Current / Pending

Pending legal charges? Yes_____ No_____				
Charge	Date of arrest	Court date	County	Attorney Involved

Legal History: Past

Past legal charges? Yes_____ No_____					
Charge	Date of arrest	Convicted?		Incarceration Dates	Supervising Officer, if applicable
		Yes	No		

Legal History: DUI

Total Number of DUI arrests: _____

DUI arrests? Yes_____ No_____ Within last 30 days? Yes_____ No_____						
Date of arrest	BAC Level	Convicted?		Incarcerated?		Attorney Involved
		Yes	No	Yes	No	

Driving History (for DUI Evaluations)

Charge	Date	Convicted?		Incarcerated?		Attorney Involved
		Yes	No	Yes	No	

Client Signature: _____ Date:_____

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Information from collateral sources, when available:			
Treatment Techniques Utilized: Cognitive Restructuring / Behavioral Intervention			
Treatment Modality Recommended	**>**	**ADIS / Early Intervention**	
	>	**Outpatient Level 1**	
	>	**Intensive Outpatient**	
	>	**Inpatient**	
	>	**Reintegration**	
	>	**Other**	
Client response to following questions:			
What are you most concerned about today?			
What is your primary goal for Treatment?			
What positive characteristics can help you with this problem?			
What barriers or roadblocks might prevent you from being successful?			
Summary and Rationale for Recommendations:			

Counselor Signature: _____ Date: _____

Personal & Substance Abuse History: slq Revised 08/15/16