Collaborative Counseling

Chemical Health Intake

Client Name: _____ Date of birth: _____

Form completed by (if someone other than the client): _____

Please state the reason you are seeking services: _____

_____

Best number to reach you at: _____ Circle: Home Cell Work

Emergency contact: _____ Phone: _____
Do you have a Primary Care Physician, Psychiatrist and/or Pediatrician? Circle: YES NO

Name of Doctor(s): _____
Would you like your therapist to coordinate care with Physician? Circle: YES NO

Please check any of the following behaviors or symptoms typical of yourself:

	Physical Aggression
	Verbal Anger
	Anxious
	Mind racing
	Avoidance
	Day dreaming
	Fear/Panic
	Irritability
	Crying Spells
	Depressed mood
	Difficulty with change
	Lack of motivation
	Withdrawn
	Worthlessness/Guilt
	Physical complaints
	Helpless Feelings
	Moody/Mood swings
	Distrusts Others
	Relational Problems
	Social Deficits
	Destroys Property

	Blames Others
	Careless/Reckless
	Impulsive
	Impatience
	Uncooperative
	Defiant/Oppositional
	Legal problems
	Lying
	Obsessions/Rituals
	Inattention
	Rigid Thinking
	Nightmares
	Sleep problems (wakeful/falling)
	Appetite Disturbance
	Weight loss/Weight gain
	Hallucinations
	Substance Use Problems
	Cutting/Self Injury
	Homicidal Thoughts/Plans
	Suicidal Thoughts/Plans
	Temper Tantrums

How Long have the above symptoms been present:_____

Treatment History

Client's Outpatient Mental Health History

Dates	Clinic	Therapist	Diagnosis/Reason

Client's Inpatient Mental Health History

Dates	Clinic	Therapist	Diagnosis/Reason

Client's Chemical Dependency History

Dates	Clinic	Therapist	Diagnosis/Reason

Medical History and Physical Health

Please list any current health conditions or concerns: _____

_____

Please list any past health concerns, conditions, or procedures: _____

_____

Please list any allergies:_____

Please list any current medications (both prescribed and over-the-counter)

Medication name	Dosage	Purpose	Date started	Side Effects	Is it working?

Please list your most recent examinations:

Type	Date	Reason	Results
Physical Exam			
Doctor's Visit			

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Vision Exam			
Hearing Exam			
Dentist Visit			

People living in the client's current household

Name	Relationship (e.g. sibling, parent)	Age

Family of Origin

Client's Family History

Parents	Age	Relationship History

Siblings	Age	Relationship History

Please list any mental health or substance use concerns within you family of origin:

_____

_____

_____

Have you had any divorce (s), major break ups with a significant other: ___Yes___No

If yes please describe:_____

Have you moved multiple times: ___Yes ___No

If yes please describe:_____

Abuse/ Trauma History

Has the client been a victim or at risk for emotional, physical or sexual abuse? ___Yes ___No

Describe: _____

Other trauma/losses: _____

Social/Peer Relationships

Are you currently satisfied with your current social life? __Yes __No Please

Describe:_____

Do most of your friends use substances: __Yes__No Please

Describe:_____

Were there relationship issues as a result of use: ___Yes ___No If yes, please describe:

_____

_____

How would you describe your typical social tendencies? (check all that apply)

	Leader
	Follower
	Outgoing
	Shy/Reserved

	Difficulty making friends
	Bossy
	Well liked by peers
	Bullies others

	Gets bullied
	Loner
	Other:
	Other:

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Please describe your special areas of interest, hobbies, and activities: _____

_____

_____

Do your hobbies and interest typically involve substance use? __Yes __No

Please Describe:_____

_____

Legal History

Do you have any history of legal issues? __Yes __No If yes, please describe:

_____

_____

Do you have current legal or pending legal problems? __Yes __No If yes, please describe:

_____

_____

Educational History

Highest Level of Education Received: _____

Are you currently in school? __Yes __No If yes where:_____

Are there any academic concerns? ? __Yes __No If yes what:_____

_____

_____

Do you have any special education needs? __Yes __No If yes what:_____

_____

Career/Work History

Currently employed? __Yes __No If yes, what is your position: _____

Are you currently satisfied with your job? _____

Have you ever lost of job because of substance use?__Yes__No

If yes, please describe: _____

_____

Religion/Spirituality

Do you or your family belong to any religious and/ or spiritual group? __Yes __No

If yes, please explain:_____

How important is religion/spirituality to you? _____

Anything else you would like to note regarding religion/spirituality? _____

_____

Support group participation: ___No ___Yes Describe: _____

Military History

Are you currently in the military? ___Yes ___No If yes, describe:_____

Were you a veteran? __Yes __ No If yes, please describe:_____

Chemical Use History in Past ONE year:

Type of Substance	**Not in Lifetime**	**Age of first use**	**Route of Admission**	**Rarely**	**1-3 times a month**	**1-5 times a week**	**Daily/almost daily**	**Last Date of Use**
Alcohol								
Cannabis								
Cocaine (powder)								
Crack Cocaine								
Methamphetamine								
Heroin								
Other Opiates								
Sedatives/Barbituates								
Mushrooms								
Tobacco								
Other:								

Experienced a blackout: __No ___ Yes Describe: _____

_____

Experienced injuries as a result of use: ___No ___ Yes Describe: _____

_____

Any increased tolerance since first age of use:___No ___Yes Describe: _____

_____

How often do you spend more time than you planned using or obtaining substances:_____

_____

Any withdrawal symptoms past year: ___No ___Yes Describe: _____

_____

Longest period of sobriety:_____

What made previous attempts at sobriety unsuccessful:_____

_____

Reason for use: _____

_____

Do you have support to assist you with your recovery:___No ___Yes Describe:_____

_____

Have you felt guilty/embarrassed about substance use:___No___Yes Describe:_____

_____

Additional comments about substance use: _____

_____

_____

_____

_____

****

Staff Use Only

Collateral Contact Call

Name of Contact:_____Relationship:_____
Date:_____ Time:_____ Phone Number: _____

Information Provided:
How frequently do you have contact with client:_____

How frequently do you see individual consume alcohol or drugs:_____

Do you think the client has a substance use problem: ___No ___Yes

Describe:_____

Are you aware of any previous attempts to cut down or quit: ___No ___Yes

Describe:_____

Are you aware of any legal problems resulting from usage: ___No ___Yes Describe: _____

_____

Are you aware of any occupational or relational problems resulting from usage: ___No___Yes

Describe: _____

Information from collateral contact supported/largely agreed with information from the:

_____

Client and associated risk ratings: ___No ___Yes

Information from collateral contact was significantly different from the client and lead to different risk ratings: ___ No ___Yes Describe: _____

Therapist Comments/other notes: _____

_____

_____

_____

_____

Therapist Signature:_____ Date: _____

Physical Exam: _____Required _____Not Required

Dimension I Ratings: Acute intoxication/Withdrawal Potential
Rating Descriptions-
__0 Client displays full functioning with good ability to tolerate and cope with withdrawal discomfort. No signs or symptoms of intoxication or withdrawal or resolving signs or symptoms.
__1 Client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Client poses minimal risk of severe withdrawal.
__2 Client has some difficulty tolerating and coping with withdrawal discomfort. Client's intoxication may be severe, but responds to support and treatment such that the client does not immediately endanger self or others. Client displays moderate signs and symptoms with moderate risk of severe withdrawal.
__3 Client tolerates and copes with withdrawal discomfort poorly. Client has severe intoxication, such that the client endangers self or others, or intoxication has not abated with less intensive levels of services. Client displays severe signs and symptoms; or risk of severe, but manageable withdrawal worsening despite detox at less intensive level.
__4 Client is incapacitated with severe signs and symptoms. Client displays severe withdrawal and is a danger to self or others.

Dimension II Ratings: Biomedical Conditions and Complications
Rating Descriptions-
__0 Client displays full functioning with good ability to cope with physical discomfort.
__1 Client tolerates and copes with physical discomfort and is able to get the services that the client needs.
__2 Client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. Client neglects or does not seek care for serious biomedical problems.
__3 Client tolerates and copes poorly with physical problems or has poor general health. Client neglects medical problems without active assistance.
__4 Client is unable to participate in CD treatment and has severe medical problems, a condition that requires immediate intervention, or is incapacitated.

Dimension III Ratings: Emotional, Behavioral, Cognitive Conditions and Complications
Ratings Descriptions-
__0 Client has good impulse control and coping skills and presents no risk of harm to self or others. Client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.
__1 Client has impulse control and coping skills. Client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral or cognitive problems. Client has mental health diagnosis and is stable. Client functions adequately in significant life areas.
__2 Client has difficulty with impulse control and lacks coping skills. Client has thoughts of suicide or harm to others without means; however, the thoughts may interfere with participation in some treatment activities. Client has difficulty functioning in significant life areas. Client has moderate symptoms of emotional, behavioral, or cognitive problems. Client is able to participate in treatment activities.

__3 Client has a severe lack of impulse control and coping skills. Client has frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's ability to participate in treatment activities.
__4 Client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. Client also has intrusive thoughts of harming self or others. Client is unable to participate in treatment activities.

Dimension IV Ratings: Readiness to Change
Rating Descriptions-
__0 Client is cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.
__1 Client is motivated with active reinforcement, to explore treatment and strategies for change, and is passively involved in treatment.
__2 Client displays verbal compliance, but lacks consistent behaviors; has low motivation for change; and is passively involved in treatment.
__3 Client displays inconsistent compliance, minimal awareness of either the clients addiction or mental disorder, and is minimally cooperative.
__4 The is: (**A**) non-compliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the illness and its implications, or (B) dangerously oppositional to the extent that the client is a threat of imminent harm to self or others.

Dimension V Ratings: Relapse/Continued Use/Continued Problem potential
Rating Descriptions-
__0 Client recognizes risk well and Is able to manage potential problems.
__1 Client recognizes relapse issues and prevention strategies, but displays come vulnerability for further substance use or mental health problems.
__2 (**A**) Client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. (**B**) Client has some coping skills inconsistently applied.
__3 Client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. Client has few coping skills and rarely applies coping skills.
__4 No awareness of the negative impact of mental health problems or substance abuse. No coping skills to arrest mental health or addiction illnesses, or prevent relapse.

Dimension VI Ratings: Recovery Environment
Rating Descriptions-
__0 Client is engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.
__1 Client has passive social network support or family and significant other are not interested in the client's recovery. The client is engaged in structured meaningful activity.
__2 Client is engaged in structured, meaningful activity, but peers, family, significant others, and living environment are unsupportive, or there is criminal justice involvement by the client or among the client's peers, significant others, or in the client's living environment.
__3 Client is not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.

__4 Client has (A) Chronically antagonistic significant other, living environment, family, peer group or long-term criminal justice involvement that is harmful to recovery or treatment progress, or (B) Client has an actively antagonistic significant other, family, work, or living environment with immediate threat to the client's safety and well being.

Summary of Risk Dimension Results

Dimension I: _____

Dimension II: _____

Dimension III: _____

Dimension IV: _____

Dimension V: _____

Dimension VI: _____