PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES
COMPREHENSIVE PSYCHOSOCIAL EVALUATION

PATIENT NAME	PATIENT ID #	ADMISSION DATE

Chemical Dependence /Abuse Update: *Please update the information below with any changes found since admissions assessment*

Substance Type	Age of Onset	Frequency/Amount/Progression	Date of last use
Alcohol ☐			
Amphetamines ☐			
Cannabis ☐			
Cocaine ☐			
Hallucinogens ☐			
Inhalants ☐			
Nicotine ☐			
Opioids ☐			
PCP ☐			
Sedatives/Hypnotics ☐			
Other ☐			

Previous Treatment History: ***Please update with any information in addition to the admissions assessment.***

Date	Treatment Providers	Completed Y/N	Signed Release Y/N

Previous Recovery/Abstinence History: ***Please list previous periods of sustained recovery/abstinence and methods of attainment.***

DATE(S)	Methods of attainment (i.e., AA/NA; Smart Recovery; other self help; church; jail;)

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

II. Physical Health:

Medication(s): *Please list additional medication information on backside of sheet as needed.*

Medication	Purpose	Prescriber

Current Medical History:

Provider(s) Name	Condition being Treated	Signed Release Y/N

Physical Examination Information:

☐ No physical examination within the past year of the admission date, patient will be:

☐ Referred for a Medical Assessment - attach completed OASAS 822 Medical Assessment form.

Referred for a Physical Examination to :

☐ Date of Exam appointment:

Signed consent for release: ☐ YES ☐ NO

☐ Physical Examination within the past year from admission date - or was admitted directly from another OASAS Certified Program - medical history and physical examination information are in the patient case record and have been reviewed by a medical staff member

Communicable Disease Assessment: ☐ Attach completed OASAS 822 Communicable Disease Assessment Form.

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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III. Mental Health History:

Medication	Purpose	Prescriber

Mental Health Treatment:

Dates	Provider	Condition being Treated	Signed Release Y/N

Brief Mental Status Exam:

Orientation (please answer the questions below):

Can the patient give his/her full name?	☐ Yes	☐ No	Does patient know where he/she is?	☐ Yes	☐ No
Does the patient know the full date?	☐ Yes	☐ No	Does the patient know why he/she is attending the session?	☐ Yes	☐ No

Intellectual/mental ability (please answer the question below):

Does the patient have the ability to develop and understand a treatment plan? ☐ Yes ☐ No

Mood (indicate currently and on most days as given below):

happy	☐ current	☐ most days	melancholic	☐ current	☐ most days	anxious	☐ current	☐ most days
sad	☐ current	☐ most days	euphoric	☐ current	☐ most days	angry	☐ current	☐ most days
despondent	☐ current	☐ most days	elated	☐ current	☐ most days	Other:	☐ current	☐ most days
irritable	☐ current	☐ most days	depressed	☐ current	☐ most days			

Lethality Assessment:

Have you ever planned to kill yourself? ☐ Yes ☐ No

Do you have current thoughts about killing yourself? ☐ Yes ☐ No
If yes please answer the below questions:

How likely are you to act on these thoughts?

If yes to any current ideology – describe plan for immediate assessment and safety plan:

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Lethality (con't)	
Have you ever planned to kill anyone else?	☐ Yes ☐ No
Are you currently planning to kill someone else? *If yes please answer the below questions:*	☐ Yes ☐ No
How likely are you to act on these thoughts:	
If yes to any current thoughts – describe plan for immediate assessment and safety plan:	
Clinician's findings and conclusions in this functional area:	
Patient's identified needs in this functional area and level of motivation:	

IV. Vocational/educational/employment Assessment:

Literacy Assessment: (based on Lisa Chow's 3 question assessment to determine health literacy, Family Medicine, 2004 Sep: 36(8):(588-94)

On a scale of 1 to 5 with 1 being "never" and 5 being "always," how often do you have someone help you read important material or documents?	
On a scale of 1 to 5 with 1 being "not at all" and 5 being "extremely, how confident are you filling out important forms yourself?	
On a scale of 1 to 5 with 1 being "never" and 5 being "always," how often do you have problems learning about important information because of difficulty understanding written material?	

Assessment evaluation and recommendations:

Education History: (check all that apply)

☐ High School Diploma; or ☐ Highest Grade Completed

Name of High School:

Last year attended:

☐ GED Year completed:

☐ College ☐ Highest Level or # of years Completed

Degree	Major	Year Graduated

☐ Vocational School Subject: Year Completed:

☐ Other

☐ No formal education

What part of your educational experience made you feel good or proud?

What did you struggle with in school?

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Employment History: ***please list history for the past two years below***

Dates	Employer	Position	Reason for Leaving

Are you currently on disability? ☐ Yes ☐ No If yes please answer the questions below:

Date approved: | Nature of disability:

What characteristics do you have that make you a good employee?

What difficulties have you had in a work environment?

How has your drug or alcohol use affected your employment?

At some point would you be interested in furthering your education or vocational opportunities? ☐ Yes ☐ No

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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V. Social/Leisure Assessment:	
Assessment of Adult Daily Living Skills (ADLS): On a scale of 1 to 10 with 1 being "very difficult" and 10 being "very easy" rate how well you complete the following tasks:	
How well are you able to cook for yourself and/or your family?	
Are you able to pay your bills on time?	
How difficult is it for you to balance your checkbook?	
How difficult is it for you to keep your living space clean?	
How difficult is it for you to get transportation?	
Are you able to take your medication(s) as prescribed?	
Are you able to use a washing machine and dryer?	
How difficult is it for you to take care of your personal hygiene (shower, deodorant, brush teeth)?	
Based on the above assessment please identify any areas where the patient would like to improve or learn new skills:	

Social/Leisure Activities:
What do you do for fun or relaxation?
Which of these activities have involved drugs or alcohol?
Who do you go to when you need to talk things through?
What would you say are your strengths as a person?
What would you say are your weaknesses as a person?

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Community Recovery Support and Services:

Please indicate which of the following meetings and/or services in which the patient has participated:

√	Service	Frequency	√	Service	Frequency
☐	Alcoholics Anonymous		☐	Cocaine anonymous	
☐	Smart Recovery		☐	Narcotics Anonymous	
☐	Rational Recovery		☐	Gamblers Anonymous	
☐	S.O.S.		☐	Sex/Love Addicts (SLAA)	
☐	Nar-Anon		☐	Al-anon	
☐	CODA		☐	Families Anonymous	
☐	Other		☐	Other	

Of the services that you checked above which ones have you attended in the last 30 days?

If you have stopped attending, what lead you to this decision?

Would you be open to returning?

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

VI. Family Assessment:

Family of Origin: ***(please fill in the following information)***

Describe growing up in your family:

How did your family solve problems?

How would describe your relationship with your parents? Siblings? Extended family?

What are your best and worst memories of growing up?

Current Family Structure: (***please fill in the following information)***

Name	Relationship	Age	Addicted?	Recovery Status

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VI. Family Assessment (con't):

How would you describe the relationship with your partner/spouse/significant other?

Have you ever hit, pushed, kicked or otherwise struck out at a partner in a relationship?	☐ Yes ☐ No	Currently? ☐ Yes ☐ No
Have you been hit, pushed, kicked or otherwise struck in a relationship with a partner?	☐ Yes ☐ No	Currently? ☐ Yes ☐ No

What role does/did alcohol and/or drugs play in your relationship with your partner/spouse/significant other?

How would you describe the relationship with your children?

What do you do well as a parent?

What do you struggle with as a parent?

Please describe any involvement you had with Child Protective Services:

Would anyone in your family be interested in participating in your treatment?	☐ Yes	☐ No
Would you be interested in improving your parenting skills?	☐ Yes	☐ No

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

VII. Legal Assessment:

Legal History: (please fill in the information below)

Date	Offense	Disposition	AOD Involved?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Are you currently involved with:

☐ Yes ☐ No Parole	☐ Yes ☐ No Probation	☐ Yes ☐ No PINS	☐ None

Contact Person:	Phone #

Address:	County	State:	Zip:

Signed Criminal Justice Consent for Release? ☐ Yes ☐ No

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

VIII. Problem Gambling Assessment:

If the patient answered yes to either of the two Lie-bet questions from the Admissions Assessment then a South Oaks Gambling Screen should be given to determine the need for further Problem Gambling Treatment Services.

Results of SOGS:

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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IX. Ancillary Information:		
Military Service:		
Did you, or a family member serve in the Military? ☐ Yes ☐ No	Dates of Service:	Branch:
Where do/did you/they serve?		
What do/did you/they do while in the service?		
How has your **or someone else's** Military Service affected your life?		
Are there areas of your Military experience that you would like to discuss further?		
Clinician's findings and conclusions in this functional area:		
Patient's identified needs in this functional area and level of motivation:		
Spirituality/Religion:		
How would you describe your Spiritual and/or Religious beliefs?		
In what way(s) is Spirituality and/or Religion important to you in your life?		
How do you see your beliefs helping you in your recovery from alcohol and/or substance abuse?		
Is Spirituality an area that you would like to work on during your treatment?		
Clinician's findings and conclusions in this functional area;		
Patient's indentified needs in this functional area and level of motivation:		

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Traumatic Brain Injury (TBI) assessment: HELPS TBI Screening Tool

Based on TBI screening tool was developed by M. Picard, D. Scarisbrick, R. Paluck, 9/91, International Center for the Disabled, TBI-NET, U.S.Department of Education, Rehabilitation Services Administration, Grant #H128A00022. The Helps Tool was updated by project personnel to reflect recent recommendations by the CDC on the diagnosis of TBI. See http://www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/diagnosis.htm. This document was supported in part by Grant 6 H21 MC 00039-03-01 from the Department of Health and Human Services (DHHS) Health Resources and Services Administration, Maternal and Child Health Bureau to the Michigan Department

H Have you ever **H**it your **H**ead or been **H**it on the Head? ☐ Yes ☐ No

NOTE: Prompt client/patient to think about all the incidents that may have occurred at any age, even those that did not seem serious: falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse; and also for service related injuries. TBI can also occur from violent shaking of the head, such as whiplash or being shaken as a baby or child.

E Were you ever seen in the **E**mergency room, hospital, or by a doctor because of an injury to your head? ☐ Yes ☐ No

L Did you **L**ose consciousness or feel dazed or confused after experiencing any of the event(s) listed above? ☐ Yes ☐ No

NOTE: People with TBI may not lose consciousness but experience an "alteration of consciousness." This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.

P Do you experience any of these **P**roblems in your daily live since you hit your head? ☐ Yes ☐ No

☐ headaches	☐ difficulty concentrating	☐ difficulty performing your job/school work
☐ dizziness	☐ difficulty remembering	☐ change in relationships with others
☐ anxiety	☐ difficulty reading, writing, calculating	☐ poor judgment (being fired from job, arrests, fights)
☐ depression	☐ poor problem solving	

NOTE: Ask your client if s/he experiences any of the following problems, and ask when the problem presented. You are looking for a combination of two or more problems that were not present prior to the injury.

S Any significant **S**icknesses? ☐ Yes ☐ No

NOTE: Traumatic brain injury implies a physical blow to the head, but acquired brain injury may also be caused by medical conditions, such as: brain tumor, meningitis, West Nile virus, stroke, seizures. Also screen for instances of oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.

Scoring the HELPS Screening Tool

A HELPS screening is considered positive for a possible TBI when the following 3 items are identified:

1.) An event that could have caused a brain injury (yes to H, E **or** S), **and**
2.) A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to L or E), **and**
3.) The presence of two or more chronic problems listed under P that were not present before the injury.

NOTE:
A positive screening is **not sufficient to diagnose TBI** as the reason for current symptoms and difficulties - other possible causes may need to be ruled out.

Some individuals could present exceptions to the screening results, such as people who do have TBI-related problems but answered "no" to some questions

Consider positive responses within the context of the person's self-report and documentation of altered behavioral and/or cognitive functioning

Clinician's findings and conclusions in this functional area;

OTHER EMERGENT AREAS OF NEED:
Clinician's findings and conclusions in this functional area:
Patient's identified needs in this functional area and level of motivation:

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DSM-IV DIAGNOSIS

Based on information gathered in the above assessments please complete the following: ***(For both Abuse and Dependence diagnosis a maladaptive pattern of substance use, leading to clinically significant impairment or distress must be present)***

Dependence Criteria	**Primary Substance**	**Secondary Substance**	**Tertiary Substance**
Please indicate the appropriate substance and √the corresponding criteria: ***(as manifested by three or more of the following occurring at any time in the same 12-month period)***			
Increased tolerance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Withdrawal	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Use more or longer than intended	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Desire to control or unsuccessful efforts to control use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pre-occupation with acquiring the drug(s)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lifestyle change due to use	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Continued use despite consequences	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Abuse Criteria	**Primary Substance**	**Secondary Substance**	**Tertiary Substance**
*Please indicate the appropriate substance and √the corresponding criteria: (****one or more criteria must have happened within the last 12 months****)*			
Recurrent failure to meet major role obligations	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recurrent use Interferes with safety	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recurrent substance Related Legal Problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Continued substance use despite persistent or recurrent social or interpersonal problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please indicate specific diagnosis of alcohol related or psychoactive substance related disorder in accordance with the current version of the DSM:

AXIS I:

PREPARED BY ***(IF OTHER THAN QHP):***	**SIGNATURE:**	**DATE** ***(WITHIN 45 DAYS OF ADMISSION)***
RESPONSIBLE Qualified Health Professional:	**SIGNATURE: (Medical assessment/physical exam requirements must be met prior to QHP signature)**	**DATE** ***(WITHIN 45 DAYS OF ADMISSION)***
OTHERS PARTICIPANTS IN EVALUATION:	**SIGNATURE:**	**DATE** ***(WITHIN 45 DAYS OF ADMISSION)***
OTHERS PARTICIPANTS IN EVALUATION:	**SIGNATURE:**	**DATE** ***(WITHIN 45 DAYS OF ADMISSION)***
OTHERS PARTICIPANTS IN EVALUATION:	**SIGNATURE:**	**DATE** ***(WITHIN 45 DAYS OF ADMISSION)***