CALVARY COUNSELING CENTER
A Safe Haven and Source of Hope

ALCOHOL/DRUG ASSESSMENT FORM

DEMOGRAPHIC INFORMATION Date_____

Client's Name_____ Age _____

Date of Birth_____

Address _____

How long have you lived at this address? _____

Type of residence (Apt. Home, Duplex, Etc.) _____

Rent? _____ Own? _____

With whom do you live?_____

What circumstances led to this assessment?_____

_____

_____

What is your behavior like when you are using alcohol or drugs?_____

_____

Who referred you or how did you hear about me?_____

SOCIAL INFORMATION

Number of meaningful relationships _____

Marital Status:

Never married ___ Married ___ Unmarried couple ___ Separated ___Divorced ___Widowed ___

How long at present status?_____ Married how many times? _____

Spouse's name _____Occupation _____

Employer _____

How many children do you have? (Please list) None ___

Name _____Age ____ Name _____ Age ____

Name _____Age ____ Name _____ Age ____

Name _____Age ____ Name _____ Age ____

How has your chemical use affected the relationship with your children?_____

_____

_____

How has your relationship with family/significant other been affected by your chemical use?

_____

Does anyone in your immediate family have a problem with chemicals?_____

_____

Have concerned person(s) complained about your use of chemicals?_____

Explain _____

Where were you raised and by whom? _____

_____

Father's name _____Father's occupation_____

Is your Father living? ___His age ___ If not, cause of death _____

Mother's name _____Mother's occupation_____

Is your Mother living? ___Her age ___ If not, cause of death _____

Parent's relationship: Married ___ Divorced ___ Never married ___

Number of children in your family (counting yourself)? _____

Which number child were you? _____

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Are your brother(s) living? #Yes ___ #No ___ sister(s) living? #Yes ___ #No___
Any history of alcoholism in your family? _____
_____
_____

PERSONAL
What are your interests/hobbies?_____
_____
What do you normally do with your leisure time? _____
How many close friends do you have? ____ Do you socialize with people who use drugs and/or alcohol? ____ Are you a member of a racial or minority group?_____
Religious preference? _____
Affectional orientation: heterosexual _____ Bi-sexual ___ Gay ___ Other _____
Have you ever been physically or sexually abused? _____
_____
What is your attitude toward the use of alcohol and/or drugs?_____
How do you feel about seeking this assessment? _____
What do you think of yourself? _____
What are some personal strengths? _____
What do you see as problem areas? _____
How has your chemical use affected your self esteem? _____
_____
How has your chemical use affected you sexually? _____

GAMBLING
Have you ever bet on horses, dogs or sporting events? Yes ____ No ____
Do you enjoy dice games such as craps? Yes ____ No ____
Have you ever played the lottery? ____ Bingo ____ Pull tabs ____ Poker ____
Slot Machines ____ Stock market ____ Other _____
What is the largest amount of money you ever gambled on at one occasion ? _____
Have you ever gambled more than you intended? _____

EDUCATION /VOCATION
What is your highest grade in school? Elementary 6 7 8 High school 9 10 11 12
Name and place of High School _____
College 1 2 3 4 5 6 7 8 Degree _____
Name and place of College _____
List any special training _____
Has your chemical use affected your education plans? ___ Explain _____
_____
Do you have any reading or writing problems? _____
Current employer _____ How long? _____
Occupation _____
Do you like your job? _____ Do you feel suited to your job? _____
Is your job in jeopardy now? _____
Do you have an employee assistance counselor? _____
Name _____ Telephone Number _____
How has chemical use affected your occupational plans? _____
_____
How has chemical use affected you financially? _____
_____
Previous consistent employment_____

Does anyone contribute to your support?

_____

MILITARY HISTORY

Were you in the Armed Forces? _____Branch _____
Total time in service _____ Highest Rank _____
Were you in combat?_____ Wounded of injured? _____
Any disciplinary action? _____ Explain _____
_____
Were they chemical- related? _____Type of discharge _____

CHEMICAL USE HISTORY

Drug of choice _____
Substance Age & year Pattern? How much? Date of last use
Date of first use How often?
Alcohol _____
Marijuana _____
LSD _____
Mushrooms _____
Amphetamines_____
Steroids _____
Inhalants _____
Diet pills _____
Cocaine _____
Crack _____
Meth. _____
Ecstacy _____
Heroin _____
PCP _____
Pain Killers _____
Valium _____
Sleeping pills _____
I.V. use _____
Other _____
_____
Percent of leisure time spent drinking/using? _____
Longest period of abstinence _____
How often have you tried to quit? _____ Result? _____
Withdrawal symptoms? _____
AA or self help group attendance? _____

NICOTINE USE HISTORY

Do you smoke? If yes, how much? _____
Have you stopped smoking? _____
Do you have a desire to stop smoking? _____

TREATMENT HISTORY

Month/Year Agency name Location # days Reason for service

_____
_____
_____
_____

_____
_____
_____
(Include DWI classes, detox, CD treatment, psychological/medical hospitalization in the last 6 months counseling/illness/accidents.)

LEGAL HISTORY

Month/year Location Offense/charge Outcome BAC Chemical

_____
_____
_____
_____
_____
_____

Court action pending: _____

Probation Officer/Social /worker:

Name _____ County _____

Address _____

Phone _____ Fax _____

MEDICAL/PSYCHOLOGICAL HISTORY

Health status _____

Date of last physical _____

Who is your personal physician?_____

Address: _____

Phone:_____

Do you have any history of eating disorders? _____

Anorexia/bulimia/compulsive overeating?_____

What medical problems, if any, are you currently having?_____

_____

Are these problems being treated?_____

By whom?_____

What diseases run in your family? _____

Check any of the following diseases/symptoms you have had:

____ Tuberculosis
____ Pneumonia
____ Emphysema
____ Asthma
____ Head Injury
____ Anemia
____ Arthritis
____ Communicable Disease
____ HIV positive
____ History of withdrawal symptoms or blackouts
____ Eating disorders/Obesity or cachectic (wasted) state
____ Thyroid disorder
____ Diabetes
____ Glaucoma
____ Cancer
____ Heart disease

____ Stroke
____ Jaundice
____ Headaches
____ Tachycardia (increased pulse over 100)
____ Weakness or limb numbness
____ Liver disease
____ Ulcer (stomach)
____ Nervous breakdown or disorder
____ Rheumatic fever
____ Hepatitis
____ Kidney disorder
____ High blood pressure
____ Bleeding tendencies
____ DT's, Agitation or Hallucinations
____ History of seizures
____ Epilepsy
What medications are you currently using? _____
_____
_____
Do you have any allergies to medications? _____
Do you have any other allergies? _____
_____
List past hospitalizations, operations or serious illnesses:
Type of illness/Operation Year Hospital/Doctor
_____
_____
_____
Have you ever had psychiatric treatment? _____When?_____
Have you ever attempted suicide? _____ When? _____
Have you ever overdosed from a drug? _____ When? _____
Do you have any vulnerable adult issues?_____

FOR FEMALES ONLY Menstrual period: Regular ____ Irregular ____ Painful ____
Date of last menstruation: _____ Are you or do you think you are pregnant? _____
Number of live births? ____ Number of abortions? ____
What type of birth control are you using? _____
Have you been treated for female disorders? _____

Please mark each of the following that you have experienced as it relates to drug/alcohol use:
____ using 1 or more times a week to intoxication
____ using drugs or alcohol to function in a social setting
____ driving while impaired by drugs or alcohol
____ loss of friends due to using behavior
____ tolerance (needing more to get the same effect
____ mood swings
____ frequently using larger amounts than planned
____ inability to set or follow through with limits of use
____ spending a good deal of money on drugs/alcohol
____ using despite medical/medication issues
____ continuing substance use despite knowledge of persistent or recurrent physical or psychological problem caused by use
____ hangovers

____ withdrawal (sweats, shaking)
____ persistent desire to cut down use
____ giving up/reducing activities in order to use
____ failure to meet obligations at home, school or work
____ using in the morning
____ using to medicate thoughts, feelings or physical pain
____ preoccupation (thinking about or planning to use)
____ using rapidly to get a buzz
____ people complaining about chemical use
____ fights or conflicts with others while under the influence
____ daily use
____ family history of alcohol/drug use
____ secretive use
____ using alone
____ repeated attempts to control use
____ protecting one's supply
____ IV use, injecting
____ drug/alcohol related legal problems
____ not remembering using events
____ using chemicals despite medication instruction
____ passing out from using

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TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND FACTUAL.

CLIENT SIGNATURE: _____DATE: _____

MAST SCREENING

Yes No

____ ____ 1. Do you feel you are a normal user/drinker?
____ ____ 2. Have you ever awakened the morning after some heavy drinking/using the night before and found that you could not remember a part of the evening before?
____ ____ 3. Does your spouse (or parents) ever worry or complain about your drinking/using?
____ ____ 4. Can you stop drinking/using without a struggle after one of two?
____ ____ 5. Do you ever feel bad about your drinking/using?
____ ____ 6. Do friends or relatives think you are a normal user/drinker?
____ ____ 7. Do you ever try to limit your using/drinking to certain times of day or to certain places?
____ ____ 8. Are you always able to stop drinking/using when you want to?
____ ____ 9. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
____ ____ 10. Have you ever gotten onto fights when drinking/using (physical/verbal)?
____ ____ 11. Has drinking/using ever created problems with you and your spouse/family?
____ ____ 12. Has your spouse (or family) ever gone to anyone for help about your drinking/using?
____ ____ 13. Have you ever lost friends or girlfriends/boyfriends because of drinking/using?
____ ____ 14. Have you ever gotten into trouble at work because of drinking/using?
____ ____ 15. Have you ever lost a job because of drinking/using?
____ ____ 16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking/using?
____ ____ 17. Do you ever drink/use before noon?
____ ____ 18. Have you ever been told you have liver trouble or health problems because of your drinking/using?
____ ____ 19. Have you ever had delirium tremors (DT's), severe shaking, heard voices or seen things that weren't there after heavy drinking or using?
____ ____ 20. Have you ever gone to anyone for help about your drinking/using?
____ ____ 21. Have you ever been in a hospital because of your drinking/using?
____ ____ 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward for a general hospital with a drinking/using related problem?
____ ____ 23. Have you ever been a patient in a psychiatric or mental clinic, gone to a doctor, social worker or clergyman for help with an emotional problem in which drinking/using was related?
____ ____ 24. Have you ever been arrested, even for a few hours, because of drinking/using behavior?
____ ____ 25. Have you ever been arrested for drunk driving or driving after using?

_____ _____ _____

Client Signature Staff Signature Date

CAGE	RESULTS
Date	___ Of 4

For most people who drink, alcohol is a pleasant addition to eating and to other social activities. Please answer the following questions Yes or No.

1. Have you ever felt you should cut down on your drinking?
   Yes

   No

2. Have people annoyed you by criticizing your drinking?
   Yes

   No

3. Have you ever felt bad or guilty about your drinking?
   Yes

   No

4. Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?
   Yes

   No

_____ _____ _____

Client Signature Staff Signature Date

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