Interviewer:____
Company Name: ____
Address: ____
Phone Number: ____________________________Fax: ______________________________
Email:____________________________________
Date of Interview: _____________________

NATIVE AMERICAN ADOLESCENT ASI QUESTIONNAIRE

Client's Name: First _____________________________________

Middle_____________________________________

Last _____________________________________

Social Security #: ☐☐☐ - ☐☐ - ☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐

Gender (M/F): ☐

Client ID:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

INSTRUCTIONS

1. Leave no blanks. Where appropriate code items:
   - Y-Yes
   - N-No
   - X-Question not applicable
   - Z-Question not answered

   Use only one character per item.

2. Space is provided after sections for additional comments.

SEVERITY RATINGS

The severity ratings are interview estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situations). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of the patient's treatment needs in a given area.

Orion Healthcare Technology is the U.S. leader in providing automated practice management solutions to the behavioral health and substance abuse fields. Our products include adult, adolescent, criminal justice and co-occurring assessments; treatment plans, patient placement, progress notes, discharge summaries, outcome research software, MIS, office scheduling and billing applications. If you would like information about the automated version of this questionnaire or others, please feel free to call our toll-free number 800-324-7966 or visit www.MyAccuCare.com. Orion allows the photocopying of this questionnaire for clinical use, but reserves the software rights for this product.

NATIVE AMERICAN ADOLESCENT ASI QUESTIONNAIRE

GENERAL INFORMATION

G1. Client ID: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

G2. Social Security #: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

G3. Provider #: [ ][ ][ ][ ][ ][ ][ ][ ]

G4. Date of Admission: [ ][ ] / [ ][ ] / [ ][ ]

G5. Date of Interview: [ ][ ] / [ ][ ] / [ ][ ]

G6. Time Begun: [ ][ ] / [ ][ ]

G7. Who referred you for an evaluation? [ ]

1-Attorney
2-Probation/Parole Officer
3-Presentence Investigator
` 4-Self
5-Judge or Court
6-Parents
7-School
8-Other

G8. Referral source's name ________________________________

Address ____

Address ____

City, State, Zip _______________________________________

Phone #: (______) ______ - __________

G9. By when do you need this assessment? [ ][ ] / [ ][ ] / [ ][ ]

G10. Why are you receiving this assessment (1-6)? [ ]

1-OWI or DWI	5-Self interest
2-Court ordered	6-Parents
3-Attorney recommended	7-School
4-Other criminal arrest	8-Other

G11. BAC: [ ][ ][ ]

G12. By whom was it ordered (1-4)? [ ]

1-Judge	3-Presentence
2-Probation	4-Parole

G13. Specify other ____

G14. Class: [ ]

1-Intake
2-Follow-up

G15. Contact Code: [ ]

1-In person
2-Phone
3-Mail

G16. Interviewer's initials: [ ][ ][ ]

COMMENTS FOR GENERAL AREA:______________________________

G17. Gender

M-Male F-Female

G18. How did the interview end?

0-Normal interview
1-Client terminated
2-Client refused
3-Client unable to respond

G19. Client's:

First name ______ Middle name ______ Last name ______

Address ______

Address ______

City ______ State ______ Zip ______

Phone number: [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

G20. How long have you lived at this address?

Years [ ][ ] Months [ ][ ]

G21. Is this address owned by you or your family (Y/N)?

G22. Date of birth: [ ][ ] / [ ][ ] / [ ][ ]

G23. Of what race do you consider yourself?

1-White
2-Black
3-American Indian
4-Alaskan Native
5-Asian or Pacific Islander
6-Hispanic-Mexican
7-Hispanic-Puerto Rican
8-Hispanic-Cuban
9-Other Hispanic

G24. What tribe do you consider yourself part of?__________________

G25. Religious preference:

1-Protestant
2-Catholic
3-Jewish
4-Islamic
5-Other
6-None
7-Traditional
8-Native American Church
9-Mormon
10-Pentecostal
11-Baptist

Specify other religion: ______________________________________

G26. Are you currently practicing this religion (Y/N)?

G27. What was the religious preference in the household where you were raised?

1-Protestant
2-Catholic
3-Jewish
4-Islamic
5-Other
6-None
7-Traditional
8-Native American Church
9-Mormon
10-Pentecostal
11-Baptist

G28. Have you been in a controlled environment in the past 30 days?

1-No
2-Juvenile detention center
3-Alcohol or drug treatment
4-Medical treatment
5-Psychiatric treatment
6-Other

Specify Other: ____

. How many days?

ADDITIONAL COMMENTS FOR GENERAL AREA: ___________________

MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? (*Include ODs, DTs, exclude detox)*

M2. How long ago was your last hospitalization for a physical problem?

Years ____ Months ____

What was it for? ____________________

M3. Do you have any chronic medical problems which continue to interfere with your life (Y/N)?

Specify: ____________________

Age at onset of chronic illness

M4. Are you taking any prescribed medication on a regular basis for a physical problem (Y/N)?

What is it? ____________________

What is it for? ____________________

M5. Do you receive financial compensation (pension, disability, etc.) for a physical disability (Y/N)?

Specify: ____________________

M6. How many days have you experienced medical problems in the past 30 days?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL
1-SLIGHTLY
2-MODERATELY
3-CONSIDERABLY
4-EXTREMELY

M7. How troubled or bothered have you been by these medical problems in the past 30 days?

M8. How important to you now is treatment for these medical problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medical treatment (0-9)?

CONFIDENCE RATINGS

Is the Medical Status information significantly distorted by:

M10. Patient's misrepresentation (Y/N)?

M11. Patient's inability to understand (Y/N)?

COMMENTS FOR MEDICAL AREA:____________________

EMPLOYMENT/SUPPORT STATUS

E1. Education completed (GED = 12 years):

Years ☐☐ Months ☐☐

E2. Training or technical education completed Months ☐☐

E3. Do you have a profession, trade or skill (Y/N)? ☐

Specify: ____

E4 Do you have a valid driver's license (Y/N)? ☐

E5. Do you have an automobile available (Y/N)? ☐

(Answer "no" if no valid driver's license)

E6. How long was your longest full-time job?

Years ☐☐ Months ☐☐

E7. Usual (or last) occupation: ☐

1a. Higher Executives
1b. Large Proprietor (Value over $180,000)
1c. Major Professionals
2a. Business Managers
2b. Proprietors of Medium-Sized Businesses
3a. Administrative Personnel
3b. Proprietors of Small Businesses (<$55,000)
3c. Minor Professionals
3d. Farmers (Owners $41,000-$60,000)
4a. Clerical and Sales Workers
4b. Technicians
4c. Proprietors of Little Business (<$10,000)
4d. Farmers (Owners $21,000-$40,000)
5a. Skilled Manual Employees and Small Farmers
5b. Small Farmers (Owners <$20,000)
6a. Machine Operators and Semi-Skilled Employees
6b. Small Farm Tenants
7. Unskilled Employees

Specify: ____

E8. Does someone contribute to your support in any way? (Y/N)? ☐

Specify: ____

Does this constitute the majority of your support (Y/N)? ☐

E9. Employment status: ☐

1-Full-time (35+ hrs/wk)`	5-Service
2-Part-time (reg. hrs.)	6-Retired/Disability
3-Part-time (irreg., daywork)	7-Unemployed
4-Student	8-In controlled environment

E10. At what age did you first start regular work? ☐☐

E11. How many days were you paid for working in the last 30? ☐☐

E12. How much money did you receive from the following sources in the past 30 days?

Employment (net income): ☐☐☐☐

Unemployment compensation: ☐☐☐☐

Public assistance: ☐☐☐☐

Pension, benefits or social security: ☐☐☐☐

Mate, family or friends: ☐☐☐☐

COMMENTS FOR EMPLOYMENT/SUPPORT AREA: ____________________

Parents, caretakers: [ ][ ][ ][ ]

Illegal: [ ][ ][ ][ ]

E13. What is your current weekly income? $ [ ][ ][ ][ ]

E14. How many people depend on you for the majority of their food, shelter, etc.? [ ][ ]

E15. How many days have you experienced employment problems in the past 30? [ ][ ]

E16. Are you currently enrolled in a school system (Y/N)? [ ]

E17. Current or last school attended:

Name: ____

Address ____

E18. Has there been a change in your school performance (Y/N)? [ ]

Explain: ____

____

E19. List the school activities that you are involved in: ______________

____

____

E20. Do you have difficulty reading (Y/N)? [ ]

E21. Do you have difficulty writing (Y/N)? [ ]

E22. What is your grade average in school? [ ] . [ ][ ]

E23. Have you ever been placed in special education classes or in a resource room (Y/N)? [ ]

Explain:____

E24. Have you failed any classes this year (Y/N)? [ ]

E25. Have you ever been suspended or expelled (Y/N)? [ ]

How many times have you been suspended? [ ][ ]

How many times have you been expelled? [ ][ ]

E26. Are you currently suspended or expelled (Y/N)? [ ]

Explain: ____

____

E27. How would you describe your attendance during the last school year (1-3)? [ ]

1-Good
2-Average
3-Poor

E28. How many days did you miss in the last semester you attended school? [ ][ ][ ]

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL
1-SLIGHTLY
2-MODERATELY
CONSIDERABLY
4-EXTREMELY

E29. How troubled or bothered have you been by these employment/education problems in the past 30 days? [ ]

E30. How important to you now is counseling for these employment/education problems? [ ]

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

E31. How would you rate the patient's need for employment counseling (0-9)? [ ]

CONFIDENCE RATINGS

Is the Employment/Support Status information significantly distorted by:

E32. Patient's misrepresentation (Y/N)? [ ]

E33. Patient's inability to understand (Y/N)? [ ]

ADDITIONAL COMMENTS FOR EMPLOYMENT/SUPPORT AREA: ______

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

DRUG/ALCOHOL USE

D1. What age did you first try alcohol or drugs? [|]

What was it? ____

		Age at 1st use	# Days Past 30	# Years in Lifetime	Route of Admin.	Date of Last Use Month/Year
D2.	Alcohol (any use at all)					/
D3.	Alcohol (to intoxication)					/
D4.	Heroin					/
D5.	Methadone					/
D6.	Other opiates/ analgesics					/
D7.	Barbiturates					/
D8.	Other sedatives hypnotics/ tranquilizers					/
D9.	Cocaine					/
D10.	Amphetamines					/
D11.	Cannabis					/
D12.	Hallucinogens					/
D13.	Inhalants					/
D14.	More than 1 substance per day (including alcohol)					/

Route of Administration

1-Oral
2-Nasal
3-Smoking
4-Non-IV injection
5-IV injection

D15. Have you ever used a needle to administer any of these drugs (Y/N)? [ ]

D16. Are you an I.V. drug user (Y/N)? [ ]

D17. According to the interviewer, which substance(s) are the major problem (00-16)? [|]

00-No problem
01-Alcohol
02-Alcohol to intox.
03-Heroin
04-Methadone
05-Opiates/analgesics
06-Barbiturates
07-Other sed/hyp/tranq
08-Cocaine
09-Amphetamines
10-Cannabis
11-Hallucinogens
12-Inhalants
15-Alcohol & one or more drugs
16-More than one drug

COMMENTS FOR DRUG/ALCOHOL AREA:_________________________

D18. (*Optional*) According to the patient, which substance(s) are the major problem? (*Use codes in question D-17*)

D19. How long was your last period of voluntary abstinence from this major substance (substance identified in D-18)? Months
(00-never abstinent)

D20. How many months ago did this abstinence end?
(00-never abstinent)

How many times have you:

D21. Had alcohol DTs?

D22. Overdosed on drugs?

How many times in your life have you been treated for:

D23. Alcohol abuse?

D24. Drug abuse?

How many of these were for detox only:

D25. Alcohol?

D26. Drug?

D27. How long ago were you last in treatment? Years

Months

D28. Name of Center ____

Address ____

Type of treatment:

1-Inpatient
2-Outpatient

How long did it last? Days

Did you complete it successfully (Y/N)?

D29. Have you been evaluated for alcohol or drugs before today (Y/N)?

Where: ____

When: __ / __ / __

How much money would you say you spent during the past 30 days on:

D30. Alcohol? $

D31. Drugs? $

D32. Do you receive any financial compensation for a drug or alcohol disability (include SSI/SSDI) (Y/N)?

D33. How many days have you been treated as on outpatient for alcohol or drugs in the past 30 days (include AA & NA)?

D34. (*Optional*) How many days have you been treated as an inpatient for alcohol or drugs in the past 30 days?

How many days in the past 30 days have you experienced:

D35. Alcohol problems?

D36. Drug problems?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 3-CONSIDERABLY
1-SLIGHTLY 4-EXTREMELY
2-MODERATELY

How troubled or bothered have you been in the past 30 days by these:

D37 Alcohol problems?

D38. Drug problems?

How important to you now is treatment for these:

D39. Alcohol problems?

D40. Drug problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

How would you rate the patient's need for treatment for (0-9):

D41. Alcohol Problems?

D42. Drug Problems?

CONFIDENCE RATINGS

Is the Drug/Alcohol Status information significantly distorted by:

D43. Patient's misrepresentation (Y/N)?

D44. Patient's inability to understand (Y/N)?

ADDITIONAL COMMENTS FOR DRUG/ALCOHOL AREA:_______________

Client Name: ___________________________________

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.) (Y/N)? ☐

L2. Are you on probation or parole? ☐

0-Neither
1-Probation
2-Parole

How many times in your life have you been arrested and charged with following?

		Count	Under the influence at the time (Y/N)?
L3.	Shoplifting/vandalism	☐☐	☐
L4.	Parole/probation violations?	☐☐	☐
L5.	Drug charges?	☐☐	☐
L6.	Forgery?	☐☐	☐
L7.	Weapons offense?	☐☐	☐
L8.	Burglary/larceny/B&E?	☐☐	☐
L9.	Robbery?	☐☐	☐
L10.	Assault?	☐☐	☐
L11.	Arson?	☐☐	☐
L12.	Rape?	☐☐	☐
L13.	Homicide/manslaughter?	☐☐	☐
L14.	Prostitution?	☐☐	☐
L15.	Contempt of court?	☐☐	☐
L16.	Other?	☐☐	☐

L17. How many of these charges resulted in convictions? ☐☐

How many times in your life have you been charged with:

L18. Disorderly conduct? ☐☐

Vagrancy? ☐☐

Public intoxication? ☐☐

L19. Driving while intoxicated? ☐☐

L20. Major driving violations? ☐☐

L21. MIP (minor in possession)? ☐☐

L22. Have you ever been placed on juvenile probation (Y/N)? ☐

L23. How many times have you been in detention? ☐☐☐

L24. How many months did you spend in juvenile detention centers? ☐☐☐

L25. How many month(s) were you incarcerated in your life? ☐☐☐

L26. How long was your last incarceration? Months ☐☐

COMMENTS FOR LEGAL AREA: ________________________________

L27. What was it for? [ ][ ]

03-Shoplifting/vandalism/theft
04-Parole/probation violation
05-Drug charges
06-Forgery
07-Weapons offense
08-Burglary/larceny/B&E
09-Robbery
10-Assault
11-Arson
12-Rape/sex related crimes
13-Homicide/manslaughter
14-Prostitution
15-Contempt of court
16-Other
18-Disorderly conduct, vagrancy
19-Driving while intoxicated
20-Major driving violations

L28. Are you presently awaiting charges, trial or sentencing (Y/N)? [ ]

For what? ____

L29. How old were you when you were first arrested? [ ][ ]

(00 if never arrested)

L30. What was your first arrest for? [ ][ ]

(Use codes 03-16, 18-20; 00 if never arrested)

03-Shoplifting/vandalism/theft
04-Parole/probation violation
05-Drug charges
06-Forgery
07-Weapons offense
08-Burglary/larceny/B&E
09-Robbery
10-Assault
11-Arson
12-Rape/sex related crimes
13-Homicide/manslaughter
14-Prostitution
15-Contempt of court
16-Other
18-Disorderly conduct, vagrancy
19-Driving while intoxicated
20-Major driving violations

L31. How many days in the past 30 were you detained or incarcerated? [ ][ ]

L32. How many days in the past 30 have you engaged in illegal activities for profit? [ ][ ]

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL
1-SLIGHTLY
2-MODERATELY
3-CONSIDERABLY
4-EXTREMELY

L33. How serious do you feel your present legal problems are? (exclude civil problems) [ ]

L34. How important to you now is counseling or referral for these legal problems? [ ]

THE QUESTIONS BELOW ARE BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

L35. How would you rate the patient's need for legal services or counseling (0-9)? [ ]

CONFIDENCE RATINGS

Is the Legal Status information significantly distorted by:

L36. Patient's misrepresentation (Y/N)? [ ]

L37. Patient's inability to understand (Y/N)? [ ]

ADDITIONAL COMMENTS FOR LEGAL AREA:______________________

FAMILY HISTORY

Which of these dependencies or other personal problems have been exhibited by members of your family? (*Use the letters listed below)*

A-Alcoholism	E-Eating disorder/compulsive overeater
D-Illegal drug dependence	C-Suicide
P-Prescription drug dependence	W-Workaholic
T-Cigarette smoker	V-Violence or frequent rages
G-Compulsive gambler	M-Mental illness
S-Sexual addiction	

Mother's Side

H1. Grandmother

H2. Grandfather

H3. Mother

H4. Aunt/Uncle

H5. Aunt/Uncle

H6. Aunt/Uncle

Which of these dependencies or other personal problems have been exhibited by members of your family? *(Use the letters listed below)*

A-Alcoholism	E-Eating disorder/compulsive overeater
D-Illegal drug dependence	C-Suicide
P-Prescription drug dependence	W-Workaholic
T-Cigarette smoker	V-Violence or frequent rages
G-Compulsive gambler	M-Mental illness
S-Sexual addiction	

Father's Side

H7. Grandmother

H8. Grandfather

H9. Father

H10. Aunt/Uncle

H11. Aunt/Uncle

H12. Aunt/Uncle

Which of these dependencies or other personal problems have been exhibited by members of your family? *(Use the letters listed below)*

A-Alcoholism	E-Eating disorder/compulsive overeater
D-Illegal drug dependence	C-Suicide
P-Prescription drug dependence	W-Workaholic
T-Cigarette smoker	V-Violence or frequent rages
G-Compulsive gambler	M-Mental illness
S-Sexual addiction	

Your Family

H13. Former Spouse/ Partner

H14. Spouse or Partner

H15. Yourself

H16. Brother/Sister

H17. Brother/Sister

H18. Brother/Sister

Which of these dependencies or other personal problems have been exhibited by members of your family? *(Use the letters listed below)*

A-Alcoholism	E-Eating disorder/compulsive overeater
D-Illegal drug dependence	C-Suicide
P-Prescription drug dependence	W-Workaholic
T-Cigarette smoker	V-Violence or frequent rages
G-Compulsive gambler	M-Mental illness
S-Sexual addiction	

Your Children

H19. Child #1

H20. Child #2

H21. Child #3

H22. Child #4

H23. Child #5

H24. Child #6

Which of these dependencies or other personal problems have been exhibited by members of your family? *(Use the letters listed below)*

A-Alcoholism	E-Eating disorder/compulsive overeater
D-Illegal drug dependence	C-Suicide
P-Prescription drug dependence	W-Workaholic
T-Cigarette smoker	V-Violence or frequent rages
G-Compulsive gambler	M-Mental illness
S-Sexual addiction	

Additional Family Members

H25. Specify: ______________________

H26. Specify: ______________________

H27. Specify: ______________________

H28. Specify: ______________________

H29. Specify: ______________________

H30. Specify: ______________________

How many siblings do you have?

H53. Brothers:

H54. Sisters:

COMMENTS FOR FAMILY HISTORY AREA:__________________________

____

____

____

____

____

____

____

____

____

____

FAMILY/SOCIAL RELATIONSHIPS

F1. What Is your current living environment? : ☐

1-Both parents
2-Single parent
3-Other relative
4-Foster home
5-Private care facility
6-Public care facility
7-Independent living
8-Parent/Step-parent
9-Other

Specify: ____

F2. Has this living arrangement changed in the past year (Y/N)? ☐

F3. Are you satisfied with your current situation at home? ☐

0-No
1-Indifferent
2-Yes

F4. Have you ever run away from home (Y/N)? ☐

F5. Have you ever lived in any of the following situations?

Y-Yes N-No X-Not applicable Z-Not answered

1. Two-parent household ☐
2. Single-parent household ☐
3. Extended family ☐
4. Other family, not parents ☐
5. Guardians, not related ☐
6. Residential schools ☐
7. Foster parents ☐
8. Orphanage ☐
9. Medical/Psychiatric institutions ☐
10. Correctional facility ☐
11. Unsupervised minor ☐

Please explain circumstances (when, where and why):

____

____

____

F6. Have you ever experienced stressful situations at home, such as family members: ☐

1-Hospitalized with a serious illness (physical or mental)
2-Died
3-Severely handicapped
4-Incarcerated (jail)
5-None
6-Other

Specify: ____

F51. What do you consider to be your first language? ________________

____

F52. Do you speak and understand your native language (Y/N)?

Understand: ☐

Speak: ☐

F53. What languages are spoken at home? ________________________

____

F54. Have you been given your Indian name? ☐

Specify: ____

F55. Why were you given this name? ___________________________

____

F56. Who gave you your name? ________________________________

F57. Were you raised on the reservation (Y/N)? ☐

F58. Has this been a positive experience for you (Y/N)? ☐

Explain why? ____

F59. Did you or a family member attend a boarding school (Y/N)? ☐

F60. Was this a positive experience for you (Y/N)? ☐

Explain why? ____

Do you live with anyone who:

F7. Has a current alcohol problem (Y/N)? ☐

F8. Uses non-prescribed drugs (Y/N)? ☐

F9. With whom do you spend most of your free time? ☐

1-Family
2-Friends
3-Alone

F10. Are you satisfied spending your free time this way? ☐

0-No
1-Indifferent
3-Yes

F11. Have you ever been a member of a gang (Y/N)? ☐

Are you currently a member (Y/N)? ☐

F12. How many days in the past 30 did you participate in sports? ☐☐

F13. How many days in the past 30 did you exercise? ☐☐

F14. Do you have a member of the family an alcohol/drug problem (Y/N)? ☐

Do you worry about their use (Y/N)? ☐

Do you feel like you are the reason for their use (Y/N)? ☐

Do you hate them when they are using (Y/N)? ☐

Do you feel guilty for hating them (Y/N)? ☐

Do you feel respected when they use (Y/N)? ☐

Do you talk to people about their use in the house (Y/N)? ☐

Do you feel embarrassed by their use (Y/N)? ☐

Do you like their drug using friends (Y/N)? ☐

Have you ever heard your parent(s) promise to quit (Y/N)? ☐

Have you lied to others about their use (Y/N)? ☐

Have you talked to them about trying to quit their use (Y/N)? ☐

Do you sometimes avoid being home when they use (Y/N)? ☐

Do you secretly wish you could make them stop using (Y/N)? ☐

Do you care if they use (Y/N)? ☐

F15. How many close friends do you have? ☐☐

F16. How many of these friends use alcohol or drugs? ☐☐

F17. Who do you feel is important to be involved in your counseling?

____

____

____

F18. *(Optional)* Sexual preference: ☐

1-Males 4-None
2-Females 5-Other
3-Both

F19. *(Optional)* How long have you had this preference? Years ☐☐

Months ☐☐

F20. *(Optional)* Are you satisfied with this sexual preference (1-3) ☐

1-No
2-Indifferent
3-Yes

F21. Do you currently have a boyfriend or girlfriend (Y/N) ☐

How long have you been in this relationship? Years ☐☐

Months ☐☐

F22. Have you ever had sex with another person (Y/N)? ☐

In the past year, how many partners have you had? ☐☐☐

Do you practice any methods that will protect you from sexually transmitted disease, or getting someone pregnant or yourself pregnant (Y/N)? ☐

Have you ever contracted a sexually transmitted disease, become pregnant or gotten someone pregnant? (Y/N)? ☐

Describe your past consequences: ____________________________

____

____

F23. Would you say you have had close, reciprocal relationships with any of the following people in your life?

Y-Yes N-No X-Not applicable Z-Not answered

Mother ☐

Father ☐

. Brothers/Sisters ☐

Sexual Partner/Spouse ☐

Children ☐

Friends ☐

COMMENTS FOR FAMILY/SOCIAL RELATIONSHIPS AREA:___________

F24. Have you had significant periods in which you have experienced serious problems getting along with:

Y-Yes *N-No* *X-Not applicable* *Z-Not answered*

	Past 30 Days	In Your Life	Has Alcohol or Drugs Affected This Relationship
Mother			
Father			
Brothers/Sisters			
Sexual Partner/Spouse			
Children			
*Other family member			
Close friends			
Neighbors			
Co-workers			
Employer			
Teachers			

*Specify other relative: ________________________________

Did any of these people abuse you:

00-None
18-Mother
19-Father
20-Brother/Sister
21-Sexual partner
22-Children
23-Other family
24-Close friends
25-Neighbors
26-Co-Workers
27-Teachers
28-Clergy
29-Yes, but does not know who or chooses not to identify person

	Past 30 days	In Your Life
F25. Emotionally (make you feel bad through harsh words)?		
F26. Physically (cause you physical harm)?		
F27. Sexually (force sexual advances or sexual acts)?		

F28. How many days in the past 30 have you had serious conflicts:

With your family?

With other people (excluding family)?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL
1-SLIGHTLY
2-MODERATELY
3-CONSIDERABLY
4-EXTREMELY

F29. How troubled or bothered have you been in the past 30 days by these:

Family problems?

Social problems?

F30. How important to you now is treatment or counseling for these:

Family problems?

Social problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

F31. How would you rate the patient's need for family and/or social counseling (0-9)?

CONFIDENCE RATINGS

Is the Family/Social Relationships information significantly distorted by:

F32. Patient's misrepresentation (Y/N)?

F33. Patient's inability to understand (Y/N)?

COMMENTS FOR FAMILY/SOCIAL RELATIONSHIPS AREA:___________

PSYCHIATRIC STATUS

P1. How many times have you been treated for any psychological or emotional problems:

In a hospital or inpatient setting? ☐☐

As an outpatient or private patient? ☐☐

P1a. Age when first treated for psychiatric or emotional problems: ☐☐

P2. Do you receive financial compensation for a psychiatric or emotional disability (include pension, SSI, SSDI, etc.) (Y/N)? ☐

Have you had a significant period (that was not a direct result of drug or alcohol use) in which you have:

Y-Yes N-No X-Not applicable Z-Not answered

	Past 30 Days	Lifetime
P3. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily functioning?	☐	☐
P4. Experienced serious anxiety/ tension - uptight, unreasonably worried, inability to feel relaxed?	☐	☐
P5. Experienced hallucinations - saw things or heard voices that others did not see or hear?	☐	☐
P6. Experienced trouble understanding, concentrating or remembering?	☐	☐
P7. Experienced trouble controlling violent behavior including episodes of rage or violence?	☐	☐
P8. Experienced serious thoughts of suicide?	☐	☐
P 9. Attempted suicide?	☐	☐
P10. Been prescribed medication for any psychological/emotional problems?	☐	☐

NOTE: For questions 7-9, include incidents that occurred when the person was under the influence of substances.

P11. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL
1-SLIGHTLY
2-MODERATELY
3-CONSIDERABLY
4-EXTREMELY

P12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐

P13. How important to you now is treatment for these psychological or emotional problems? ☐

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

At the time of the interview, is the patient (Y/N)?

P14. Obviously depressed/withdrawn? ☐

P15. Obviously hostile? ☐

P16. Obviously anxious/nervous? ☐

P17. Having trouble with reality testing, thought disorders, paranoid thinking? ☐

P18. Having trouble comprehending, concentrating, remembering? ☐

P19. Having suicidal thoughts? ☐

INTERVIEWER SEVERITY RATING

P20. How would you rate the patient's need for psychiatric/psychological treatment (0-9)? ☐

CONFIDENCE RATINGS

Is the Psychiatric Status information significantly distorted by:

P21. Patient's misrepresentation (Y/N)? ☐

P22. Patient's inability to understand (Y/N)? ☐

COMMENTS FOR PSYCHIATRIC AREA: ____________________________

SPIRITUALITY

S1. Do you have a belief in the Creator (Y/N)? ☐

S2. What is your relationship with your Creator now? ________________

____

S3. Have you been given any spiritual teachings (Y/N)? ☐

Specify: ____

S4. How have these influenced your life in the past and today?

____

____

S5. Do you attend:

Church (Y/N)? ☐

Traditional ceremonies (Y/N)? ☐

S6. When was the last time you attended? ____________________

S7. Do you participate in any of the following:

Sweatlodge Ceremony (Y/N)? ☐

Pipe Ceremony (Y/N)? ☐

Talking Circle (Y/N)? ☐

Mentoring (Y/N)? ☐

Other (Y/N)? ☐

Specify: ____

S8. Why are they important to you? ________________________

____

S9. Whom do you seek out for help?

Medicine People (Y/N)? ☐

Traditional Practitioners (Y/N)? ☐

S10. Are you comfortable with your spirituality and beliefs (Y/N)? ☐

S11. How has the use of alcohol and/or drugs affected any of these important life areas? ________________________________

____

JCAHO SUPPLEMENT

In the space below, indicate how you spent your time prior to entering treatment with us. Answer "yes" to those time periods when you usually drank or got high (50% of the time or more).

A Typical Work Day

Y-Yes N-No X-Not applicable Z-Not answered

6-8 AM ____________________________ ☐

8-10 AM ____________________________ ☐

10 AM-12 PM ____________________________ ☐

12-2 PM ____________________________ ☐

2-4 PM ____________________________ ☐

4-6 PM ____________________________ ☐

6-8 PM ____________________________ ☐

COMMENTS FOR SPIRITUALITY AREA: ____________________

____

COMMENTS FOR JCAHO SUPPLEMENT: ____________________

____

8-10 PM ______________________________ ☐

10 PM-12 AM ______________________________ ☐

12-2 AM ______________________________ ☐

2-4 AM ______________________________ ☐

4-6 AM ______________________________ ☐

Document regular events such as waking, meals and sleeping. Note if there is no fixed schedule.

In the space below, indicate how you spent your time prior to entering treatment with us. Answer "yes" to those time periods when you usually drank or got high (50% of the time or more).

A Typical Day Off

Y-Yes N-No X-Not applicable Z-Not answered

6-8 AM ______________________________ ☐

8-10 AM ______________________________ ☐

10 AM-12 PM ______________________________ ☐

12-2 PM ______________________________ ☐

2-4 PM ______________________________ ☐

4-6 PM ______________________________ ☐

6-8 PM ______________________________ ☐

8-10 PM ______________________________ ☐

10 PM-12 AM ______________________________ ☐

12-2 AM ______________________________ ☐

2-4 AM ______________________________ ☐

4-6 AM ______________________________ ☐

Document regular events such as waking, meals and sleeping. Note if there is no fixed schedule.

Free Time: Read through the entire list of activities and select at least five things that you like to do.

Swim	Religious activities
Listen to music	Go out to dinner
Yoga	Community work
Crafts	Artwork
Bird watch	Cook
Go sailing	Photography
Knit	Golf
Needlepoint	Play tennis
Carpentry/furniture making	Meditate
Return to school	Horseback riding
Exercise	Read
Hike in the woods	Chess
Play with my kids	Pinball
Target shooting	Racquetball
Travel (foreign)	Go camping
Martial arts (karate, etc)	Travel
Volunteer work	Singing/Choir
Go to a museum	Computers
Go to the movies	Making clothes
Go fishing	Other
Go to theater productions	Help at school w/kids
Learn magic tricks	Play a musical instrument
Play basketball	Aerobics
Go to arcades	Dance
	Archery

Values: From the list below, select the five items that are most important to you.

Personal freedom	God
Being sober	Cars
Sex life	Looking good
Intelligence	Being right
Wisdom	Approval from others
Peace of mind	Family
Happiness	Mother
Spouse	Father
Being a parent	Being content
Wealth	Being safe
Health	Being loving
	Being loved

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (Check box)

Work/School Situations

Around people who drink/use ☐

After taking a test ☐

Workers invite me to drink/use ☐

I just got paid; I've got money ☐

I'm away from my supervisor ☐

Hassle with a boss or coworker ☐

After working hard ☐

Peers invite me to drink/use ☐

Away from school or teachers ☐

Hassle with a friend or peer ☐

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check box)

Family Situations

After I have a problem with a family member ☐

I drink/use with certain family members ☐

Just thinking about my family upsets me ☐

When someone in my house drinks/uses ☐

Family events include drinking/drug use ☐

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check box)

Social Situations

Being at parties where people are drinking/using ☐

Weekend/end of work week ☐

Free time ☐

Special occasions (weddings, etc.) ☐

Dancing ☐

Someone I date drinks/uses drugs ☐

I used to go to bars to socialize ☐

I play sports with people who drink/use ☐

Almost all my friends drink or use drugs ☐

- [ ] Being in any group situation is upsetting
- [ ] Any kind of gambling
- [ ] I get uptight whenever I go out of my house
- [ ] Being alone bothers me

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check one)

Moods, Mental and Physical State

Lonely	☐	Bored	☐
Cannot sleep	☐	Angry	☐
Guilt	☐	Hunger	☐
Uptight	☐	Envious or jealous	☐
Worried	☐	Self-pity	☐
Depressed	☐	Fear	☐
Sexually turned on	☐	Feeling powerful	☐
Having a success	☐	Good news	☐
Winning	☐	Loss of loved one	☐
Tired	☐	Drug/drinking dreams	☐

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check one)

People, Places and Things

- [ ] People I've gotten high with in the past
- [ ] Seeing things that look like drugs
- [ ] News reports about drugs
- [ ] Watching certain TV programs
- [ ] Playing musical instruments
- [ ] Eating at restaurants
- [ ] Rock concerts
- [ ] Seeing drug-related things
- [ ] Seeing people drinking or using drugs
- [ ] Seeing a place where I used to drink/use
- [ ] Being in my car
- [ ] Driving through certain neighborhoods
- [ ] Seeing a drug deal take place
- [ ] Seeing or hearing a beer/alcohol ad
- [ ] Listening to certain music
- [ ] Going to casinos

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check box)

Romantic/Sexual Settings

- [ ] Trying to find a lover/romantic partner
- [ ] Thinking about sex/sexual fantasy
- [ ] Any kind of sexual activity
- [ ] Having certain kinds of sex
- [ ] Having sex with a prostitute
- [ ] Being in a new relationship
- [ ] Being rejected
- [ ] Asking for a date

Time Begun: ☐☐ : ☐☐

Time End: ☐☐ : ☐☐

ADDITIONAL COMMENTS FOR JCAHO SUPPLEMENT: ______________

INTERVIEWER'S ASSESSMENT

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

DIAGNOSTIC IMPRESSION

SASSI-3:

- RAP? ☐
- FVA? ☐
- FVOD? ☐
- SYM? ☐
- OAT? ☐
- SAT? ☐
- DEF? ☐
- SAM? ☐
- FAM? ☐
- COR? ☐

DSM-IV

AXIS I:

____
____

Description:

____
____
____

AXIS II:

____
____

Description:

____
____
____

AXIS III:

____
____

AXIS IV:

____
____

AXIS V:

____
____

COMMENTS FOR DIAGNOSTIC IMPRESSION: ____________________
____
____
____
____
____
____
____
____
____
____
____

RECOMMENDATION FOR TREATMENT

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

LEVEL OF CARE RECOMMENDATION

(Check one):

1. Not applicable ☐
2. Level I – (Outpatient treatment) ☐
3. Level II – (Intensive outpatient/partial hospitalization) ☐
4. Level III – (Medically monitored intensive inpatient) ☐
5. Level IV – (Medically managed intensive inpatient) ☐