Community Intervention & Educational Services Home of The COOL Program

SUBSTANCE ABUSE ASSESSMENT

1225 EAST 5TH STREET, WS NC 27101 | 336-776-0322

Substance Abuse Intake Date: _____ Participant: _____

Interviewer: _____

Name: _____ DOB: Age:

Address
Street Number: _____ Street Name: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ SSN: _____

Marital Status (check): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status (check): ☐ Full-time ☐ Part-time ☐ Student ☐ Unemployed

MEDICAL HISTORY

This medical information is used to detect possible medical problems that may require a doctor's attention. Responses may result in the recommendation that you see your doctor for a physical examination.

Your Physician's Name: _____ Allergies: _____

Current Medications: _____

Please check the symptoms or conditions that have applied to you at any time:

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Cancer/Tumors
☐ Diabetes ☐ Drug abuse ☐ Epilepsy ☐ High blood pressure
☐ Eating problems ☐ Hearing problems ☐ Kidney disease ☐ Head trauma
☐ Seizures ☐ Stroke ☐ Heart disease

Please check the symptoms or conditions that frequently apply:

☐ Abdominal pain ☐ Bedwetting ☐ Breathing difficulty ☐ Chest pain
☐ Colds ☐ Constipation ☐ Decreased appetite ☐ Diarrhea
☐ Fainting ☐ Frequent urination ☐ Headaches ☐ Menstrual pain
☐ Nausea ☐ Numbness ☐ Sleep disturbance ☐ Stomachaches
☐ Vision changes ☐ Chills/Hot flashes ☐ Sweating ☐ Heart pounding
☐ Rapid heartbeat ☐ Shortness of breath ☐ Dizziness ☐ Fatigue
☐ Skin problems ☐ Stuttering ☐ Blackouts ☐ Choking sensations
☐ Trembling/shaking ☐ Tic/Twitches ☐ Muscle tension ☐ Muscle spasms
☐ Jaw pain ☐ Muscle or joint pain ☐ Sexual problems
☐ Other: _____

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CHIEF CONCERN/SITUATION

Please describe the primary problem/concern for which you have come to the office:

What do you consider to be the top three stressors in your life?

1. _____

2. _____

3. _____

Do you have problems with your work performance or boss? ☐ Yes ☐ No

If yes, explain: _____

Do you have any legal problems? ☐ Yes ☐ No

If so, please state: _____

Who/what is your support system? _____

PSYCHOLOGICAL SYMPTOMS

Emotions (Select any of the following emotions that you find troublesome and/or apply to you in the last month):

☐ Hopeless	☐ Happy	☐ Fearful	☐ Confused	☐ Tense	☐ Contented
☐ Anxious	☐ Angry	☐ Distrustful	☐ Lonely	☐ Jealous	☐ Guilty
☐ Sad	☐ Helpless	☐ Bored	☐ Frustrated	☐ Excited	☐ Energetic
☐ Relaxed	☐ Restless	☐ Suspicious	☐ Other:		

Behaviors (Select any of the following behaviors that you find troublesome and/or apply to you in the last month):

☐ Under eating	☐ Temper outburst	☐ Impulsiveness	☐ Vomiting	☐ Aggressive	☐ Hurting others
☐ Overeating	☐ Nightmares	☐ Spending sprees	☐ Crying	☐ Decreased interest	☐ Odd behavior
☐ Sleeping problems	☐ Increased drinking	☐ Hurting self	☐ Impulsiveness	☐ Isolation	☐ Social withdrawal
☐ Increased energy	☐ Increased smoking	☐ Flashbacks	☐ Loss of control	☐ Fears	☐ Unable to keep job
☐ Decreased energy	☐ Taking too many risks	☐ Concentration problems	☐ Avoiding activities	☐ Avoiding places	☐ Avoiding people
☐ Mood altering with drugs	☐ Other: _____				

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MENTAL HEALTH HISTORY

Have you previously been seen for a mental health reason, in an office, clinic, or hospital? ☐ Yes ☐ No

If yes, please indicate below the date(s), location(s), Inpatient/Outpatient, and the diagnosis:

Date:	Facility:	Inpatient/Outpatient:	Diagnosis:

Do you currently have trouble with alcohol and/or drugs? ☐ Yes ☐ No

If yes, explain: _____

Have you had trouble with alcohol and/or drugs in the past? ☐ Yes ☐ No

If yes, explain: _____

Have you been treated in the past for substance abuse? ☐ Yes ☐ No

If yes, explain: _____

If yes, are you actively working a recovery program? ☐ Yes ☐ No

FAMILY HISTORY

Please state which family members may have had any of the following:

Mental illness: _____ Intellectual Disability: _____

Cancer/Tumors: _____ Alcoholism: _____

Other substances: _____ Heart disease: _____

Any history of physical, sexual, emotional, or mental abuse? ☐ Yes ☐ No

EDUCATIONAL HISTORY

What is the highest grade/level of education you have completed? _____

Did you have any conduct or behavioral problems in school? ☐ Yes ☐ No

If yes, explain: _____

Did you have a learning disability or need for special education services? ☐ Yes ☐ No

If yes, explain: _____

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GOALS FOR TREATMENT

What are your goals for treatment and what would you like to see change or be different?

INFORMED CONSENT / TREATMENT AGREEMENT

- ☐ I agree to make a commitment to the treatment process. I understand this means
- ☐ I agree to active involvement in all aspects of treatment, including
- ☐ Attending sessions (or letting my provider know when I cannot make it)
- ☐ Voicing my opinions, thoughts, and feelings honestly and openly whether negative or positive
- ☐ Being actively involved during sessions
- ☐ Completing homework assignments
- ☐ Experimenting with new behaviors and new ways of doing things Taking medication as prescribed
- ☐ Implementing my crisis response plan.
- ☐ I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it is not working, I will discuss it with my provider.

Patient's Signature _____ Date: _____

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SUBSTANCE ABUSE/ALCOHOL SCREENING

1. At what age did you first drink alcohol?_____
2. Who introduced you to alcohol? _____
3. How much do you drink? _____
4. What do you drink?_____
5. Date of last drink: _____
6. Are any members of your family heavy drinkers or alcoholics? _____
7. What is your drinking pattern? alone daily weekly binges | other: _____
8. Has your drinking been problematic with any of the following? spouse children extended family friends work other:_____
9. Have you ever been arrested related to drinking? | DWI/DUI | drunken fights disorderly behavior underage drinking other _____
10. Have you ever been hospitalized for alcohol use?_____
11. What are your symptoms? blackouts tremors D.T.s | seizures hallucinations other
12. Have you ever taken Dilantin or any other drugs for seizures?_____
13. Are you aware of changes in the amount of alcohol required to get the effect you want? _____
14. Do you have, or were you treated for: pancreatitis cirrhosis hepatitis esophagitis
15. Have you had previous treatment? detoxification rehabilitation | halfway house outpatient other _____
16. Have you experienced tingling, pain, or numbness in your hands or feet (neuropathy)? _____
17. Have you ever attended AA meetings? _____
18. Have you ever had a sponsor?_____

DRUG HISTORY

1. At what age did you first use drugs? _____
2. Who introduced you to drugs?_____
3. Have you ever been arrested for using and/or selling drugs?_____
4. Do you expect to benefit from this program? Yes No
   If so, how?_____If not, why not? _____
5. Have you received any other type of mental health treatment or counseling? | Yes | No
   If so, why, when, and where? _____
6. Have you ever attempted suicide? Yes No
   If so, when and how? _____

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Have you used any of the following drugs?

☐ Marijuana	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Inhalants	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Cocaine	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Crack	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Heroin	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Methadone	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Tranquilizers	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Valium	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Librium	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Quaaludes	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Pills	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Dust	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ LSD/PCP	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Black tar	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Prescription	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Over the counter	Age at 1st use: _____	Frequency: _____	Last Use: _____
☐ Other	Age at 1st use: _____	Frequency: _____	Last Use: _____

ANALYSIS OF CURRENT PROBLEMS

Check any of the current behaviors that apply to you:

☐ Weight gain/loss	☐ Suicide attempts	☐ Lazy	☐ Frequent crying	☐ Drinking too much
☐ Self-harm	☐ Loss of control	☐ Withdrawal	☐ Smoking	☐ Working too hard
☐ Can't keep a job	☐ Sleep problems	☐ Using drugs	☐ Extreme fears	☐ Outbursts of temper
☐ Hyperactive behavior	☐ Working too much	☐ Other: _____		

Check any of the feelings that often apply to you:

☐ Anger	☐ Bored	☐ Content	☐ Jealous	☐ Optimistic
☐ Unhappy	☐ Guilty	☐ Hopeless	☐ Relaxed	☐ Helpless
☐ Energetic	☐ Confused	☐ Sad	☐ Lonely	☐ Restless
☐ Hopeful	☐ Tense	☐ Rested	☐ Happy	☐ Depressed
☐ Panic	☐ Joyful	☐ Ashamed	☐ Other: _____	

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Circle any of the physical symptoms that apply to you:

☐ Headaches	☐ Tiredness	☐ Blackouts	☐ Sexual problems	☐ Fainting spells
☐ Stomachaches	☐ Chest pain	☐ Tensions	☐ Tremors	☐ Forgetfulness
☐ Dry mouth	☐ Twitches	☐ Back pain	☐ Numbness	☐ Hearing things
☐ Dizziness	☐ Rapid heartbeat	☐ Tingling	☐ Spasms	☐ Excessive sweating

☐ Other:_____

Identify any serious health problems that you have (include dates):

FINANCIAL POLICY

The following is our financial policy, which we request you read, understand, and sign prior to treatment.

Billing: Payment for all client statements is due in full upon receipt. A divorce decree cannot assign responsibility for an adult or child's account. Failure to pay your bill could result in your account being turned over to a collection agency. Only your name and account status will be discussed with the collection agency.

Payments will only be accepted by Square or Cash

I understand that if I carry a balance greater than $100. I will not be allowed to continue classes until my account is caught up._____

I understand I have the option to have an automatic draft from my account through Square. _____

I understand that I will not receive a certificate until I pay off my entire balance. _____

I understand that payments must be made weekly or every two weeks according to my work schedule. _____

Payments will go as follows:

30 hrs or more	$80 / week	or $160 every 2 weeks	for 10 weeks total
20 hrs	$66.67 / week	or $133.34 every 2 weeks	for 6 weeks total
16 hrs	$37 / week	or $74 every 2 weeks	for 5 weeks total

My signature acknowledges that I have read, understand, and agree to all parts of the financial policy of Pattison Professional Counseling Center. I also understand that my account will be turned over to a collection agency if it becomes delinquent.

Client Signature: _____ Date:_____

Staff Signature: _____ Date:_____

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EDUCATIONAL SERVICES: STATEMENT OF CLIENTS' RIGHTS

Community Intervention & Educational Services provides services to all clients without regard to race, color, religion, national origin, gender, sexual orientation, age, disability, veteran status, or any other discriminatory factor recognized by law.

When you receive services from Community Intervention you also have certain rights. Listed below is a summary of those rights. If you would like more detailed information about these rights, please ask your primary service provider. At Eliza's Helping Hands and Community Intervention, we strive to provide the highest quality of services possible while striving to protect and enhance the rights and quality of life of all of our clients.

You have the right to know the basic expectations for use of the organization's services. The main offices of Community Intervention & Educational Services are located at 1225 East 5th Street Winston Salem, NC and are open Monday & Wednesday from 9 a.m. to 1 p.m. Tuesday through Thursday from 9 a.m. to 7:30 p.m., and on Friday from 9 a.m. to 1 p.m., Saturday 8:30 a.m. to 1 p.m. You will be given written information explaining the various services that we offer, the specific locations and hours of operation for each service, and the expectations required to receive those services. You will also be notified in writing of any rules, behavioral expectations, and other factors that could result in discharge or termination of services. Termination of services may result if you violate one or more of the conditions as specified in your individual service agreement.

You have the right to a treatment plan or a plan for your services. You have the right to participate in the development of your plan. A written plan of services or treatment, based on your individual needs, must be implemented within 30 days of admission to services. For Medicaid recipients of mental health services, a treatment plan will be developed upon admission to services.

You have the right to refuse services or treatment. You have the right to consent to treatment or services and may withdraw your consent at any time. If you refuse a recommended service, treatment, or medication, the organization will attempt to inform you of the consequences of such refusal. The only time that you can be treated without your consent is in an emergency, when it has been court-ordered, or if you are a minor and your parent or guardian has given consent.

You have the right to confidentiality. Unless the law requires it, your records and other information about you will not be released without your written permission (or if you are a minor, the written permission of your parent or legal guardian). Circumstances under which we may be required by law to share information with another about the services you receive include:

- If you give written permission, we may share information with any person or agency your name
- If we believe that you are an imminent danger to yourself or to others, or if we believe you are likely to commit a crime, we may share information with law enforcement and with threatened individuals.
- The court may order us to release your records without your permission.
- If we suspect that you have neglected or abused a child or dependent adult, or you are being investigated for child abuse or neglect, we are required by law to share information with county protective services officials. If you are HIV positive and we are aware that you are not following proper control measures, we are required to report this to agents charged with the protection of public health. Our attorney may need to see your file because of legal proceedings.

COMMUNITY INTERVENTION ACKNOWLEDGEMENT OF RECEIPT OF WRITTEN STATEMENT OF CLIENTS' RIGHTS

I have received and reviewed a copy of Community Intervention & Educational Services Inc Services Statement of Clients' Rights explaining my rights. I have received and reviewed a copy of the Privacy Notice For COOl Care Services.

Client Name (please print): _____

Client Signature: _____ Date: _____
(Or Legal Guardian if a minor)

Staff Signature: _____ Date: _____

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PRIVACY NOTICE
C.A.R.E & COOL PROGRAM SERVICES

THE FOLLOWING NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF YOUR RIGHTS AS DEFINED IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

Protected health information (PHI) is individually identifiable health information that relates to the covered person's past, current, or future health status, the provision of health services, or payment for the provision of health care services to covered persons.

CIES is legally required to maintain the privacy of Community Intervention & Educational Services and to abide by the terms of this notice and the Health Insurance Portability and Accountability Act (HIPAA).

Information regarding your health care, including payment for health care, is protected by the two federal laws: the Health Insurance Portability and Accountability Act of 1996(HIPAA), 42U.S.C. 1320D ET SEQ., 45C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C.290dd-2, 42C.F.R. Part 2. Under these laws, Triangle Family Services may not disclose to a person outside Triangle Family Services that a person attends the program, nor may Triangle Family Services disclose any information identifying a person as an alcohol or drug abuser or a participant in our prevention program, nor disclose any other protected information except as permitted by federal law

CIES will typically ask for your written authorization to share or obtain information from others. However, we may use and disclose information about you without your authorization in the following circumstances:

- To coordinate treatment within the agency. For example, you therapist may share information with another therapist or with your physician to coordinate services
- **Payment:** We may use and disclose necessary information about you to obtain payment for our services. For example, this information could include information that your health insurance plan may require before it approves or pays for treatment services.
- **Health Care Operations:** We may need to use or disclose information for our agency activities which might include assessment of the quality of our services, clinical supervision of staff, education and training of students and other professionals, and compliance activities required to ensure that we are following policies, procedures, laws, regulations, and professional standards.

PHI may be released without your consent if required by state or federal law.

We may use or disclose information to notify or assist in notifying a family member,personal representative, or another person responsible for your care, your location and general condition. We may leave a message on your answering machine or on voicemail as a means of communication. We may mail you a written notice as a means of communication. We may e-mail you as a means of communication. Unless otherwise instructed in writing, these methods of communication will be used.

- PHI may not be released for any purposes other than those identified in this notice. Other disclosures and uses will be made only with your written authorization or consent and you may revoke such authorization/consent at any time.
- The plan reserves the right to make changes to this notice and to continue to maintain the confidentiality of all healthcare information. You will receive notice of any changes within 60 days of making a change.
- You have the right to inspect and copy your CIE.
- You have the right to request that your PHI be amended when you believe that it is inaccurate or incomplete. If your care provider does not agree to amend it, you may add an explanation to your record.
- You have the right to request restrictions on the use or disclosure of your PHI, even though the agency is not required to agree to the requested restrictions.
- You have the right to obtain an accounting of instances in which the plan has disclosed PHI for purposes other than treatment, payment, or health care operations, except for disclosures made at your

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You have the right to receive written notice of the policy regarding privacy and access to PHI. You can also obtain a copy of this Privacy Notice upon request.

You have the right to complain to CIES if you believe your privacy rights have been violated. You can mail your complaint to Privacy Officer, 1225 East 5th Street. You may also make a written complaint to the U.S. Department of Health and Human Services. This complaint must be filed within 180 days of the time you became or should have become aware of the problem. You will not be retaliated against for filing a complaint.

If you have any concerns regarding your case, please discuss it with your care provider.

For further information about this Privacy Notice, please contact Kenya Thornton, 336-776-0322.

This notice is effective as of May 5, 2020.

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TWO WAY CONSENT FOR RELEASE

Information to be released by:

Agency/School/Persons: _____

Address: _____

Telephone: _____ Fax: _____

Name/Position: _____

Information to be released to:

Agency/School/Persons: _____

Address: _____

Telephone: _____ Fax: _____

Name/Position: _____

☐ I also give my permission for the exchange of information (oral and/or written) between the above named agencies/schools/persons.

Print Name: _____

Signature of Participant: _____ Date: _____

CIES Caseworker Name (print): _____

CIES Caseworker Name (signature): _____ Date: _____

YOUR INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt#: _____ Driver's License: _____

City: _____ Social Security #: _____

State: _____ Zip: _____

Race: (Check) ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Multi Racial ☐ Native American

Cell Phone #: _____ Work Phone #: _____

Employer Phone #: _____

Relationship to you: _____ Phone #: _____

Referral Source: (Check) ☐ Criminal Court ☐ Civil Court ☐ Probation/Parole ☐ DSS ☐ Voluntary ☐ Other

County: (Check) ☐ Forsyth ☐ Davie ☐ Davidson ☐ Guilford ☐ Montgomery ☐ Stokes ☐ Surry ☐ Other

Probation: (Check) ☐ Supervised ☐ Unsupervised ☐ PJC ☐ Deferred Prosecution ☐ Not Applicable

Probation/Court Officer: _____ DSS Case Worker: _____

Email Address: _____

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SUBSTANCE ABUSE PARTICIPANT SIGN-IN SHEET

Start Date: _____ Group _____ Time: _____

Client Name: _____ Phone: (_____) _____

Email Address: _____

☐ BAC ☐ No Diagnoses ☐ Active Diagnoses ☐ Remission

☐ PO ☐ CS ☐ DSS ☐ Attorney Name: _____

	Date of Session	Present / Absent	Amount Paid	Assignment Completed	Staff Initials
Assess. / ADETS		☐ Yes ☐ No			
1 (1.5 hours)		☐ Yes ☐ No			
2 (3 hours)		☐ Yes ☐ No			
3 (4.5 hours)		☐ Yes ☐ No			
4 (6 hours)		☐ Yes ☐ No			
5 (7.5 hours)		☐ Yes ☐ No			
6 (9 hours)		☐ Yes ☐ No			
7 (10.5 hours)		☐ Yes ☐ No			
8 (12hours)		☐ Yes ☐ No			
9 (13.5 hours)		☐ Yes ☐ No			
10 (15 hours)		☐ Yes ☐ No			
11 (16.5 hours)		☐ Yes ☐ No			
12 (18 hours)		☐ Yes ☐ No			
13 (19.5 hours)		☐ Yes ☐ No			
14 (21 hours)		☐ Yes ☐ No			
15 (22.5 hours)		☐ Yes ☐ No			
16 (24 hours)		☐ Yes ☐ No			
17 (25.5 hours)		☐ Yes ☐ No			
18 (27 hours)		☐ Yes ☐ No			
19 (28.5 hours)		☐ Yes ☐ No			
20 (30 hours)		☐ Yes ☐ No			

Program Requirement = Assessment / ADETS + Sessions Needed

Program Name: SUBSTANCE Completed On: _____

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SUBSTANCE ABUSE INFORMATION SHEET

Date of Intake:_____

# of Classes Needed: _____

Email address: _____

Entered into therapy note on: _____ by: _____

Client Name:_____ DOB: _____

Client Phone Number: _____ Client Email: _____

Race: _____ Ethnicity: _____

Language: _____ Marital Status: _____

Employment Status: _____

Highest Level of Education:_____ Hours Needed: _____

START Date:_____ Group Day: _____

Attorney:_____ Virtual or in person: _____

Date Completed Class: _____

Intake Assessment completed by: _____ on_____

Assessment Amount Paid: _____ # of classes paid: _____

Date Completed: _____