NYS Office of Alcoholism and Substance Abuse Services

Client Admission Report

FOR ADMISSIONS DATED 1/1/2007 AND BEYOND

Provider Number __ __ __ __ __ **Program Number** __ __ __ __ __

Provider Client ID __ __ __ __ __ __ __ __ __ __ **Special Project (See instructions):**_____

Sex ☐ Male ☐ Female **Birth Date** __ __/__ __/__ __ __ __ **Last 4 SSN** __ __ __ __ **Last Name First 2 Letters** __ __ (Birth Name)

Admission Date __ __ / __ __ / __ __ __ __

No. of Assessment Visits/Days __ **Significant Other** ☐ Yes ☐ No

Race
- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other

Hispanic Origin
- ☐ Cuban
- ☐ Mexican
- ☐ Other Hispanic
- ☐ Hispanic, Not Specified
- ☐ Puerto Rican
- ☐ Not of Hispanic Origin

Primary Language
- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Greek
- ☐ Hindi
- ☐ Japanese
- ☐ Portuguese
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ Other

Veteran Status ☐ Yes ☐ No **Zip Code of Residence** ___ ___ ___ ___ ___ (For Canada use 88888)

County of Residence _____

Type of Residence
- ☐ Private Residence
- ☐ Homeless, Shelter
- ☐ Homeless, No Shelter
- ☐ Single Resident Occupancy
- ☐ CD Community Residence
- ☐ MH/MRDD Community Residence
- ☐ Other Group Residential Setting
- ☐ Institution, Other (jail, hospital)
- ☐ Other

Living Arrangements ☐ Living Alone ☐ Living w/ Non-Related Persons ☐ Living with Spouse/Relatives

Principal Referral Source
- ☐ Self-Referral
- ☐ Family, Friends, Other Individual
- ☐ AA/NA and Other Self-Help

Chemical Dependence Treatment
- ☐ CD Medically Managed Detoxification
- ☐ CD Med. Supervised Withdrawal Inpatient/Resid.
- ☐ CD Medically Supervised Withdrawal Outpatient
- ☐ CD Medically Monitored Withdrawal
- ☐ CD Inpatient Rehabilitation
- ☐ CD Intensive Residential
- ☐ CD Residential Chemical Dependency for Youth
- ☐ CD Outpatient Chemical Dependency for Youth
- ☐ CD Community Residence
- ☐ CD Outpatient Clinic
- ☐ CD Outpatient Rehab Program
- ☐ CD Methadone Treatment
- ☐ CD Non-medically Supervised Outpatient

Prevention/Intervention Services
- ☐ Community Education and Intervention
- ☐ Youth Education and Intervention (non SAP)
- ☐ Student Assistance Program/School Based
- ☐ Hospital and Health Care Intervention Services
- ☐ Employee Assistance Program
- ☐ Other Prevention/Intervention Program

Criminal Justice Services
- ☐ Drinking Driver Referral
- ☐ Police
- ☐ Family Court/Probation
- ☐ Other Court/Probation
- ☐ Alternatives to Incarceration
- ☐ City/County Jail
- ☐ NYS Department of Correctional Services
- ☐ NYS Division of Parole
- ☐ Drug Courts
- ☐ Office of Children and Family Services

Health Care Services
- ☐ Developmental Disabilities Program
- ☐ Mental Health Provider
- ☐ Managed Care Provider
- ☐ Health Care Provider
- ☐ AIDS Related Services

Employer/Educational/Special Services
- ☐ Employer/Union (Non-EAP)
- ☐ School (Other than Prevention Program)
- ☐ Special Services (Homeless/Shelters)

Social Services
- ☐ Local Social Services-Child Protect Services/CWA
- ☐ Local Social Services Dist-Income Maintenance
- ☐ Local Social Services Dist Treatment Mandate/Public Assistance
- ☐ Local Social Services Dist Treatment Mandate/Medicaid Only
- ☐ Other Social Services Provider

*****
- ☐ Other

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Highest Grade Completed

- ☐ No education
- ☐ 1st
- ☐ 2nd
- ☐ 3rd
- ☐ 4th
- ☐ 5th
- ☐ 6th
- ☐ 7th
- ☐ 8th
- ☐ 9th
- ☐ 10th
- ☐ 11th
- ☐ High School Diploma
- ☐ General Equivalency Diploma
- ☐ Vocational Cert w/o Diploma/GED
- ☐ Vocational Cert w/ Diploma/GED
- ☐ Some College-No degree
- ☐ Associates Degree
- ☐ Bachelors Degree
- ☐ Graduate Degree

Employment Status

- ☐ Employed Full Time-35+ hrs/wk
- ☐ Employed Part Time-<35 hrs/wk
- ☐ Employed in Sheltered Workshop
- ☐ Unemployed, In Treatment
- ☐ Unemployed, Looking for Work
- ☐ Unemployed, Not Looking for Work
- ☐ Not employed/Able to Work
- ☐ Not in Labor Force, Child Care
- ☐ Not in Labor Force, Disabled
- ☐ Not in Labor Force, In Training
- ☐ Not in Labor Force, Inmate
- ☐ Not in Labor Force, Retired
- ☐ Not in Labor Force, Student
- ☐ Not in Labor Force, Other
- ☐ Social Services Work Exp Program
- ☐ Unable to Work, Mandated Treatment

Primary Source of Income at Admission

- ☐ None
- ☐ Wages/Salary
- ☐ Alimony/Child Support
- ☐ Department of Veterans Affairs
- ☐ Family and/or Spouse Contribution
- ☐ SSI/SSDI or SSA
- ☐ Safety Net Assistance (SNA)
- ☐ Temp Asst for Needy Families (TANF)
- ☐ Other

Family History

Marital Status ☐ Married ☐ Never Married ☐ Living as Married ☐ Separated ☐ Divorced ☐ Widowed

Child of Alcoholic/Substance Abuser ☐ No ☐ Both ☐ Child of Alcoholic(s) ☐ Child of Substance Abuser(s)

No. of children ___ No. of children living with Client ___ No. of Children living in Foster Care ___

Case with Child Protective Services ☐ Yes ☐ No

Criminal Justice Information

- ☐ None
- ☐ Pre-Court Sentence (non-alt to incarc - ATI)
- ☐ Pre-Court Sentence (alt to incarc – ATI)
- ☐ Probation – non-alt to incarc
- ☐ Probation – ATI
- ☐ Other Alternative to Incarceration
- ☐ Correctional-based Setting
- ☐ Post Correctional Supervision

No. of Arrests in Prior 30 Days ___ ___

No. of Arrests in Prior 6 Months ___ ___ **No. of Days Incarcerated in Prior 6 Months** ___ ___ ___

Primary Substance

- ☐ None
- ☐ Alcohol
- ☐ Cocaine
- ☐ Crack
- ☐ Marijuana/Hashish
- ☐ Heroin
- ☐ Buprenorphine
- ☐ Non-Rx Methadone
- ☐ OxyContin
- ☐ Other Opiate/Synthetic
- ☐ Alprazolam (Xanax)
- ☐ Barbiturate
- ☐ Benzodiazepine (Klonopin)
- ☐ Catapres (Clonidine)
- ☐ Other Sedative /Hypnotic
- ☐ Elavil
- ☐ GHB
- ☐ Khat
- ☐ Other Tranquillizer
- ☐ Methamphetamine
- ☐ Other Amphetamine
- ☐ Other Stimulant
- ☐ PCP
- ☐ Ectasy
- ☐ Other Hallucinogen
- ☐ Ephedrine
- ☐ Inhalant
- ☐ Ketamine
- ☐ ROHYPNOL
- ☐ Viagra
- ☐ Over-the-Counter
- ☐ Other

Primary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other

Primary Frequency ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times p/week ☐ 3-6 times p/week ☐ Daily

Primary Age of First Use ___ ___

Secondary Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ectasy	☐ Other

Secondary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Secondary Frequency ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times p/week ☐ 3-6 times p/week ☐ Daily
Secondary Age of First Use ___ ___

Tertiary Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ectasy	☐ Other

Tertiary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Tertiary Frequency ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times p/week ☐ 3-6 times p/week ☐ Daily
Tertiary Age of First Use ___ ___

Nicotine
Smoked tobacco in last week: ☐ Yes ☐ No Used smokeless tobacco in last week: ☐ Yes ☐ No

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Prior Treatment Episodes

Enter the number of prior Substance/Alcohol Abuse treatment episodes __ *(Enter 0 to 5).*
If the number of prior treatment episodes is greater than 5, use 5.

Physical Health Related Conditions

Pregnant	☐ Yes	☐ No	Speech Impairment	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No	Sight Impairment	☐ Yes	☐ No
Mobility Impairment	☐ Yes	☐ No	Other Major Physical Health Condition	☐ Yes	☐ No

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Mental Health Related Conditions
Mental Retardation/Developmental Disability ☐ Yes ☐ No Co-existing Psychiatric Disorder ☐ Yes ☐ No

History of Mental Health Treatment

Ever Treated for Mental Illness Problem	☐ Yes	☐ No
Ever Hospitalized for Mental Illness	☐ Yes	☐ No
Ever Hospitalized 30 or More Days for Mental Illness	☐ Yes	☐ No

Six Months Prior to Admission
No. Days in Inpatient Detox ___ ___ No. of Emergency Room Episodes ___ ___
No. of Days Hospitalized for Non-Detox Services ___ ___
Reason for Hospitalization ☐ Medical ☐ Psychiatric ☐ Both

Orientation to Change *(For use only by Residential Rehabilitation for Youth Programs)*

Which statement best characterizes this patient's orientation to change with respect to alcohol/drug use at the time of admission?

- ☐ Ambivalent
- ☐ Change Oriented
- ☐ Planning Change
- ☐ Active Early Recovery
- ☐ Ongoing Recovery and Relapse Prevention

Medicaid Claim Data MATS Consent (TRS-2.3)

Consent Granted ☐ **Yes** ☐ **No** **Effective Date:** _____

If consent granted, effective date should be date consent is signed. If consent not granted, effective date should be admission date.

Expiration Date: [ ] ****Pre-filled by CDS. Will be 5 years from effective date if consent is granted.***

For Provider Use (Optional)

_____	_____	_____
Signature	**Title**	**Date**