New York State Office of Alcoholism and Substance Abuse Services

CLIENT ASSESSMENT REPORT

Provider Number: __ __ __ __ __ **Program (PRU) Number:** __ __ __ __ __ **Client ID:** __ __ __ __ __ __ __ __ __ __

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

Assessment Date: __ __ / __ __ / __ __ __ __

Number of Assessment Visits: __ __

Admission Disposition:

- ☐ Admitted to CD Treatment
- ☐ Referred to Another Chemical Dependence Treatment Unit
- ☐ Close Case Pending Action of Referring Agency
- ☐ No Treatment Necessary/Referred To AA, etc.
- ☐ No Treatment Necessary, No CD Referral
- ☐ Treatment Recommendation Refused
- ☐ Further Services Refused
- ☐ Lost To Contact
- ☐ Other

Optional Items

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

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
- ☐ CD Supportive Living
- ☐ MH/MRDD Community Residence
- ☐ Other Group Residential Setting
- ☐ Institution, Other (Jail, Hospital)
- ☐ Other

Living Arrangements*: (Complete only for clients under the age of 19)*
☐ 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 Program in New York State
- ☐ CD Program Out of State
- ☐ CD VA Program
- ☐ CD Private Practitioner

Prevention/Intervention Services
- ☐ School-Based Prevention Program
- ☐ Community-Based Prevention Program
- ☐ Employee Assistance Program
- ☐ Other Prevention/Intervention Program

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

CLIENT ASSESSMENT REPORT

Highest Grade Completed:

- ☐ No education
- ☐ 1st
- ☐ 2nd
- ☐ 3rd
- ☐ 4th
- ☐ 5th
- ☐ 6th
- ☐ 7th
- ☐ 8th
- ☐ 9th
- ☐ 10th
- ☐ 11th
- ☐ High School Diploma
- ☐ General Equivalency Diploma (GED)
- ☐ 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 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
- ☐ Social Services Determined, Not Employed/Able to Work
- ☐ Social Services Determined, 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: ___

Criminal Justice Status:

- ☐ None
- ☐ Probation
- ☐ Parole
- ☐ Work Release
- ☐ In Prison/Jail
- ☐ In OCFS Facility
- ☐ Charges Pending
- ☐ Any Treatment or Specialty Court
- ☐ Other

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
- ☐ Ecstasy
- ☐ Other Hallucinogen
- ☐ Ephedrine
- ☐ Inhalant
- ☐ Ketamine
- ☐ ROHYPNOL
- ☐ Viagra
- ☐ Over-the-Counter
- ☐ Other

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

Primary Frequency: ☐ No use in last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

Primary Age of First Use: __ __

CLIENT ASSESSMENT REPORT

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	☐ Ecstasy	☐ Other

Secondary Route: ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Secondary Frequency: ☐ No use in last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per 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	☐ Ecstasy	☐ Other

Tertiary Route: ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Tertiary Frequency: ☐ No use in last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
Tertiary Age of First Use: __ __

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