

**CLIENT ASSESSMENT REPORT**

**FOR ASSESSEMENTS DATED 10/1/2014 AND BEYOND**

Provider Number: \_\_\_\_\_ Program Number: \_\_\_\_\_ Provider Client ID: \_\_\_\_\_

Sex (at birth):  Male  Female Birth Date: \_\_\_/\_\_\_/\_\_\_ Last 4 SSN: \_\_\_\_\_ Last Name 2 Letters: \_\_\_\_\_  
(Birth Name)

Assessment Date: \_\_\_/\_\_\_/\_\_\_

Number of Assessment Visits: \_\_\_

**Admission Disposition:**

- |   |   |
|---|---|
| <input type="checkbox"/> Admitted to CD Treatment                               | <input type="checkbox"/> Treatment Recommendation Refused |
| <input type="checkbox"/> Referred to Another Chemical Dependence Treatment Unit | <input type="checkbox"/> Further Services Refused         |
| <input type="checkbox"/> Close Case Pending Action of Referring Agency          | <input type="checkbox"/> Lost To Contact                  |
| <input type="checkbox"/> No Treatment Necessary/Referred To AA, etc.            | <input type="checkbox"/> Other                            |
| <input type="checkbox"/> No Treatment Necessary, No CD Referral                 |   |

**Optional Items**

Significant Other:  Yes  No

**Race**

<input type="checkbox"/> Alaska Native	<input type="checkbox"/> Hawaiian or other Pacific Islander
<input type="checkbox"/> American Indian	<input type="checkbox"/> White
<input type="checkbox"/> Asian	<input type="checkbox"/> Other
<input type="checkbox"/> Black or African American	

**Hispanic Origin**

<input type="checkbox"/> Cuban	<input type="checkbox"/> Other Hispanic
<input type="checkbox"/> Mexican	<input type="checkbox"/> Hispanic, Not Specified
<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Not of Hispanic Origin

Veteran Status  Yes  No

Zip Code of Residence: \_\_\_\_\_ (For Canada use 88888) County of Residence: \_\_\_\_\_

**Type of Residence**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Private Residence         | <input type="checkbox"/> CD Community Residence          | <input type="checkbox"/> Institution, Other (Jail, Hospital) |
| <input type="checkbox"/> Homeless, Shelter         | <input type="checkbox"/> CD Supportive Living            | <input type="checkbox"/> Other                               |
| <input type="checkbox"/> Homeless, No Shelter      | <input type="checkbox"/> MH/MRDD Community Residence     |  |
| <input type="checkbox"/> Single Resident Occupancy | <input type="checkbox"/> Other Group Residential Setting |  |

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

**Principal Referral Source**

**Criminal Justice Services**

- District Attorney
- Drug Court
- Probation
- Parole, general
- Parole Release, Shock
- Parole Release Willard
- Parole Release Resentence
- Drinking Driver Referral
- Police
- Family Court
- Other Court
- Alternatives to Incarceration
- City/County Jail
- NYS Department of Correctional Services
- Office of Children and Family Services

**Self, Family, other**

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

HOPEline

**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

**Health Care Services**

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

Physician

Comprehensive Psychiatric Emergency Program (CPEP)

Hospital Emergency Department

TBI Waiver

**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 (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, Synthetic Cannabinoid, Heroin, Buprenorphine, Non-Rx Methadone, OxyContin, Other Opiate/Synthetic, Alprazolam (Xanax), Barbiturate, Benzodiazepine, Catapres (Clonidine), Other Sedative/ Hypnotic, Elavil, GHB, Khat, Other Tranquillizer, Methamphetamine, Other Amphetamine, Synthetic Stimulant, 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: \_\_\_\_

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**Secondary Substance**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> None                             | <input type="checkbox"/> OxyContin                | <input type="checkbox"/> Khat                           | <input type="checkbox"/> Ephedrine        |
| <input type="checkbox"/> Alcohol                          | <input type="checkbox"/> Other Opiate/Synthetic   | <input type="checkbox"/> Other Tranquillizer            | <input type="checkbox"/> Inhalant         |
| <input type="checkbox"/> Cocaine                          | <input type="checkbox"/> Alprazolam (Xanax)       | <input type="checkbox"/> Methamphetamine                | <input type="checkbox"/> Ketamine         |
| <input type="checkbox"/> Crack                            | <input type="checkbox"/> Barbiturate              | <input type="checkbox"/> Other Amphetamine              | <input type="checkbox"/> Rohypnol         |
| <input type="checkbox"/> Marijuana/Hashish                | <input type="checkbox"/> Benzodiazepine           | <input checked="" type="checkbox"/> Synthetic Stimulant | <input type="checkbox"/> Viagra           |
| <input checked="" type="checkbox"/> Synthetic Cannabinoid | <input type="checkbox"/> Catapres (Clonidine)     | <input checked="" type="checkbox"/> Other Stimulant     | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> Heroin                           | <input type="checkbox"/> Other Sedative/ Hypnotic | <input type="checkbox"/> PCP                            | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Buprenorphine                    | <input type="checkbox"/> Elavil                   | <input type="checkbox"/> Ecstasy                        |   |
| <input type="checkbox"/> Non-Rx Methadone                 | <input type="checkbox"/> GHB                      | <input type="checkbox"/> Other Hallucinogen             |   |

**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**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> None                             | <input type="checkbox"/> OxyContin                | <input type="checkbox"/> Khat                           | <input type="checkbox"/> Ephedrine        |
| <input type="checkbox"/> Alcohol                          | <input type="checkbox"/> Other Opiate/Synthetic   | <input type="checkbox"/> Other Tranquillizer            | <input type="checkbox"/> Inhalant         |
| <input type="checkbox"/> Cocaine                          | <input type="checkbox"/> Alprazolam (Xanax)       | <input type="checkbox"/> Methamphetamine                | <input type="checkbox"/> Ketamine         |
| <input type="checkbox"/> Crack                            | <input type="checkbox"/> Barbiturate              | <input type="checkbox"/> Other Amphetamine              | <input type="checkbox"/> Rohypnol         |
| <input type="checkbox"/> Marijuana/Hashish                | <input type="checkbox"/> Benzodiazepine           | <input checked="" type="checkbox"/> Synthetic Stimulant | <input type="checkbox"/> Viagra           |
| <input checked="" type="checkbox"/> Synthetic Cannabinoid | <input type="checkbox"/> Catapres (Clonidine)     | <input checked="" type="checkbox"/> Other Stimulant     | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> Heroin                           | <input type="checkbox"/> Other Sedative/ Hypnotic | <input type="checkbox"/> PCP                            | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Buprenorphine                    | <input type="checkbox"/> Elavil                   | <input type="checkbox"/> Ecstasy                        |   |
| <input type="checkbox"/> Non-Rx Methadone                 | <input type="checkbox"/> GHB                      | <input type="checkbox"/> Other Hallucinogen             |   |

**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: <input type="checkbox"/> Yes <input type="checkbox"/> No            | Speech Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Hearing Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Acquired or Traumatic Brain Injury: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Mobility Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Major Physical Health Condition: <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| Sight Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No    |   |

**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

**For Provider Use (Optional)**

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_