New York State Office of Alcoholism and Substance Abuse Services

Client Assessment Report

FOR ASSESSEMENTS DATED 04/01/2017 AND BEYOND

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

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

Sex (at birth)**:** ☐ Male ☐ Female **Birth Date:** __ __ /__ __/__ __ __ __ **Last 4 SSN:** __ __ __ __

Last Name 2 Letters: __ __ **Assessment Date:** __ __ **/** __ __ **/** __ __ __ _
(Birth Name)

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/ Congregate
- ☐ CD Supportive Living/Scatter-Site
- ☐ MH/DD Community Residence
  Other Group Residential Setting
- ☐ Institution, Other (Jail, Hospital)
- ☐ Other

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

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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 Protective 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

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- ☐ Other

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

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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)

Number of children: ___ **Number 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

Number of Arrests in Prior 30 Days ___ ___

Number of Arrests in Prior 6 Months ___ ___ **Number 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
☐ 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: __ __

Secondary 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
☐ Over-the-Counter
☐ 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
☐ 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
☐ Over-the-Counter
☐ 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	Acquired or Traumatic Brain Injury	☐ Yes	☐ No
Mobility Impairment:	☐ Yes	☐ No	Other Major Physical Health Condition:	☐ Yes	☐ No
Sight Impairment:	☐ Yes	☐ No			

Mental Health-Related Conditions

Intellectual Disability/Developmental Disability: ☐ Yes ☐ No Co-existing Psychiatric Disorder: ☐ Yes ☐ No

History of Mental Health Treatment

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

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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**