

**Client Assessment Report**

**FOR ASSESSEMENTS DATED 10/01/2018 AND BEYOND**

Provider Number: \_\_\_\_\_ Program Number: \_\_\_\_\_

Client ID: \_\_\_\_\_ Special Project (See instructions): \_\_\_\_\_

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

Last Name 2 Letters: \_\_\_\_\_  
(Birth Name)

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

Number of Assessment Visits: \_\_\_

**Admission Disposition:**

- |   |   |
|---|---|
| <input type="checkbox"/> Admitted to SUD Treatment                          | <input type="checkbox"/> Treatment Recommendation Refused |
| <input type="checkbox"/> Referred to Another SUD 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 Self-Help, etc. | <input type="checkbox"/> Other                            |
| <input type="checkbox"/> No Treatment Necessary, No SUD Referral            |   |

SUD=Substance Use Disorder

**Optional Items**

Significant Other:  Yes  No

- Race**
- |   |  |
|---|--|
| <input type="checkbox"/> Alaska Native                      | <input type="checkbox"/> Middle Eastern or North African                 |
| <input type="checkbox"/> Asian                              | <input type="checkbox"/> Native American, Indigenous, or American Indian |
| <input type="checkbox"/> Black or African American          | <input type="checkbox"/> White   |
| <input type="checkbox"/> Hawaiian or other Pacific Islander | <input type="checkbox"/> Some other race, ethnicity, origin              |

- Asian Origin**
- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="checkbox"/> Asian Indian (East Indian) | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Sri Lankan           |
| <input type="checkbox"/> Bangladeshi                | <input type="checkbox"/> Japanese   | <input type="checkbox"/> Taiwanese            |
| <input type="checkbox"/> Burmese                    | <input type="checkbox"/> Korean     | <input type="checkbox"/> Thai                 |
| <input type="checkbox"/> Cambodian                  | <input type="checkbox"/> Laotian    | <input type="checkbox"/> Tibetan              |
| <input type="checkbox"/> Chinese                    | <input type="checkbox"/> Malaysian  | <input type="checkbox"/> Vietnamese           |
| <input type="checkbox"/> Filipino                   | <input type="checkbox"/> Nepalese   | <input type="checkbox"/> Asian, Not Specified |
| <input type="checkbox"/> Hmong                      | <input type="checkbox"/> Pakistani  | <input type="checkbox"/> Not of Asian Origin  |

- Hispanic Origin**
- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Cuban        | <input type="checkbox"/> Hispanic, Latino/a/x, Not Specified |
| <input type="checkbox"/> Mexican      | <input type="checkbox"/> Not of Hispanic Origin              |
| <input type="checkbox"/> Puerto Rican |  |

- Pacific Islander Origin**
- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Fijian    | <input type="checkbox"/> Tongan                          |
| <input type="checkbox"/> Guamanian | <input type="checkbox"/> Pacific Islander, Not Specified |
| <input type="checkbox"/> Hawaiian  | <input type="checkbox"/> Not of Pacific Island Origin    |
| <input type="checkbox"/> Samoan    |  |

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**Primary Language**

- |                                  |   |  |
|----------------------------------|---|--|
| <input type="checkbox"/> Arabic  | <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Portuguese    |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Hindi          | <input type="checkbox"/> Russian       |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian        | <input type="checkbox"/> Spanish       |
| <input type="checkbox"/> English | <input type="checkbox"/> Japanese       | <input type="checkbox"/> Yiddish       |
| <input type="checkbox"/> French  | <input type="checkbox"/> Korean         | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Greek   | <input type="checkbox"/> Polish         | <input type="checkbox"/> Other         |

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**Veteran Status:**     Yes    No

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

**Type of Residence**

- |  |  |
|--|--|
| <input type="checkbox"/> Private Residence                         | <input type="checkbox"/> Other Group Residential Setting     |
| <input type="checkbox"/> Homeless/Unstably Housed, Shelter         | <input type="checkbox"/> MH/DD Community Residence           |
| <input type="checkbox"/> Homeless/Unstably Housed, No Shelter      | <input type="checkbox"/> County Operated or Other Local Jail |
| <input type="checkbox"/> Single Residence Occupancy                | <input type="checkbox"/> DOCCS Operated Prison               |
| <input type="checkbox"/> Residential Services for SUD/Congregate   | <input type="checkbox"/> Institution, Other (Hospital, etc.) |
| <input type="checkbox"/> Residential Services for SUD/Scatter-Site | <input type="checkbox"/> Other                               |

**Living Arrangements:**

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

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**Principal Referral Source**

**Criminal Legal System**

**Involvement**

- District Attorney
- Drug Court
- Probation
- Parole, general
- Parole Release Resentence
- Impaired Driver Referral
- Police
- Family Court
- Other Court
- Alternatives to Incarceration
- City/County Jail
- NYS Department of Corrections and Community Supervision
- Office of Children and Family Services

**Self, Family, other**

- Self-Referral
- Family, Friends, Other Individual
- Self-Help Group
- HOPEline

**Substance Use Disorder (SUD)**

**Treatment**

- SUD Program in New York State
- SUD Program Out of State
- SUD VA Program
- SUD 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
- Primary Care Health Professional
- 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 (e.g., 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

**Recovery Support Services**

- Recovery Community and Outreach Center
- Youth Clubhouse
- Peer Advocate
- Open Access Center
- Family Support Navigator
- Regional Addiction Resource Center

\*\*\*\*\*

- Other

**Highest Grade Completed**

- |                                       |                               |  |   |
|---------------------------------------|-------------------------------|--|---|
| <input type="checkbox"/> No education | <input type="checkbox"/> 6th  | <input type="checkbox"/> 11th                              | <input type="checkbox"/> Some College-No degree |
| <input type="checkbox"/> 1st          | <input type="checkbox"/> 7th  | <input type="checkbox"/> High School Diploma               | <input type="checkbox"/> Associates Degree      |
| <input type="checkbox"/> 2nd          | <input type="checkbox"/> 8th  | <input type="checkbox"/> General Equivalency Diploma (GED) | <input type="checkbox"/> Bachelors Degree       |
| <input type="checkbox"/> 3rd          | <input type="checkbox"/> 9th  | <input type="checkbox"/> Vocational Cert w/o Diploma/GED   | <input type="checkbox"/> Graduate Degree        |
| <input type="checkbox"/> 4th          | <input type="checkbox"/> 10th | <input type="checkbox"/> Vocational Cert w/Diploma/GED     |   |
| <input type="checkbox"/> 5th          |                               |  |   |

**Employment Status**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Employed Full Time-35+ hrs/wk    | <input type="checkbox"/> Not in Labor Force, Child Care  | <input type="checkbox"/> Not in Labor Force, Other                                      |
| <input type="checkbox"/> Employed Part Time-<35 hrs/wk    | <input type="checkbox"/> Not in Labor Force, Disabled    | <input type="checkbox"/> Social Services Work Exp Program                               |
| <input type="checkbox"/> Employed in Sheltered Workshop   | <input type="checkbox"/> Not in Labor Force, In Training | <input type="checkbox"/> Social Services Determined, Not Employed/Able to Work          |
| <input type="checkbox"/> Unemployed, In Treatment         | <input type="checkbox"/> Not in Labor Force, Inmate      | <input type="checkbox"/> Social Services Determined, Unable to Work, Mandated Treatment |
| <input type="checkbox"/> Unemployed, Looking for Work     | <input type="checkbox"/> Not in Labor Force, Retired     |   |
| <input type="checkbox"/> Unemployed, Not looking for Work | <input type="checkbox"/> Not in Labor Force, Student     |   |

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**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 Someone Who Misuses Alcohol/Other Substances**     No     Both
- Child of Someone Who Misuses Alcohol     Child of Someone Who Misuses Other Substances

**Number of children:** \_\_\_\_    **Number of children living with Client:** \_\_\_\_

**Criminal Legal System Involvement**

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> None      | <input type="checkbox"/> Work Release     | <input type="checkbox"/> Charges Pending                  |
| <input type="checkbox"/> Probation | <input type="checkbox"/> In Prison/Jail   | <input type="checkbox"/> Any Treatment or Specialty Court |
| <input type="checkbox"/> Parole    | <input type="checkbox"/> In OCFS Facility | <input type="checkbox"/> Other                            |

**Number of Criminal Arrests in Prior 30 Days** \_\_\_\_

**Number of Criminal Arrests in Prior 6 Months** \_\_\_\_

**Number of Days Incarcerated in Prior 6 Months** \_\_\_\_

**Primary 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 type="checkbox"/> Synthetic Stimulant | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> Synthetic Cannabinoid | <input type="checkbox"/> Catapres (Clonidine)     | <input type="checkbox"/> Other Stimulant     | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Heroin                | <input type="checkbox"/> Other Sedative/ Hypnotic | <input type="checkbox"/> PCP                 |   |
| <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  |   |

**Primary Route:**     Inhalation     Injection     Oral     Smoking     Vaping     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**

- |  |   |  |   |
|--|---|--|---|
| <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 type="checkbox"/> Synthetic Stimulant | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> Synthetic Cannabinoid | <input type="checkbox"/> Catapres (Clonidine)     | <input type="checkbox"/> Other Stimulant     | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Heroin                | <input type="checkbox"/> Other Sedative/ Hypnotic | <input type="checkbox"/> PCP                 |   |
| <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  |   |

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Secondary Route: [ ] Inhalation [ ] Injection [ ] Oral [ ] Smoking [ ] Vaping [ ] 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 [ ] Vaping [ ] 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
Hearing Impairment: [ ] Yes [ ] No
Mobility Impairment: [ ] Yes [ ] No
Sight Impairment: [ ] Yes [ ] No
Speech Impairment: [ ] Yes [ ] No
Acquired or Traumatic Brain Injury: [ ] Yes [ ] No
Other Major Physical Health Condition: [ ] 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

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