Salvation Army The Harbour Light –

Concurrent Disorders Treatment Program

ASSESSMENT INTERVIEW

ASSESSMENT DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADMISSION DATE:\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Name Last name at birth

DOB: OHIP#

Address City Postal Code

How long at this address?

Phone number Alternate number

Email/Fax

Source of referral Marital status:

Languages spoken Ethnicity

|  |  |
| --- | --- |
| Substance Use History Drugs of choice |  |
| Last date of use |  |
| How long have you been using? |  |
| At what age did you start using substances? |  |
| Are you able to stop when you want to? |  |
| Have you had long periods of sobriety? |  |
| Can you make it through one week without using? |  |
| Do you use more than one substance at a time? |  |
| Have you ever abused prescription drugs? |  |
| Substances used in the past 12 months  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Alcohol |  | Cocaine |  | Glue/Inhalants |  | GHB |  | | Amphetamines/Stimulants |  | Cannabis |  | Mushrooms |  | Steroids |  | | Benzodiazepines/pams |  | Special K |  | Ecstasy |  | Gravol |  | | Prescription Opiates |  | Barbiturates |  | Crystal Meth |  |  |  | | Over the counter codeine |  | Tobacco |  | Heroin/Opium |  | **CPD** |  |   1= didn’t use 2= 1-3 times monthly 3= 1-2 times weekly  4= 3-6 times weekly 5= daily usage 6= binge using  **INJECTION USE: GAMBLING ISSUES**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Never injected |  | Do you have a gambling problem | | | |  | | Injected prior to one year ago |  | Have you engaged in gambling activities the past 12 months | | | | | | Injected in the last 12 months |  | types |  | frequency |  | | | | |

**Treatment History:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Agency | Year | Duration | Completed | Clean Time |
|  |  |  |  |  |
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**We require discharge summary from past treatment programs;**

**contact the agency and request the summary and fax to 416-363-6305**

###### Family History

Do you have a relationship with your family members?

Are they supportive of you?

Drug abuse

Alcohol abuse

Psychiatric illness

**What other supports do you have?**

|  |  |  |
| --- | --- | --- |
| Name: | Relation: | Contact: |
| Name: | Relation: | Contact: |

**Employment and Education History**

Are you currently employed? Where

Last job held? From To

Reason for leaving?

Have you lost/given up jobs due to substance use?

Highest level of education achieved

Is treatment a requirement for employment?

**HEALTH ISSUES AND MEDICATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medical problems due to using |  | | | |
| Medical concerns | | |  | |
| Have you been TB tested? | | |  | |
| To your knowledge, are you Hep C or HIV positive? | | |  | |
| Have you received treatment for Hep C or HIV? | | |  | |
| Have you experienced a heart attack? | | | How recent? | |
| Have you ever been prescribed heart medications? | | |  | |
| Have you experienced a stroke? | | | How recent? | |
| Is there a family history of strokes/heart desease? | | |  | |
|  | | | | |
| **Medication** | | **Dosage** | | **length of use** |
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### Taper information required

***In the past 12 months have you:***

Been hospitalized overnight for medical problems? # of times

Been hospitalized overnight for substance related problems? # of times

Been hospitalized overnight for mental health issues? # of times

Have you had any emergency room visits in the last three months? # of times

## DO YOU HAVE/ ARE YOU

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Visually impaired |  | | Hearing impaired | | | | |  | Mobility impaired | | | |  | |
| Psychiatric disorder |  | | | | | | |  | Learning disabilities | | | |  | |
|  | | | | | | | | | | | | | | |
| Do you wear glasses | |  |  | | |  | Need eyeglasses | | | |  | Have coverage | |  |
| Need dental work done | | | |  | Have coverage | | | |  | Need referrals | | | |  |

**PSYCHIATRIC follow up:**

|  |
| --- |
| At what age was the psychiatric diagnosis? |
| Past psychiatric medications: |
|  |
| What symptoms do you experience? |
|  |
| What tools do you use to help you? |
|  |
| What are your current sleep patterns? |
| Additional comments on sleeping patterns (ie. Nightmares/sweats/intermittent) |
|  |

**TRAUMA SYMPTOMS  *(Trauma Systems Checklist)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms | Never >>>>>>>>>>>>>>>>>>>> Often | | | |
| 0 | 1 | 2 | 3 |
| 1. Headaches |  |  |  |  |
| 2. Insomnia |  |  |  |  |
| 4. Stomach problems |  |  |  |  |
| 5. Feeling isolated from others |  |  |  |  |
| 6. “Flashbacks” (sudden, vivid, distracting memories) |  |  |  |  |
| 7. Anxiety attacks |  |  |  |  |
| 8. Nightmares |  |  |  |  |
| 9. “Spacing out” (going away in your mind) |  |  |  |  |
| 10. Sadness |  |  |  |  |
| 11. Dizziness |  |  |  |  |
| 12. Trouble controlling your temper |  |  |  |  |
| 13. Waking up early and can’t get back to sleep |  |  |  |  |
| 14. Uncontrollable crying |  |  |  |  |
| 15. Fear of others (men, women) |  |  |  |  |
| 16. Memory problems |  |  |  |  |
| 17. Desire to physically hurt others |  |  |  |  |
| 18. Feeling that things are “unreal” |  |  |  |  |
| 19. Feelings of inferiority |  |  |  |  |
| 20. Feeling tense all the time |  |  |  |  |
| 21. Feelings of guilt |  |  |  |  |
| 22. Feeling that you are not always in your body |  |  |  |  |
| 23. Trouble breathing |  |  |  |  |
| 24. Not feeling rested in the morning |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Family Doctor | | |  | | Phone # |  | | |
| Last appointment: | | |  | |  |  | | |
| Psychiatrist | | |  | | Phone # |  | | |
| Last appointment: | | |  | |  |  | | |
| Upcoming appointments | | | |  | allergies |  | | |
| Is getting a medical professional (family doctor/psychiatrist) a part of your plan for treatment? | | | | | | | | |
| Will you release your current medications/prescriptions to our program’s medical office? | | | | | | | | |
| If no, why? | | | | | | | | |
| Dietary restrictions | |  | | | Food sensitivities | |  | |
| Is there any reason why you might not be able to participate in all aspects of the program? | | | | | | | |  |
| If yes what? |  | | | | | | | |

###### EMOTIONAL HEALTH

***Have you ever been treated by a family doctor or Psychiatrist for:***

Anxiety

Yes No Currently How often

Depression

Yes No Currently How often

How does your anxiety/depression exhibit itself in daily life?

**HAVE YOU EVER BEEN**:

***Admitted to a Psychiatric Facility:***

Yes No Currently How often

Have you ever attempted suicide

Yes No # of times Methods last time

When was the last time you thought of suicide? Did you have a plan?

Hospitalized for suicide attempts or ideation? # of times

Do you practice self harm? Last time: method:

## LEGAL STATUS

Do you have a valid Drivers License? Do you currently drive?

Do you currently have any matters before the courts?

Are you on Bail? Conditions:

Court dates?

Are you on Probation/ Parole? Conditions:

Is treatment a requirement of your probation/parole?

Do you have previous convictions? For?

Have you ever been incarcerated? # of times total length of time

Have you ever been charged for weapons? Violence? How many times?

Have you ever had trafficking charges?

Have you ever been charged with impaired driving? How many times?

Is treatment a requirement to reinstate your license?

**A probation or bail order must be attached to the assessment in order for it to be considered complete.**

**Parenting information:**

Do you have Children? How many? Ages?

Who has custody of your children?

Is there any Child services involvement?

Name, phone # and address of worker

Visitation arranged? Dates and times

Requirements of Children’s services for custody? Example: treatment, drug testing….

**Financial Information**

What type of income do you currently have?

Are you expected to be looking for work?

Does your income expire? If so, when?

Do you have drug benefits?

Do you have dental coverage?

Do you pay a deductible for medication?

Do you require a letter of participation to maintain your benefits?

Address of social services office

Phone number

Name of worker

**Spirituality:**

|  |  |
| --- | --- |
| Are you familiar with the twelve-step program? |  |
| Do you have a belief in God or a Higher Power? |  |
| At any point in your life have you been involved in a Church or Spiritual Organization? |  |
| Do you practice any spiritual exercises currently? |  |
| Are you willing to participate in the following Spiritual Components of this program? | |
| Church options Spirituality Class MorningDevotions | |

**MENTAL STATUS EXAMINATION *(to be completed by intake worker; circle all that apply)***

|  |  |
| --- | --- |
| **APPEARANCE/GROOMING** | *Unkempt; clean; odor; disheveled; neat; appears hygienic; healthy; unhealthy* |
| **ATTITUDE/RELATEDNESS** | *Controlling; Submissive; challenging; Guarded; Uncooperative; Negative; overly dramatic; childlike; cooperative* |
| **SPEECH** | *Rapid; Slow; Loud; Soft; slurred* |
| **AFFECT** | *Blunted, dull, flat; Euphoria, elation; Anger, hostility; Depression, sadness; Anxious; Irritable; Inappropriate; fair/appropriate* |
| **ORIENTATION** | *Confused; present* |
| **MEMORY/CONCENTRATION** | *Answers with ease and clarity; Vague or difficult to recall; poor concentration* |
| **POSTURE** | *Shows little self-control (fidgety/little understanding of personal space); reasonable control of body; introverted/collapsed posture* |
| **COGNITIVE** | *Alertness; distractibility* |

Additional Observations:

NOTES AND FOLLOW UP DOCUMENTATION

To be used for any further communications prior to entry.

Date:

Date:

Date:

Date:

Date:

Date:

Date:

Catalyst entered.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_