PRE-ASSESSMENT FORM

Name: _____
Date: _____
Date of Birth:_____

Welcome to ASAC! Thank you for taking the time to answer the following questions. If you have any questions or would like assistance completing this form, please let us know and we will be happy to assist you. If there are any questions that you are unsure how to answer or that you would prefer to answer verbally, please feel free to leave them blank.

I identify my gender as: _____

Have you gone by any other name(s)? _____

Ethnicity: ☐Puerto Rican ☐Cuban ☐Mexican ☐Other Hispanic or Latino
☐Not Spanish, Hispanic, Latino or Mexican ☐Unknown

Race: ☐Caucasian ☐Black/African American ☐American Indian ☐Asian
☐Alaskan Native ☐Hawaiian or Pacific Islander ☐Unknown

Are you a veteran? ☐Yes ☐No
If yes, what type of discharge, combat history, etc._____

Communication Method: ☐Communication device such as TDD ☐Sign language ☐Verbal
When possible, I prefer to be contacted via: ☐ Home phone ☐ Cell phone ☐ Email ☐ Text msg
Would you like an appointment reminder by text message: ☐ No ☐ Yes

Have you used by IV (needles) in the last 30 days? ☐ No ☐ Yes

GAMBLING:
Have you ever felt the need to bet more and more money? ☐ No ☐ Yes
Have you ever had to lie to people important to you about
how much money you gambled? ☐ No ☐ Yes

Do you have a DHS case worker or are you currently involved with DHS? ☐ No ☐Yes ☐N/A
If yes, what is your worker's name? _____
If so, are your children removed from the home? ☐No ☐Yes
Is there an open Child in Need of Assistance (CINA)? ☐No ☐Yes
Was the CINA filed within the last 6 months? ☐No ☐Yes

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HEALTH INFORMATION:

How would you rate your health? ☐Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Any medical concerns that impacts with daily life or may impact treatment? ☐ No ☐ Yes

If yes, please specify: _____

Mental health concerns that impacts with daily life or may impact treatment? ☐ No ☐ Yes

If yes, please specify: _____

CURRENT HEALTH CARE PROVIDERS:

Primary Care Doctor _____ Practice/City _____

Specialist/Specialty_____ Practice/City _____

Dentist_____ Practice/City _____

Mental Health Provider _____ Practice/City _____

Other: _____ Practice/City _____

INFECTIOUS DISEASES/RISK FACTORS:

Do you have:

Known Sexually Transmitted Infections (STI)	☐No	☐Yes	☐Decline to answer
TB?	☐No	☐Yes	☐Decline to answer
Hepatitis?	☐No	☐Yes	☐Decline to answer
Other: _____	☐No	☐Yes	☐Decline to answer

Have you experienced:

Sexual contact without barrier projection?	☐No	☐Yes	☐Decline to answer
Yellow jaundice/hepatitis?	☐No	☐Yes	☐Decline to answer
Share needles/works?	☐No	☐Yes	☐Decline to answer
Exchanged sex for money or drugs?	☐No	☐Yes	☐Decline to answer
Been involved in a sexual assault?	☐No	☐Yes	☐Decline to answer

ABUSE/TRAUMA HISTORY:	VICTIM	WITNESS	PERPETRATOR
Have you ever been a victim, witness, or perpetrator of physical abuse?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Have you ever been a victim, witness, or perpetrator of emotional abuse?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Have you ever been a victim, witness, or perpetrator of sexual abuse?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Have you ever been a victim, witness, or perpetrator of domestic violence?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Have you ever experienced or witnessed a traumatic event of any type?	☐No ☐Yes	☐No ☐Yes	

Any current trauma that you may be experiencing? _____

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EDUCATION:

What is the last grade you completed? _____

Do you have your GED/HiSET? ☐No ☐ Yes

Did you ever receive special education services? ☐No ☐ Yes

Do you have difficulty reading or writing? ☐No ☐ Yes

Do you have a history of developmental delay? ☐No ☐ Yes

FINANCES/EMPLOYMENT:

Are you currently in need of food, clothing or shelter? ☐No ☐Yes

Do you have any financial concerns at this time? ☐No ☐Yes ☐ Not Applicable

Do you have a valid driver's license: ☐No ☐Yes

CURRENT LIVING SITUATION: Please include all of your children (even if they do not live with you)

Names (with last name)	Relationship to You	Gender	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any family issues that you would like to address in treatment?

_____

_____

Does anyone in your household currently use alcohol or drugs? ☐ No ☐ Yes

Does anyone in your household currently have a mental health condition? ☐ No ☐ Yes

Emergency Contact:

Name: _____ Relationship to you: _____

Address: _____ Phone: _____

LEGAL HISTORY:

Number of lifetime arrests? _____ Any arrests in last 30 days? _____

Are you currently on probation or parole? ☐ Probation ☐ Parole ☐ Neither

Probation or parole officer (if applicable): _____

Is this assessment court ordered? ☐ No ☐ Yes

Do you have a pending court date? ☐ No ☐ Yes, when? _____

Is this assessment due to being under a committal? ☐ No ☐ Yes

Is this assessment for OWI or Zero Tolerance Offense? ☐ No ☐ Yes, which? _____

If you received an alcohol-rated charge, If yes, what was your blood alcohol level at the time of the arrest? ☐ No ☐ Yes, _____

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LEGAL HISTORY CONTINUED:

Did you refuse the Breathalyzer test? ☐ No ☐ Yes _____

Do you currently have any legal issues related to alcohol or drug offenses pending? ☐ No ☐ Yes _____

Do you have any past legal issues related to alcohol or drug offenses? ☐ No ☐ Yes _____

Have you ever been in jail or prison? ☐ No ☐ Yes _____

Are you presently awaiting charges, trial or sentencing? ☐ No ☐ Yes _____

Do you have a Durable Power of Attorney for Healthcare Decisions/ Psychiatric Advance Directive (PAD)? ☐ No ☐ Yes

If you do not have a Healthcare Decisions/ Psychiatric Advance Directive (PAD), would you like more information about how to secure one? ☐ No ☐ Yes

OTHER:

Do you identify with a particular cultural group? ☐ No ☐ Yes _____

Are you currently experiencing any concerns related to your gender or sexual orientation? ☐ No ☐ Yes _____

Do you identify with a particular religious group or spiritual practice? ☐ No ☐ Yes _____

How did you hear about ASAC Services?

☐ A friend/family member ☐ My P.O. ☐ Television
☐ Received services before ☐ My DHS worker ☐ Radio
☐ My attorney ☐ Internet ☐ Newspaper
☐ Other _____

NEEDING ANY ASSISTANCE:

Are you or your family in need of assistance in any of the following areas?

☐ Family Counseling ☐ Budgeting ☐ Continuing Education
☐ Mental Health Counseling ☐ Housing
☐ Specialized Treatment Services ☐ Transportation

Does your family need assistance in securing any of the following services for children?

☐ Making and keeping pediatric and dental appointments
☐ Ensuring children's immunizations are up to date
☐ Applying for Head Start or admission to school
☐ Obtaining WIC or other supports
☐ Maintaining regular visitation with children not in your custody
☐ Providing for children's daily needs (e.g., meals, laundry)
☐ Obtaining childcare for times when you are at work or school

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WHO WOULD YOU LIKE YOUR ASSESSMENT RESULTS SENT TO? (for example: DHS worker, legal representative, public defender, attorney, PO, physician, employer, etc.)
Please provide name, phone number, and address.

_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)
Over the last 2 weeks, how often have you been bothered by any of the following problems? Please place a check mark next to your answer.

	Not at All	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
Feeling down, depressed or hopeless	☐0	☐1	☐2	☐3
Trouble falling or staying asleep, or sleeping too much too much	☐0	☐1	☐2	☐3
Feeling tired or having little energy	☐0	☐1	☐2	☐3
Poor appetite or overeating	☐0	☐1	☐2	☐3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐0	☐1	☐2	☐3
Trouble concentrating on things, such as reading the newspaper or watching television	☐0	☐1	☐2	☐3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐0	☐1	☐2	☐3
Thoughts that you would be better off dead, or of hurting yourself	☐0	☐1	☐2	☐3

TOTAL: _____

If you have checked off any problems, how difficult have these problems made it for you to do your work take care of things at home or get along with other people?

☐Not difficult at all
☐Somewhat difficult
☐Very difficult
☐Extremely difficult

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ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)
Because alcohol use can affect your health and can interfere with certain medication and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place a check next to the choice that best describes your answer to each question.

Questions

How often do you have a drink containing alcohol? ____Score
- ☐Never = 0
- ☐Monthly or less = 1
- ☐2-4 times/month = 2
- ☐2-3 times/week = 3
- ☐4 or more times/week = 4

How many drinks containing alcohol do you have on a typical day when you are drinking? ____Score
- ☐1 or 2 = 0
- ☐3 or 4 = 1
- ☐5 or 6 = 2
- ☐7 to 9 = 3
- ☐10 or more = 4

How often do you have six or more drinks on one occasion? ____Score
- ☐Never = 0
- ☐Less than monthly = 1
- ☐Monthly = 2
- ☐Weekly = 3
- ☐Daily or almost daily = 4

How often during the last year have you found that you were not able to stop drinking once you had started? ____Score
- ☐Never = 0
- ☐Less than monthly = 1
- ☐Monthly = 2
- ☐Weekly = 3
- ☐Daily or almost daily = 4

How often during the last year have you failed to do what was normally expected of you because of drinking? ____Score
- ☐Never = 0
- ☐Less than monthly = 1
- ☐Monthly = 2
- ☐Weekly = 3
- ☐Daily or almost daily = 4

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? ____Score
- ☐Never = 0
- ☐Less than monthly = 1
- ☐Monthly = 2
- ☐Weekly = 3
- ☐Daily or almost daily = 4

How often during the last year have you had a feeling of guilt or remorse after drinking? ____Score
- ☐Never = 0
- ☐Less than monthly = 1
- ☐Monthly = 2
- ☐Weekly = 3
- ☐Daily or almost daily = 4

How often during the last year have you been unable to remember what happened the night before because of your drinking? ____Score
- ☐Never = 0
- ☐Less than monthly = 1
- ☐Monthly = 2
- ☐Weekly = 3
- ☐Daily or almost daily = 4

Have you or someone else been injured because of your drinking? ____Score
- ☐No = 0
- ☐Yes, but not in the last year = 2
- ☐Yes, during the last year = 4

Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? ____Score
- ☐No = 0
- ☐Yes, but not in the last year = 2
- ☐Yes, during the last year = 4

____Total Score

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Name: _____

DRUG ABUSE SCREENING TEST (DAST-10)

The following questions concern information about your possible involvement with drugs (not including alcoholic beverages) during the past 12 months. "Drug abuse" refers (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then chose the response that is mostly right.

In the past 12 months…

Have you used drugs other than those required for medical reason?	☐Yes	☐No
Do you abuse more than one drug at a time?	☐Yes	☐No
Are you able to stop using drugs when you want to?	☐Yes	☐No
Have you ever had blackouts or flashbacks as a result of drug use?	☐Yes	☐No
Do you ever feel bad or guilty about your drug use?	☐Yes	☐No
Does your spouse (or parents) ever complain about your involvement with drugs?	☐Yes	☐No
Have you ever neglected your family because of your drug use?	☐Yes	☐No
Have you engaged in illegal activities in order to obtain drugs?	☐Yes	☐No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐Yes	☐No
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	☐Yes	☐No

____**SCORE** (count the # of yes answers)

TRAUMA SCREENER

Over the last 3-4 weeks have you experienced any of the following? Please place a check mark next to your answer.

Upsetting thoughts or memories about the event that have come into your mind against your will?	☐Yes	☐No
Upsetting dreams about the event?	☐Yes	☐No
Acting or feeling as though the even were happening again?	☐Yes	☐No
Feeling upset by reminders of the event?	☐Yes	☐No
Bodily reactions (such as fast heartbeat, stomach churning)?	☐Yes	☐No
Difficulty falling or staying asleep?	☐Yes	☐No
Irritability or outbursts of anger?	☐Yes	☐No
Difficulty concentrating?	☐Yes	☐No
Heightened awareness of potential dangers to yourself and others?	☐Yes	☐No
Feeling jumpy or being startled by something unexpected?	☐Yes	☐No

____**SCORE** (count the # of yes answers)

_____ **RESULT**