ADULT PACKET

NAME: ________________________________ DATE: ________________

1. **Reason for entry:**
   ____
   ____
   ____

2. **What services are you seeking:**

□ Alternative Services	□ Adult Inpatient	□ Women's Inpatient
□ Adolescent/Outpatient	□ Withdrawal Mgmt	
□ Adolescent Inpatient	□ Opioid or Other Medicated Assisted Treatment	□ ADSAP □ Assessment

3. **Have you attended Withdrawal Mgmt, Inpatient or other outpatient programs for alcohol or drug use in the past? □ Yes or □ No**

4. **Describe where/when/why you received AOD Treatment:**
   ____
   ____

5. **When was the last time you used any alcohol or drugs, and how much and for how long you have been using?**
   ____
   ____
   ____

6. **Have you ever wanted to stop drinking/using but have been unable to do so? □ Yes or □ No**

7. **Are you supposed to be taking any medications? □ Yes or □ No**

8. **What medications are you supposed to be taken and for what?**
   ____
   ____

9. **Do you feel like you are in danger of harming yourself or others? □ Yes or □ No**

10. **Described the thoughts you have of harming yourself or others:**
   ____
   ____

11. **Have you suffered/ still suffer with depression, anxiety or other mental health problems in the past?** □ **Yes or** □ **No**

12. **Describe the mental issues you have: ____**

____

13. **Do you gamble?** □ **Yes or** □ **No**

14. **Have you gambled in the past?** □ **Yes or** □ **No**

15. **Have you ever thought you had a problem with gambling?** □ **Yes or** □ **No**

16. **Has anyone ever told you they thought you had a problem with gambling?**

□ **Yes or** □ **No**

17. **Do you have insurance or Medicaid? (If so, your card is required to access benefits)**

□ **Yes or** □ **No**

If applicable, who is the insurance carrier/ Medicaid/ or MCO:

____

****

Staff use only: Special population?

□ **1. Pregnant Woman** □ **No 3. HIV** □**No 5. Patients w other medical problems**

□ **No 2. IV Drug User** □ **No 4. Court Ordered**

ADULT PACKET

AUDIT

1. How often do you have a drink containing alcohol?

- **Never**
- **Monthly or less**
- **2-4 times a month**
- **2-3 times a week**
- **4 or more times a week**

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- **1 or 2**
- **3 or 4**
- **5 or 6**
- **7 to 9**
- **10 or more**

3. How often do you have six or more drinks on one occasion?

- **Never**
- **Less than monthly**
- **Monthly**
- **Weekly**
- **Daily or almost daily**

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- [ ] **Never**
- [ ] **Less than monthly**
- [ ] **Monthly**
- [ ] **Weekly**
- [ ] **Daily or almost daily**

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- [ ] **Never**
- [ ] **Less than monthly**
- [ ] **Monthly**
- [ ] **Weekly**
- [ ] **Daily or almost daily**

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- [ ] **Never**
- [ ] **Less than monthly**
- [ ] **Monthly**
- [ ] **Weekly**
- [ ] **Daily or almost daily**

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- [ ] **Never**

- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, how often have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the past year
- Yes, during the past year

DAST-10

DAST(10) Questionnaire

These Questions Refer to the Past 12 Months			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Source: Yudko et al., 2007

WITHDRAWAL SYMPTOM HISTORY

□ Sweating/Tachycardia □ Flu-Like Symptoms □ Psychomotor Agitation/Retardation

□ Depressed/Dysphoric Mood □ Hallucinations □ Restlessness

□ Diarrhea □ Increased/Decreased appetite □ Runny Nose □ Irritability, Anger, or Aggression

□ Seizures □ Difficulty Concentrating □ Fatigue □ Muscle Aches or Stomach Cramps

□ Fevers or Chills □ Nervousness or Anxiety □ Sleep Difficulty (Insomnia/Disturbing Dreams)