GAIN-Short Screener (GAIN-SS)
Version [GVER]: GAIN-SS 2.0.3

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/_____

The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).		2 to 12 months ago	1+ years ago	Never
	3	2	1	0

IDScr 1. <u>When was the last time</u> that you had <u>significant</u> problems…

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 3 2 1 0

b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? 3 2 1 0

c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? 3 2 1 0

d. with becoming very distressed and upset when something reminded you of the past? 3 2 1 0

e. with thinking about ending your life or committing suicide? 3 2 1 0

EDScr 2. <u>When was the last time</u> that you did the following things <u>two or more times</u>?

a. Lied or conned to get things you wanted or to avoid having to do something? 3 2 1 0

b. Had a hard time paying attention at school, work, or home? 3 2 1 0

c. Had a hard time listening to instructions at school, work, or home? 3 2 1 0

d. Were a bully or threatened other people? 3 2 1 0

e. Started physical fights with other people? 3 2 1 0

SDScr 3. <u>When was the last time</u> that…

a. you used alcohol or other drugs weekly or more often? 3 2 1 0

b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs? 3 2 1 0

c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 3 2 1 0

d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events? 3 2 1 0

e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? 3 2 1 0

(Continued) After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, “In the past month” (3), “2-12 months ago” (2), “1 or more years ago” (1), or “Never” (0).		2 to 12 months ago	1+ years ago	Never
	3	2	1	0

CVScr

4. When was the last time that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	3	2	1	0
b. took something from a store without paying for it?	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	3	2	1	0

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... Yes 1 No 0

   v1. _____

   v2. _____

   v3. _____

6. What is your gender? (If other, please describe below) ……1-Male 2-Female 99-Other

   v1. _____

7. How old are you today? |__|__| years

Trauma Screening

a. Have you been through any experience that caused you to think that you might get physically hurt or that you might not even live through it? 0 - No 1 - Yes

b. Have you been through any experience that caused you to feel that you would never be safe or secure again? 0 - No 1 - Yes

c. If you answered yes to question 1 or 2, is this situation current? 0 - No 1 - Yes

d. If you answered yes to question 1 or 2, would you like to be able to talk with someone in more detail about these experiences that you have been through? 0 - No 1 - Yes

For Staff Use Only
8. Site ID: _____ Site Name v. _____
9. Staff ID: _____ Staff Name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2s and 3s: IDSscr: ____ EDScr: ____ SDScr: ____ CVScr: ____ TDScr: ____
13. Referral: MH____ SA ____ ANG ____ Other ____ 14. Referral Code: _____
15. Referral comments:
v1. _____
v2. _____
v3.

AUTHORIZATION TO USE/DISCLOSE OF MY INFORMATION

_____

Client Name DOB SS# Medical Record#

_____

Client Address Phone

By initializing the following blank(s), I authorize the named agencies (including their local community counterpart providers) where I receive (d) treatment or care to use and disclose my information:

_____ County DJJ
_____ County AOD
_____ County Mental Health
_____ Continuum of Care
_____ County DSS

The information to be shared includes my name and other personal identifying information, clinical health information and other information pertaining to my treatment. This information will be used to coordinate and evaluate my treatment and improve service delivery.

The purpose of sharing information with the agencies is to evaluate my treatment needs and to provide for the delivery of these services. This information may also be used in reports to improve the operations of the treatment program, to evaluate changes in policy and to assist in the provision of services for people having similar problems, to identify any needs not being met, and to help staff with the administration of the program. Reports are confidential and no information identifying me will be released. Only authorized staff will have access to this information. Furthermore, names and/or identities will never appear in any report for public distribution.

I understand that my information is protected by federal law 42 CFR Part 2 (alcohol and drug treatment) and 45 CFR Part 160 et. Seq. (HIPAA) and cannot be disclosed without my written authorization unless otherwise allowed by law. I understand that I can revoke this consent at any time, except to the extent that action has already been taken. I also understand that I may revoke this authorization at any time either verbally or in writing. This authorization expires when I am no longer participating in the treatment programs provided by the above listed agencies, or one year from this date, whichever comes first. I have been given a copy of this completed authorization.

_____

Client Signature (or if applicable, parent/guardian or other personal representative) Date

_____

(If signed by a parent/guardian or other personal representative, describe that person's authority to act for the client)

REVOCATION OF AUTHORIZATION

I hereby revoke (cancel) my authorization _____

Client's Signature Date

General Agreements of the Adolescent Group

1. **I understand no one may attend services under the influence of alcohol and or drugs.**

2. **I understand member's names and all personal information shared in groups is confidential. "Whatever is said in group must stay in group".**

3. **I understand there are to be no more than 2 excused absences from group sessions. Any absence must be for a general illness or for an emergent reason. Proof of illness/emergency may be required. Three (3) or more absences will require result in a treatment team review of your case.**

4. **I understand that honesty, respect for others talking, participation, and creating a culture of safety (No Threats) is an expectation.**

5. **Appropriate dress code is necessary. Therefore, no miniskirts or short shorts, crop/halter/ or tank tops, no midriff exposure, or any article of clothing advertising alcohol/drugs/ or racial bias. It is further requested that no hats, sunglasses, or heavy perfume/cologne be worn.**

6. **No food or beverages.**

7. **Group is to start and end on time.**

8. **Restroom use is only to occur at break times, if applicable.**

9. **Mutual- Help Groups (AA/NA/CA) may be a treatment plan objective. As applicable, I will take sign-in sheets to those groups to gather necessary signatures and bring back to group.**

10. **I shall complete and return all assignments.**

11. **I understand I will need to return all borrowed materials to the group leader, and clean up any messes I make.**

12. **I understand that parents/ legal guardian involvement in treatment will be requested.**

I UNDERSTAND FAILURE TO COMPLY WITH ANY OF THE ABOVE MAY IMPACT A POSITIVE TREATMENT OUTCOME, A CONCERNED STAFFING, OR POTENTIAL DISCHARGE FROM SERVICES.

Patient Signature: _____ Date: _____

Parents Legal Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____