NAME:		<b>D</b> A	<b>DATE:</b>		
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.	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 take	xing any medications? □ Y	es or Do		
8.	What medications are you supposed to be taken and for what?  Do you feel like you are in danger of harming yourself or others? □ Yes or □ No  Described the thoughts you have of harming yourself or others:				
9. 10.					
10.		a nave of narming yoursen	or omers.		

11.	Have you suffered/still suffer with depression, anxiety or other mental health problems in the past? $\Box$ Yes or $\Box$ No				
12.	Describe the mental issues you have:				
13.	Do you gamble?				
14.					
15.					
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 ap	plicable, who is the insurance carrier/ Medicaid/ or MCO:				
****					
Staff	fuse only: Special population?				
□ <b>1.</b> ]	Pregnant Woman □ No 3. HIV □No 5. Patients w other medical problems				
□ No	2. IV Drug User				

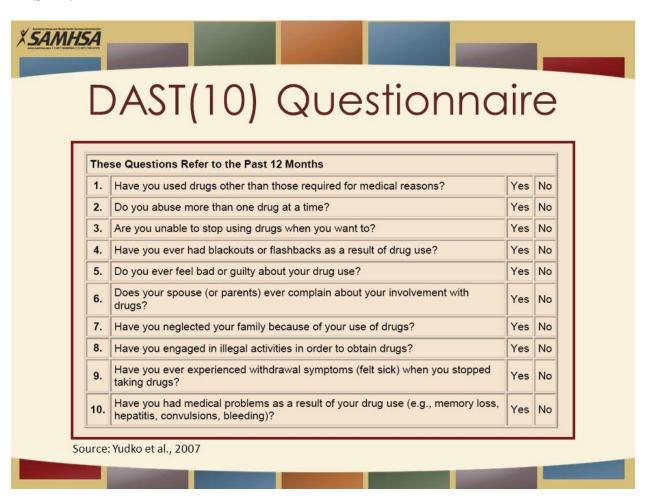
# **AUDIT** 1. How often do you have a drink containing alcohol? Never Monthly or less C 2-4 times a month C 2-3 times a week 4 or more times a week 2. How many standard drinks containing alcohol do you have on a typical day when drinking? 1 or 2 3 or 4 ° 5 or 6 ° 7 to 9 10 or more 3. How often do you have six or more drinks on one occasion? Never Less than monthly Monthly <sup>O</sup> Weekly O 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?

0	Never
0	Less than monthly
0	Monthly
0	Weekly
0	Daily or almost daily
	Ouring the past year, how often have you failed to do what was normally expected you because of drinking?
0	Never
0	Less than monthly
0	Monthly
0	Weekly
0	Daily or almost daily
	During the past year, how often have you needed a drink in the morning to get urself going after a heavy drinking session?
0	Never
0	Less than monthly
0	Monthly
0	Weekly
0	Daily or almost daily
	Ouring the past year, how often have you had a feeling of guilt or remorse after nking?
0	Never

0	Less than monthly		
0	Monthly		
0	Weekly		
0	Daily or almost daily		
	During the past year, how often have you been unable to remember what opened the night before because you had been drinking?		
0	Never		
0	Less than monthly		
0	Monthly		
0	Weekly		
0	Daily or almost daily		
9. Have you or someone else been injured as a result of your drinking?			
0	No		
0	Yes, but not in the past year		
0	Yes, during the past year		
	Has a relative or friend, doctor or other health worker been concerned about or drinking or suggested you cut down?		
0	No		
0	Yes, but not in the past year		
0	Yes, during the past year		

#### DAST-10



#### WITHDRAWAL SYMPTOM HISTORY

☐ Sweating/Tachycardia Agitation/Retardation	□ Flu-Like Sympton	ns			
□ 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 ☐ Nervousnes (Insomnia/Disturbing Dreams)	ss or Anxiety 🗆 Slee	ep Difficulty			