ETRS Phone: (800) 213-ETRS (3877)
ETRS Website: etrsmichigan.com

ETRS
Client Bio-Psycho-Social Intake

Today's Date:_____

Identifying Information

Name (Last, First, Middle) DOB Age Case/MDOC#_____

_____ _____ _____ Male _____Female _____Other_____

Street Address City State Zip Code

_____ _____ _____ _____

Home/Cell Phone Number Email address

_____ _____

Emergency contact person:_____ Phone # _____

Legal Information

Referring court:_____ Probation Officer:_____ Phone No. _____

Legal Status: On probation_____ On parole_____ Awaiting trial/pre-trial/sentencing_____

Probation/Parole End Date:_____ Is treatment part of your sentencing? Yes _____No_____

Type of offense:_____ Date of offense:_____ BAC %_____

State your version of the incident that led to your arrest:_____

_____

_____

Have you had a positive alcohol/drug test while on probation/parole? Yes_____ No_____ If yes, please explain.

_____

Interviewer Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List Prior Arrests and Convictions

Date	Charge	City	Sentence	Drug/Alcohol Related? Yes or No

Education/Employment

Circle Highest School Grade Completed

6 7 8 9 10 11 12 Year of Graduation_____College _____ Trade School _____ Did you obtain a GED?_____

Are you employed?_____ Full-Time_____ Part-Time_____ Occupation:_____

Present Employer:_____ Last Employer:_____

Do you receive Social Security benefits/Disability or SSI?_____ Do you receive health benefits? Yes _____ No _____

Health Status and History

Check all that apply to your current health status: Excellent _____ Good_____ Fair _____ Poor_____ Stable _____

Doctor's name:_____ Dr. Phone No. _____

Date of last physical exam:_____ Outcome:_____

Any immediate health concerns?_____

Current illnesses and medications taken:_____

_____

_____

List any past hospitalizations and treatments including those for alcohol or other substance use

Facility	Dates	Diagnosis	Type of Care	Outcome

Interviewers Notes: _____

_____

_____

_____

Personal and Emotional Status

Check any items below that describe your current emotional/psychological status:

_____Calm _____Upset _____Confused _____Hyper _____Bored/Tired _____Worried/Stressed

Check any symptoms below that you have been experiencing lately:

_____Anxiousness _____Anger/Hostility _____Depression _____Fears _____Guilt

_____Low Self-Worth _____Mood Swings _____Poor sleep/appetite

Have you ever had suicidal thoughts? _____Yes _____No

Are you interested in a referral for counseling or support? _____Yes _____No

Are you currently receiving mental health services? _____Yes _____No Name of therapist _____

If yes, name of provider:_____ Telephone No._____

May we discuss your case with them? _____Yes _____No *If yes, please request a release of information to be signed.

Marital/Relationship History

Current Marital Status: _____Never Married _____Married _____Life Partner _____Divorced _____Widowed

Marriages_____ # Divorces_____ Reasons for Divorce:_____

Ages of Children:_____ Who currently lives in your household with you?_____

_____

Indicate any areas of conflict with your relationship partner: _____Money _____Friends _____Jobs _____In-laws

_____Sex _____Alcohol/Drugs _____Legal Problems _____Communication _____Domestic Violence

Family of Origin

Who raised you? _____Both Parents _____Mother Only _____Father Only _____Relative _____Other

How was/is your relationship with your parents?____Good ____Poor How many siblings do you have?_____

Who are you closest to in your family?_____

Do you have any other family members who have experienced any alcohol or drug-related problems? _____Yes _____No

If yes, whom?_____

Military Service/History

Branch of Service:_____ Rank/Role/Responsibility:_____

Overseas Deployment? _____Yes _____No Stateside? _____Yes _____No Combat? _____Yes

_____No

Type of Discharge: _____Honorable _____Dishonorable _____Other

VA Assistance? _____Yes _____No

Interviewers Notes:_____

_____

_____

_____

_____

_____

_____

Consequences of Substance Use

1. Has anyone ever expressed concern about your alcohol/drug use? _____ Who?_____

   Their comments_____

2. Have you ever changed or tried to limit your alcohol/drug use?_____If yes, when and why: _____

   _____

3. Have you ever used more or for longer than you intended?_____

4. How many drinks does it take to make you feel intoxicated?_____

5. How would you describe your tolerance to alcohol?_____

6. Have you ever forgotten something or had periods of time you couldn't account for when drinking or drugging?

   _____

7. What undesirable physical reactions, if any, have you had while using or after use? _____

   _____

8. Have you ever overdosed or come close to an overdose?_____ No _____Yes If yes, explain: _____

   _____

9. Have you ever gotten sick after discontinuing drinking/drug use? _____No _____ Yes

10. While drinking or using drugs, do you ever behave in ways that would normally be unacceptable to you?

    _____No _____Yes: Explain_____

11. What percentage of your friends drink/use drugs? _____

12. While drinking or using other drugs, have you ever been suicidal or homicidal? _ No _____Yes Explain _____

    _____

13. Have there been periods of time when you chose to be alcohol and drug free? _____No _____Yes

    a. When and for how long_____

    b. Why at that time _____

14. Describe any changes that might have occurred in the last year in your:

    Living Arrangements: _____ Job Situation: _____

    Relationships: _____ Leisure Activities: _____

15. Do you seek emotional support when you need it? _____If yes, from whom: _____

_____ _____

Client Signature Date

Interviewer Notes: MAST Score: _____DAST Score: _____ AUDIT: _____

Identified Symptoms_____

_____

_____

ETRS Substance Use Assessment

Client: _____ Date Completed: _____

Substance Type	Age When First Tried	Age of Regular Use	Maximum amount used at 1 sitting	Present Use: How much/how often?	Date last used	Use in last 24 hours	Use in last 48 hrs.
Alcohol							
Sedatives-sleeping pills, benzodiazepines (Xanax, Klonopin, tranquilizers							
Stimulants-amphetamines, cocaine, crack, diet pills, methamphetamine							
Hallucinogens-LSD, mescaline, PCP, peyote							
Marijuana, Hashish, Wax							
Narcotics-morphine, codeine, heroin, Norco, Vicodin, Darvon, Percocet, Oxycodone, etc.							
Prescription & Over-the-counter drugs-cough syrup, diet pills, sleeping aids, decongestants, etc.							
Club drugs-ecstasy, ketamine, GHB, Rohypnol							
Other drugs-steroids, inhalants, glue, gas, whip-its, etc.							
Fentanyl/ Carfentanil							

Drug of First Choice: _____ Other Drugs of Choice: _____

Have you ever attended any self-help or 12-Step Groups (AA, NA, Smart Recovery, Alanon, etc.? _____Yes _____No

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Name:_____

Date: _____

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AUDIT Questionnaire

Please circle the answer that is correct for you.

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

ETRS
AUDIT Questionnaire

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, 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

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The Michigan Alcoholism Screening Test (MAST)

Patient Name:_____ Date:_____

Please circle either **Yes** or **No** for each item as it applies to you.

1. Do you feel you are a normal drinker? (By normal we mean do you drink less than or as much as most other people.)	Yes	No
2. Have you ever woke up the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
3. Does your significant other, parent or other near relative ever worry or complain about your drinking?	Yes	No
4. Can you stop drinking without a struggle after one or two drinks?	Yes	No
5. Do you ever feel guilty about your drinking?	Yes	No
6. Do friends or relatives think you are a normal drinker?	Yes	No
7. Are you able to stop drinking when you want to?	Yes	No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA) ?	Yes	No
9. Have you gotten into physical fights when drinking?	Yes	No
10. Has your drinking ever created a problem between you and your significant other, a parent, or any other relative?	Yes	No
11. Has your significant other (or other family members) ever gone to anyone for help about your drinking?	Yes	No
12. Have you ever lost friends because of drinking?	Yes	No
13. Have you ever gotten into trouble at work or school because of drinking?	Yes	No
14. Have you ever lost a job because of drinking?	Yes	No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because of you were drinking?	Yes	No
16. Do you drink before noon fairly often?	Yes	No
17. Have you ever been told you have liver trouble? Cirrhosis?	Yes	No
18. After heavy drinking have you ever had Delirium Tremens (DT's) or severe shaking, or heard voices or seen things that really were not there?	Yes	No
19. Have you ever gone to anyone for help about your drinking?	Yes	No
20. Have you ever been in a hospital because of drinking?	Yes	No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	Yes	No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times_____)	Yes	No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior) (If YES, how many times_____)	Yes	No

DAST (Drug Abuse Screening Test)

Name: _____

Date: _____

Instructions: CIRCLE the word "yes" or "no", which you honestly feel describes your position in regard to each of the questions below. The key to answering the questions...HONESTY

1. Have you used drugs other than those required for medical reasons? Yes No

2. Have you ever abused prescription drugs? Yes No

3. Do you abuse more than one drug at a time? Yes No

4. Can you get through the week without using drugs (other than those used for medical reasons)? Yes No

5. Are you always able to stop using drugs when you want to? Yes No

6. Do you abuse drugs on a continuous basis? Yes No

7. Do you try to limit your drug use to certain situations? Yes No

8. Have you had "blackouts" or "flashbacks" as a result of drug use? Yes No

9. Do you ever feel bad about your drug abuse? Yes No

10. Does your spouse (or parents) ever complain about your involvement with drugs? Yes No

11. Do your friends or relatives know or suspect you abuse drugs? Yes No

12. Has drug abuse ever created problems between you and your spouse? Yes No

13. Has any family member ever sought help for problems related to your drug use? Yes No

14. Have you ever lost friends because of your use of drugs? Yes No

15. Have you ever neglected your family or missed work because of your drug use? Yes No

16. Have you ever been in trouble at work because of drug abuse? Yes No

17. Have you ever lost a job because of drug abuse? Yes No

18. Have you gotten into fights when under the influence of drugs? Yes No

19. Have you ever been arrested because of unusual behavior while under the influence of drugs? Yes No

20. Have you ever been arrested for driving while under the influence of drugs? Yes No

21. Have you engaged in illegal activities to obtain drugs? Yes No

22. Have you ever been arrested for possession of illegal drugs? Yes No

23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? Yes No

24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)? Yes No

25. Have you ever gone to anyone for help for a drug problem? Yes No

26. Have you ever been in the hospital for medical problems related to your drug use? Yes No

27. Have you ever been involved in a treatment program specifically related to drug use? Yes No

28. Have you ever been treated as an outpatient for problems related to drug abuse? Yes No