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: ____

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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: ____

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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:____

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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

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