

## DBHR Target Data Elements Assessment/Admission Setup

STAFF IDENTIFICATION
AGENCY NUMBER

**Section I: Client Identification**

1. LAST NAME	2. FIRST NAME	3. MIDDLE NAME	4. OTHER LAST NAME
5. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	6. DATE OF BIRTH	7. SOCIAL SECURITY NUMBER *	8. WASHINGTON DRIVER'S LICENSE OR ID NO.
9. WHICH RACE / ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK A MAXIMUM OF FOUR THAT APPLY)			
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Non-federal tribe	
<input type="checkbox"/> Black / African American	<input type="checkbox"/> Native American		
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Other Asian		
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Pacific Islander		
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Race	Tribal Code (No. 1) _____	
<input type="checkbox"/> Guamanian	<input type="checkbox"/> Refused to Answer		
<input type="checkbox"/> Hawaiian (Native)	<input type="checkbox"/> Samoan	Tribal Code (No. 2) _____	
<input type="checkbox"/> Japanese	<input type="checkbox"/> Thai		
<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese		
<input type="checkbox"/> Laotian	<input type="checkbox"/> White / European American		
10. SPANISH/HISPANIC/LATINO (CHECK ONE)			
<input type="checkbox"/> Cuban	<input type="checkbox"/> Not Spanish/Hispanic/Latino	<input type="checkbox"/> Puerto Rican	
<input type="checkbox"/> Mexican, Mexican American, Chicano	<input type="checkbox"/> Other Spanish/Hispanic/Latino	<input type="checkbox"/> Refused to Answer	

NOTES

\* The Social Security Act provides for the collection of Social Security Number to assist in the administration of public funded programs.

# Assessment / Admission and Discharge

Assess       Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

## Section II: Assessment Setup

1. ASSESSMENT DATE	4. ASSESSMENT TYPE (CHECK ONE)		
2. ASSESSMENT TIME : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/> ADATSA Assessment	<input type="checkbox"/> Expanded Assessment	
3. DATE OF FIRST CONTACT	<input type="checkbox"/> CD and Gambling	<input type="checkbox"/> Gambling	
	<input type="checkbox"/> Deferred Prosecution	<input type="checkbox"/> Involuntary Commitment	
	<input type="checkbox"/> DUI/Dept. of Licensing	<input type="checkbox"/> Other than the Above (CD)	
5. ENTRY REFERRAL (CHECK ALL THAT APPLY)			
<input type="checkbox"/> ADATSA Assessment Center	<input type="checkbox"/> Employer / EAP	<input type="checkbox"/> Other Health Care Provider	
<input type="checkbox"/> At Risk Youth (ARY / CHINS)	<input type="checkbox"/> First Steps or PPP Case	<input type="checkbox"/> Pharmacist	
<input type="checkbox"/> Attorney	<input type="checkbox"/> Gambling Facility	<input type="checkbox"/> Phone book	
<input type="checkbox"/> BECCA Involved	<input type="checkbox"/> Group Care	<input type="checkbox"/> Police	
<input type="checkbox"/> Court / Probation	<input type="checkbox"/> 24 Hour Help line	<input type="checkbox"/> School/Education	
<input type="checkbox"/> DCFS / CPS	<input type="checkbox"/> Involuntary Commitment	<input type="checkbox"/> Self Help	
<input type="checkbox"/> Department of Corrections (DOC)	<input type="checkbox"/> JRA	<input type="checkbox"/> Self / Family	
<input type="checkbox"/> Department of Licensing (DOL)	<input type="checkbox"/> Mass media	<input type="checkbox"/> Social Security Administration	
<input type="checkbox"/> Detoxification Facility	<input type="checkbox"/> MD / Primary Care Provider	<input type="checkbox"/> Website	
<input type="checkbox"/> Diversion	<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> Other:	
<input type="checkbox"/> DSHS Community Services Office	<input type="checkbox"/> Other Alcohol / Drug Facility		
6. CLIENT REGISTRY PARTICIPATION <input type="checkbox"/> Permitted <input type="checkbox"/> Refused <input type="checkbox"/> Revoked	7. REGISTRY STATUS DATE	8. REFERRING CSO/HCS	9. CSO REFERRAL DATE

## Section III: Admission Setup

1. ADMISSION DATE	4. BECCA admission? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. ADMISSION TIME : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	5. Is this an ADATSA admission? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. DATE OF FIRST CONTACT	6. Admission type: <input type="checkbox"/> CD <input type="checkbox"/> Gambling <input type="checkbox"/> Both		
7. ENTRY REFERRAL (CHECK ALL THAT APPLY)			
<input type="checkbox"/> ADATSA Assessment Center	<input type="checkbox"/> Employer / EAP	<input type="checkbox"/> Other Health Care Provider	
<input type="checkbox"/> At Risk Youth (ARY / CHINS)	<input type="checkbox"/> First Steps or PPP Case	<input type="checkbox"/> Pharmacist	
<input type="checkbox"/> Attorney	<input type="checkbox"/> Gambling Facility	<input type="checkbox"/> Phone book	
<input type="checkbox"/> BECCA Involved	<input type="checkbox"/> Group Care	<input type="checkbox"/> Police	
<input type="checkbox"/> Court / Probation	<input type="checkbox"/> 24 Hour Help line	<input type="checkbox"/> School/Education	
<input type="checkbox"/> DCFS / CPS	<input type="checkbox"/> Involuntary Commitment	<input type="checkbox"/> Self Help	
<input type="checkbox"/> Department of Corrections (DOC)	<input type="checkbox"/> JRA	<input type="checkbox"/> Self / Family	
<input type="checkbox"/> Department of Licensing (DOL)	<input type="checkbox"/> Mass media	<input type="checkbox"/> Social Security Administration	
<input type="checkbox"/> Detoxification Facility	<input type="checkbox"/> MD / Primary Care Provider	<input type="checkbox"/> Website	
<input type="checkbox"/> Diversion	<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> Other:	
<input type="checkbox"/> DSHS Community Services Office	<input type="checkbox"/> Other Alcohol / Drug Facility		
8. REFERRING AGENCY		9. REFERRING ASSESSMENT DATE	
10. REFERRING CSO		11. CLIENT REGISTRY PARTICIPATION <input type="checkbox"/> Permitted <input type="checkbox"/> Refused <input type="checkbox"/> Revoked	12. REGISTRY DATE
NOTES			

DBHR TARGET DATA ELEMENTS  
**Assessment/Admission and Discharge**

Assess       Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

**Section IV: Client Milestones**

**A. LANGUAGE SKILLS**

1. PRIMARY LANGUAGE USED IN YOUR HOME IF OTHER THAN ENGLISH (CHECK ONE BOX ONLY)

- |   |                                    |   |   |   |
|---|------------------------------------|---|---|---|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Farsi     | <input type="checkbox"/> Ilocano          | <input type="checkbox"/> Marathi        | <input type="checkbox"/> Samoan           |
| <input type="checkbox"/> Amharic                | <input type="checkbox"/> Finnish   | <input type="checkbox"/> Indian (General) | <input type="checkbox"/> Mien           | <input type="checkbox"/> Spanish          |
| <input type="checkbox"/> Arabic                 | <input type="checkbox"/> French    | <input type="checkbox"/> Italian          | <input type="checkbox"/> Norwegian      | <input type="checkbox"/> Tagalog          |
| <input type="checkbox"/> Cambodian              | <input type="checkbox"/> German    | <input type="checkbox"/> Japanese         | <input type="checkbox"/> Other Language | <input type="checkbox"/> Thai             |
| <input type="checkbox"/> Cantonese              | <input type="checkbox"/> Greek     | <input type="checkbox"/> Korean           | <input type="checkbox"/> Polish         | <input type="checkbox"/> Tigrigna         |
| <input type="checkbox"/> Chinese                | <input type="checkbox"/> Gujarati  | <input type="checkbox"/> Lakota Sioux     | <input type="checkbox"/> Puyallup       | <input type="checkbox"/> Ukrainian        |
| <input type="checkbox"/> Czech                  | <input type="checkbox"/> Hindi     | <input type="checkbox"/> Laotian          | <input type="checkbox"/> Romanian       | <input type="checkbox"/> Unknown Language |
| <input type="checkbox"/> Dutch                  | <input type="checkbox"/> Hmong     | <input type="checkbox"/> Malay            | <input type="checkbox"/> Russian        | <input type="checkbox"/> Vietnamese       |
|   | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Mandarin         | <input type="checkbox"/> Salish         | <input type="checkbox"/> Yakama           |

**B. FAMILY AND SOCIAL ARRANGEMENTS**

1. In the last 30 days: How many times have you attended a self-help session related to recovery from substance abuse or dependence? (199 means not collected)

2. RESIDENCY (CHECK ONE BOX ONLY)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Controlled Environment                | <input type="checkbox"/> Jail/Prison           | <input type="checkbox"/> Student Residence            |
| <input type="checkbox"/> Drug-Free Shared/Transitional Housing | <input type="checkbox"/> No Stable Arrangement | <input type="checkbox"/> Transient Quarters           |
| <input type="checkbox"/> Foster/Group Home                     | <input type="checkbox"/> On the Street         | <input type="checkbox"/> Work/Training Release Center |
| <input type="checkbox"/> Homeless Shelter/Mission              | <input type="checkbox"/> Personal Residence    |   |
| <input type="checkbox"/> Hospital/Other Institution            | <input type="checkbox"/> Single Room Occupancy |   |

3. STREET ADDRESS      4. CITY      5. STATE      6. ZIP CODE

7. COUNTY      8. TELEPHONE NUMBER

9. Do you have a valid driver's license (ASI)?  
 Yes     No

10. Do you have an automobile available (ASI)?  
 Yes     No

11. MARITAL STATUS (CHECK ONE BOX ONLY)

- Divorced     Married or Committed Relationship     Never Married     Separated     Widowed

12. Are you satisfied with your current marriage or relationship status (ASI)?     Yes     No     Indifferent

13. WHO ARE YOU LIVING WITH (CHECK ONE BOX)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alone                     | <input type="checkbox"/> Other Family Members with or without Child(ren) | <input type="checkbox"/> Spouse/Partner Alone          |
| <input type="checkbox"/> Child(ren) Alone          | <input type="checkbox"/> Parent(s)/Parent(s) with Child(ren)             | <input type="checkbox"/> Spouse/Partner and Child(ren) |
| <input type="checkbox"/> Foster parents/Group Home | <input type="checkbox"/> Roommates                                       |  |
| <input type="checkbox"/> Friends                   |  |  |

14. HOW DO YOU IDENTIFY YOUR SEXUAL ORIENTATION?

- Bisexual     Choosing Not to Disclose     Gay/Lesbian     Heterosexual     Questioning     Transgender

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# Assessment / Admission and Discharge

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## Section IV: Client Milestones (Continued)

### B. FAMILY AND SOCIAL ARRANGEMENTS (CONTINUED)

15. Persons in household (including you): \_\_\_\_\_
16. Number of your children or siblings under 18 years living with you: \_\_\_\_\_
17. Number of your children or siblings under 18 years not living with you: \_\_\_\_\_
18. Number of other children under 18 years living with you: \_\_\_\_\_
19. In the last thirty days, have you had significant periods in which you have experienced serious problems getting along with (ASI):
- |  |                                    |  |
|--|------------------------------------|--|
| <input type="checkbox"/> Children      | <input type="checkbox"/> Father    | <input type="checkbox"/> Other Significant Family Member |
| <input type="checkbox"/> Close Friends | <input type="checkbox"/> Mother    | <input type="checkbox"/> Sister/Brother                  |
| <input type="checkbox"/> Co-workers    | <input type="checkbox"/> Neighbors | <input type="checkbox"/> Spouse/Sexual Partner           |
20. In the last 30 days (ASI):  
 How many times have you had serious conflicts with your family members: \_\_\_\_\_  
 How troubled or bothered have you been by family problems (ASI Scale Number): \_\_\_\_\_
21. How important to you now is treatment or counseling for these family problems (ASI Scale Number): \_\_\_\_\_
22. Is your current living environment conducive to recovery?     Yes     No
23. IF UNDER 18 YEARS, HOW MANY TIMES HAVE YOU RUN AWAY IN THE PAST YEAR?
- |                                  |                                  |                                  |   |   |
|----------------------------------|----------------------------------|----------------------------------|---|---|
| <input type="checkbox"/> 0 times | <input type="checkbox"/> 2 times | <input type="checkbox"/> 4 times | <input type="checkbox"/> 6 to 10 times  | <input type="checkbox"/> More than 20 times |
| <input type="checkbox"/> 1 time  | <input type="checkbox"/> 3 times | <input type="checkbox"/> 5 times | <input type="checkbox"/> 11 to 20 times |   |

### C. EDUCATION

1. **ACADEMIC/TRAINING ACHIEVEMENT (CHECK ONE BOX ONLY)**
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AA Degree (Academic)   | <input type="checkbox"/> No Degree            | <input type="checkbox"/> Vocational Training (Certificate)    |
| <input type="checkbox"/> AA Degree (Vocational) | <input type="checkbox"/> Post-Graduate Degree | <input type="checkbox"/> Vocational Training (No Certificate) |
| <input type="checkbox"/> GED                    | <input type="checkbox"/> Undergraduate Degree |   |
| <input type="checkbox"/> High School Diploma    | <input type="checkbox"/> Unknown              |   |
2. YEARS OF EDUCATION: \_\_\_\_\_
3. In the last twelve months:  
 How many times have you been suspended from school: \_\_\_\_\_  
 How many schools have you been expelled from: \_\_\_\_\_
4. **CURRENT SCHOOL STATUS (CHECK ONE)**
- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dropped Out | <input type="checkbox"/> Not Enrolled |
| <input type="checkbox"/> Expelled    | <input type="checkbox"/> Part Time    |
| <input type="checkbox"/> Full Time   | <input type="checkbox"/> Suspended    |

### D. EMPLOYMENT AND INCOME

1. **EMPLOYMENT ACTIVITY (CHECK ONE BOX ONLY)**
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Employed Full-Time                      | <input type="checkbox"/> Institutionalized             | <input type="checkbox"/> Retired                     |
| <input type="checkbox"/> Employed Part-Time (less than 30 hours) | <input type="checkbox"/> Military                      | <input type="checkbox"/> Under Age Not in Workforce  |
| <input type="checkbox"/> Employed Temporary/On Call/Intermittent | <input type="checkbox"/> Not in Work Force             | <input type="checkbox"/> Unemployed Not Seeking Work |
| <input type="checkbox"/> Homemaker                               | <input type="checkbox"/> Not Working Due to Disability | <input type="checkbox"/> Unemployed Seeking Work     |

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# Assessment / Admission and Discharge

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AGENCY NUMBER	STAFF IDENTIFICATION
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## Section IV: Client Milestones (Continued)

### D. EMPLOYMENT AND INCOME (CONTINUED)

2. PRIMARY SOURCE OF INCOME OR SUPPORT (CHECK ONE BOX ONLY)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Disability                           | <input type="checkbox"/> Other              | <input type="checkbox"/> Social Security (SSA/SSDI) |
| <input type="checkbox"/> Family/Friend (most Youth fall here) | <input type="checkbox"/> Public Assistance  | <input type="checkbox"/> Unemployment Compensation  |
| <input type="checkbox"/> None                                 | <input type="checkbox"/> Retirement Pension | <input type="checkbox"/> Wages/Salary               |

3. MONTHLY HOUSEHOLD GROSS INCOME  
(Immediate family ONLY)

4. MONTHLY PERSONAL INCOME (GROSS)

5. In the last 30 days (ASI):

How many days were you paid for working: \_\_\_\_\_

How much money did you receive from employment: \_\_\_\_\_

How much money did you receive from illegal activities: \_\_\_\_\_

### E. MILITARY VETERAN

1. Have you ever served on active duty in the U.S. Military?

- Yes     No     Refused

Start month/year: \_\_\_\_\_ End month/year: \_\_\_\_\_

2. What branch of service?

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Air Force   | <input type="checkbox"/> Marine Corps |
| <input type="checkbox"/> Army        | <input type="checkbox"/> Navy         |
| <input type="checkbox"/> Coast Guard |                                       |

3. Have you ever been a member of the National Guard or Reserves?

- National Guard     No     Refused     Reserves

Start month/year: \_\_\_\_\_ End month/year: \_\_\_\_\_

4. Are you the spouse, partner or dependent minor of someone who has served or is serving in the U.S. Military, National Guard, or Reserves?

- |                                |  |
|--------------------------------|--|
| <input type="checkbox"/> Child | <input type="checkbox"/> Spouse/Domestic Partner |
| <input type="checkbox"/> No    | <input type="checkbox"/> Widow                   |
| <input type="checkbox"/> Other | <input type="checkbox"/> Refused                 |

Start month/year: \_\_\_\_\_ End month/year: \_\_\_\_\_

### F. PHYSICAL HEALTH

1. PREVIOUS MEDICAL TREATMENT – NOT PREVENTATIVE

In the last 30 days (ASI):

How many days have you experienced medical problems: \_\_\_\_\_

How troubled or bothered have you been by these medical problems (ASI Scale Number): \_\_\_\_\_

How important to you now is treatment for these medical problems (ASI Scale Number): \_\_\_\_\_

(FOR ASSESSMENTS AND ADMISSIONS, PREVIOUS MEANS THE LAST YEAR, FOR DISCHARGE, PREVIOUS MEANS SINCE ADMISSION)

2. Number of previous emergency room visits: \_\_\_\_\_

3. Number of previous outpatient/clinic visits: \_\_\_\_\_

4. Number of previous hospital inpatient admissions: \_\_\_\_\_

5. Number of previous hospital inpatient days: \_\_\_\_\_

6. How many times have you been tested for STD in the last year? \_\_\_\_\_

7. Currently under care for infectious disease?

YES	NO	IN NEED
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Have you ever had a traumatic head injury that resulted in loss of consciousness?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

9. Currently under care for traumatic injury?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

10. Currently under care for continuing illness?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

11. Currently under care for dental?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

NOTES

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# Assessment / Admission and Discharge

Assess       Admit

## Section IV: Client Milestones (Continued)

### H. PHYSICAL HEALTH (CONTINUED)

12. DISABILITY – MAJOR LIMITATIONS (CHECK ALL THAT APPLY)

- |   |   |                                      |  |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> ADHD/ADD             | <input type="checkbox"/> Hearing              | <input type="checkbox"/> Mobility    | <input type="checkbox"/> Speech-Impaired |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Learning             | <input type="checkbox"/> None        | <input type="checkbox"/> Vision          |
| <input type="checkbox"/> Developmental        | <input type="checkbox"/> Mental/Psychological | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Other:          |

13. HAVE YOU EVER BEEN A VICTIM OF DOMESTIC VIOLENCE?  
 Yes     No     Uncertain

14. ARE YOU CURRENTLY A VICTIM OF DOMESTIC VIOLENCE?  
 Yes     No     Uncertain

### G. PREGNANCY STATUS

- |                                    |   |                                    |
|------------------------------------|---|------------------------------------|
| 1. ESTIMATED DUE DATE (MM/DD/YYYY) | 2. HAS PRENATAL PROVIDER?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 3. PREGNANCY END DATE (MM/DD/YYYY) |
|------------------------------------|---|------------------------------------|

### H. MENTAL/PSYCHOLOGICAL CONDITIONS

- |  |   |
|--|---|
| 1. PREVIOUS MENTAL TREATMENT (FOR ASSESSMENTS AND ADMISSIONS, PREVIOUS MEANS THE LAST YEAR. FOR DISCHARGE, PREVIOUS MEANS SINCE ADMISSION.) (CHECK ONE BOX ONLY)<br><input type="checkbox"/> No/NA <input type="checkbox"/> Unknown <input type="checkbox"/> With Hospitalization <input type="checkbox"/> With Outpatient Treatment | 2. DAYS HOSPITALIZED FOR MENTAL TREATMENT |
|--|---|

3. CURRENT PSYCHOLOGICAL EVALUATION (CHECK ONE BOX ONLY)

- |  |   |
|--|---|
| <input type="checkbox"/> No Evaluation Made                              | <input type="checkbox"/> Psychological Evaluation Made, Problem Diagnosed |
| <input type="checkbox"/> Problem Indicated, Referral Made                | <input type="checkbox"/> Re-evaluation Needed                             |
| <input type="checkbox"/> Psychological Evaluation Made, No Problem Found |   |

4. Does anyone in your immediate family or current living situation have a diagnosed mental illness?     Yes     No

5. In the last 30 days (ASI):

How many days have you experienced psychological or emotional problems: \_\_\_\_\_

How troubled or bothered have you been by psychological or emotional problems (ASI Scale Number): \_\_\_\_\_

6. How important to you now is treatment for these psychological problems (ASI Scale Number): \_\_\_\_\_

7. In the past 30 days have you had a significant period of time (that was not a direct result of A/D use) in which you have (ASI):

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily functions? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Experienced serious anxiety/tension - uptight, unreasonably worried, inability to feel relaxed?            | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Experienced hallucinations - saw things or heard voices that were not there?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Experienced trouble understanding, concentrating, or remembering?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>For the next three items below, patient can have been under the influence of alcohol / drugs.</b>          |                          |                          |
| e. Experienced trouble controlling violent behavior including episodes of rage or violence?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Experienced serious thoughts of suicide (patient seriously considered a plan for taking his/her life)?     | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Attempt suicide (include actual suicide gestures or attempts)?   | <input type="checkbox"/> | <input type="checkbox"/> |

8. CURRENTLY RECEIVING MENTAL HEALTH SERVICES?  
 Yes     No     In Need

9. CURRENTLY ON PRESCRIBED PSYCHIATRIC MEDICATIONS?  
 Yes     No     Unknown

10. QUADRANT PLACEMENT

NOTES

# Assessment / Admission and Discharge

Assess       Admit

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## Section IV: Client Milestones (Continued)

### I. ARRESTS AND LEGAL ISSUES

1. PREVIOUS ARREST(S) (FOR ASSESSMENTS AND ADMISSIONS, PREVIOUS MEANS THE LAST YEAR. FOR DISCHARGE, PREVIOUS MEANS SINCE ADMISSION.) (CHECK ALL THAT APPLY)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Crime(s) Unknown                  | <input type="checkbox"/> Embezzlement                             | <input type="checkbox"/> None                        |
| <input type="checkbox"/> Criminal Trespass                 | <input type="checkbox"/> Forgery                                  | <input type="checkbox"/> Other Public-Order Offenses |
| <input type="checkbox"/> Domestic Violence                 | <input type="checkbox"/> Fraud (includes bad checks)              | <input type="checkbox"/> Property Crimes             |
| <input type="checkbox"/> Driving Under the Influence       | <input type="checkbox"/> ID Theft                                 | <input type="checkbox"/> Theft                       |
| <input type="checkbox"/> Drug Possession                   | <input type="checkbox"/> Malicious Mischief or Disorderly Conduct | <input type="checkbox"/> Violent Crimes              |
| <input type="checkbox"/> Drug Trafficking or Manufacturing |   |  |

2. How many times in the last 30 days have you been arrested? \_\_\_\_\_

3. How many times have you ever been charged with (NOTE: Adult offense only) (ASI):

- |                               |                              |                       |
|-------------------------------|------------------------------|-----------------------|
| Arson _____                   | Forgery _____                | Rape _____            |
| Assault _____                 | Homicide _____               | Robbery _____         |
| Burglary _____                | Other Criminal Offense _____ | Shoplifting _____     |
| Contempt of Court _____       | Probation Violation _____    | Weapons Offense _____ |
| Drug Related Violations _____ | Prostitution _____           |                       |

4. CURRENT LEGAL INVOLVEMENT (CHECK ALL THAT APPLY)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Awaiting Charges             | <input type="checkbox"/> Drug Court - Adult                 | <input type="checkbox"/> Incarcerated, Pre-Trial                  |
| <input type="checkbox"/> Awaiting Trial               | <input type="checkbox"/> Drug Court - Juvenile              | <input type="checkbox"/> None                                     |
| <input type="checkbox"/> Child Custody Issue          | <input type="checkbox"/> In DUI Deferred Prosecution Status | <input type="checkbox"/> On Probation or Parole                   |
| <input type="checkbox"/> Convicted, Awaiting Sentence | <input type="checkbox"/> In Other Supervised Program        | <input type="checkbox"/> On Trial                                 |
| <input type="checkbox"/> CPS Court Involved           | <input type="checkbox"/> Incarcerated, Post-Conviction      | <input type="checkbox"/> Petitioning for DUI Deferred Prosecution |
| <input type="checkbox"/> Diversion                    |   |   |

5. How many days in the past 30 days have you engaged in illegal activities for profit: \_\_\_\_\_ (ASI)

6. How serious do you feel your present legal problems are (ASI Scale Number): \_\_\_\_\_

7. How important to you now is counseling or referral for these legal problems (ASI Scale Number): \_\_\_\_\_

### J. GAMBLING ISSUE

1. In the last twelve months:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. Have there been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement?         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you continued to gamble in spite of adverse consequences that have affected your finances, family relationships, work, or other parts of your life?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you lied to family members, friends, or others about how much you gamble?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have there been periods lasting two weeks or longer when you spent a lot of time thinking about you gambling experiences or planning out future gambling ventures or bets? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you tried but not succeeded in stopping cutting, down, or controlling your gambling behavior?   | <input type="checkbox"/> | <input type="checkbox"/> |

2. In the last twelve months:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Have you contemplated or attempted suicide?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Have you contemplated or attempted to do physical harm to another person? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

3. Score on South Oaks Gambling Screen (SOGS): \_\_\_\_\_

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# Assessment / Admission and Discharge

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CLIENT NAME	

## Section IV: Client Milestones (Continued)

### J. GAMBLING ISSUE (CONTINUED)

4. In the past 30 days, how many days have you played (enter quantity):
- |  |   |
|--|---|
| Bingo _____                                    | Gambling and substance use in the same day _____          |
| Bowl, pool, golf or other games of skill _____ | Internet gambling _____                                   |
| Card Games (non Casino) _____                  | Lottery, numbers, instant tickets (scratch-offs) _____    |
| Casino table games _____                       | Other forms of gambling _____                             |
| Dice games, dominoes _____                     | Play slots, poker machines, video lottery terminals _____ |
| Horses, dogs _____                             | Sports _____  |
| Gambling more than you can afford _____        | Stock options, commodities _____                          |

5. **In the past 30 days:**

- How much money would you say you spent per week on gambling? \$ \_\_\_\_\_
- Number of gambling episodes per week \_\_\_\_\_

### K. SUBSTANCE ABUSE

- If administered a breath test, what were the results: \_\_\_\_\_
- In the past 30 days (ASI):
  - How much money would you say you spent on alcohol: \$ \_\_\_\_\_
  - How much money would you say you spent on drugs: \$ \_\_\_\_\_
  - How many days have you experienced alcohol problems: \_\_\_\_\_
  - How troubled or bothered have you been by these alcohol problems (ASI Scale Number): \_\_\_\_\_
  - How important to you now is treatment for these alcohol problems (ASI Scale Number): \_\_\_\_\_
  - How many days have you experienced drug problems: \_\_\_\_\_
  - How troubled or bothered have you been by these drug problems (ASI Scale Number): \_\_\_\_\_
  - How important to you now is treatment for these drug problems (ASI Scale Number): \_\_\_\_\_
- Does anyone in your immediate family or current living situation have an alcohol problem?  Yes  No
- Does anyone in your immediate family or current living situation have a problem with drugs other than alcohol or tobacco?  Yes  No
- Does anyone in your immediate family or current living situation have a gambling problem?  Yes  No
- How many times in the last 30 days have you used alcohol to intoxication: \_\_\_\_\_ (ASI)

NOTES



AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

# Assessment / Admission and Discharge

Assess       Admit

## Section IV: Client Milestones (Continued)

### L. SUBSTANCE USE HISTORY

#### KEY CODES

PST CODES	ADMINISTRATION CODES	FREQUENCY OF USE/PEAK USE PER MONTH
Primary (1)	Inhalation (I)    Oral (O)	1 - No use      4 - 13 or more times
Secondary (2)	Injection (J)    Other (X)	2 - 1 to 3 times    5 - Daily
Tertiary (3)	Intra nasal (N)    Smoking (S)	3 - 4 to 12 times    6 - Unknown

#### SUBSTANCES

SUBSTANCE	PST (CHECK ONE BOX PER SUBSTANCE)			SUBSTANCE	PST (CHECK ONE BOX PER SUBSTANCE)		
	1	2	3		1	2	3
1. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. No substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Other Sedatives or Hypnotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other Opiates and Synthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Over the Counter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Oxy/Hydro Codone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Prescribed Opiate Substitute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Major tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Substance Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Marijuana – Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Tobacco products (cannot be primary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 1. IN THE FOLLOWING TABLE DESCRIBE SUBSTANCE USE WITH THE ABOVE KEY CODES.

PST	SUBSTANCE (CODE)	ADMIN (CODE)	AGE OF FIRST USE	FREQUENCY OF USE IN LAST 30 DAYS (CODE)	PEAK USE PER MONTH IN LAST YEAR (CODE)	DATE LAST USED MM/DD/YYYY	AMOUNT TAKEN/COMMENTS
1							
2							
3							

### 2. CURRENT STAGE OF USE

Chemically Dependent (Addicted)       Experimental Use       In Recovery  
 Abuse       No Significant Problem

3. Have you ever used needles to illicitly inject drugs?     Continuously     Intermittently     Rarely     Never  
 4. Inject drugs in the last 30 days?     Yes     No    **This option for abort discharge ONLY:**     Unknown  
 5. Currently use tobacco products:     Smoke     Chew     Both     None  
 Ever tried to quit using tobacco products?     Yes     No  
 Want to quit using tobacco products now?     Yes     No

### NOTES

# Assessment / Admission and Discharge

Assess       Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

## Section V: Client Referrals, Modality, and Funding

Complete the section that corresponds to the client's assessment or admission. Note: If this is for an ADATSA Assessment, do not use this form instead continue with the DSHS 04-433(X), ADATSA Assessment Addendum.

**A. ASSESSMENT COMPLETION (NON-ADATSA)**

### REFERRALS

1. FORWARD REFERRAL (CHECK ALL THAT APPLY)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADATSA Assessment Agency        | <input type="checkbox"/> CSO                     | <input type="checkbox"/> No Referral          |
| <input type="checkbox"/> ADATSA Treatment                | <input type="checkbox"/> Detoxification          | <input type="checkbox"/> Non-ADATSA Treatment |
| <input type="checkbox"/> Alcohol/Drug Information School | <input type="checkbox"/> Gambling Treatment      | <input type="checkbox"/> Other (specify):     |
| <input type="checkbox"/> ATR Services                    | <input type="checkbox"/> Medical/Dental Services | <input type="checkbox"/> Self-Help Group      |
| <input type="checkbox"/> CD Involuntary Commitment       | <input type="checkbox"/> Mental Health Services  |   |

2. Did you suggest client apply for DSHS Public Assistance?

Yes     No

3. RECOMMENDED ASAM PLACEMENT LEVEL

### FUNDING SOURCE

1. SPECIAL PROJECT STATE

2. SPECIAL PROJECT COUNTY

3. SPECIAL PROJECT AGENCY

4. CURRENT PUBLIC ASSISTANCE (CHECK ONE BOX ONLY)

- |  |   |
|--|---|
| <input type="checkbox"/> ADATSA                          | <input type="checkbox"/> None   |
| <input type="checkbox"/> Applicant                       | <input type="checkbox"/> Refugee Assistance                             |
| <input type="checkbox"/> Disability Lifeline             | <input type="checkbox"/> Supplemental Security Income (SSI; S01)        |
| <input type="checkbox"/> Disability Lifeline - Expedited | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) |
| <input type="checkbox"/> Medical Assistance Only         |   |

5. CONTRACT (CHECK ONE BOX ONLY)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADATSA                   | <input type="checkbox"/> Criminal Justice – Innovation | <input type="checkbox"/> Other/None            |
| <input type="checkbox"/> Adult Outpatient         | <input type="checkbox"/> DOC - COM                     | <input type="checkbox"/> Pregnant/Parenting    |
| <input type="checkbox"/> Adult Residential        | <input type="checkbox"/> DOC - Jail                    | <input type="checkbox"/> TANF (ESA)            |
| <input type="checkbox"/> ATR – Access to Recovery | <input type="checkbox"/> Gov2Gov (Non XIX)             | <input type="checkbox"/> Tribe MOA (Title XIX) |
| <input type="checkbox"/> CDDA (COMM)              | <input type="checkbox"/> Indian Health Services (IHS)  | <input type="checkbox"/> WA-CARES              |
| <input type="checkbox"/> CDDA (LS)                | <input type="checkbox"/> Local Sales Tax               | <input type="checkbox"/> WASBIRT               |
| <input type="checkbox"/> Criminal Justice (CJ)    | <input type="checkbox"/> Molina – Managed Care         | <input type="checkbox"/> Youth Treatment       |

6. FUND SOURCE CD (CHECK ONE BOX ONLY)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Agency Funded             | <input type="checkbox"/> Federal Direct | <input type="checkbox"/> State Direct              |
| <input type="checkbox"/> County Community Services | <input type="checkbox"/> Other          | <input type="checkbox"/> State DSHS (Non DASA)     |
| <input type="checkbox"/> DOC                       | <input type="checkbox"/> Private Pay    | <input type="checkbox"/> Tribal Community Services |

7. FUND SOURCE GAMBLING (Check One Box Only)

State Direct     Private Pay     Other

8. TITLE XIX FUNDED

Yes     No

9. GOVERNING COUNTY (If Not County Of Facility)

10. ASSESSMENT STAFF ID

11. CASE MONITOR (IF DIFFERENT)

12. ASSESSMENT DURATION  
HOURS                  MINUTES

13. INTERVIEWER'S SIGNATURE

14. DATE

NOTES

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

# Assessment / Admission and Discharge

Assess       Admit

## Section V: Client Referrals, Modality, and Funding (Continued)

### B. ADMISSION COMPLETION

1. CURRENT PUBLIC ASSISTANCE (CHECK ONE BOX ONLY)

- |  |   |
|--|---|
| <input type="checkbox"/> ADATSA                          | <input type="checkbox"/> None   |
| <input type="checkbox"/> Applicant                       | <input type="checkbox"/> Refugee Assistance                             |
| <input type="checkbox"/> Disability Lifeline             | <input type="checkbox"/> Supplemental Security Income (SSI)             |
| <input type="checkbox"/> Disability Lifeline - Expedited | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) |
| <input type="checkbox"/> Medical Assistance Only         |   |

2. MODALITY (CHECK ONE BOX ONLY)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Detoxification           | <input type="checkbox"/> Intensive Inpatient   | <input type="checkbox"/> Recovery House                          |
| <input type="checkbox"/> Group Care Enhancement   | <input type="checkbox"/> Intensive Outpatient  | <input type="checkbox"/> Methadone/Opiate Substitution Treatment |
| <input type="checkbox"/> Housing Support Services | <input type="checkbox"/> Long-Term Residential | <input type="checkbox"/> Outpatient                              |

3. CONTRACT (CHECK ONE BOX ONLY)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADATSA                   | <input type="checkbox"/> Criminal Justice – Innovation | <input type="checkbox"/> Other/None            |
| <input type="checkbox"/> Adult Outpatient         | <input type="checkbox"/> DOC - COM                     | <input type="checkbox"/> Pregnant/Parenting    |
| <input type="checkbox"/> Adult Residential        | <input type="checkbox"/> DOC - Jail                    | <input type="checkbox"/> TANF (ESA)            |
| <input type="checkbox"/> ATR – Access to Recovery | <input type="checkbox"/> Gov2Gov (Non XIX)             | <input type="checkbox"/> Tribe MOA (Title XIX) |
| <input type="checkbox"/> CDDA (COMM)              | <input type="checkbox"/> Indian Health Services (IHS)  | <input type="checkbox"/> WA-CARES              |
| <input type="checkbox"/> CDDA (LS)                | <input type="checkbox"/> Local Sales Tax               | <input type="checkbox"/> WASBIRT               |
| <input type="checkbox"/> Criminal Justice (CJ)    | <input type="checkbox"/> Molina – Managed Care         | <input type="checkbox"/> Youth Treatment       |

4. FUND SOURCE (CHECK ONE BOX ONLY)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Agency Funded             | <input type="checkbox"/> Federal Direct | <input type="checkbox"/> State Direct              |
| <input type="checkbox"/> County Community Services | <input type="checkbox"/> Other          | <input type="checkbox"/> State DSHS (Non DASA)     |
| <input type="checkbox"/> DOC                       | <input type="checkbox"/> Private Pay    | <input type="checkbox"/> Tribal Community Services |

5. FUND SOURCE GAMBLING (CHECK ONE BOX ONLY)

- State Direct     Private Pay     Other

6. TITLE XIX FUNDED

- Yes     No

8. RECOMMENDED ASAM PLACEMENT LEVEL

9. SPECIAL PROJECT STATE

10. SPECIAL PROJECT COUNTY

11. SPECIAL PROJECT AGENCY

12. GOVERNING COUNTY (IF NOT COUNTY OF FACILITY)

13. INSURANCE PAYMENT (PRIVATE) (CHECK ONE BOX ONLY)

- No Insurance Payment     50% or greater     Less than 50%

14. ADMISSION STAFF ID

15. COUNSELOR STAFF ID

16. ADMISSION DURATION  
Hours:                      Minutes:

17. COURT ORDERED

- CD     MH     Both     None

18. DOC SUPERVISION

- Yes     No

19. CONSENT STATUS

- Permitted     Refused     Revoked

20. CONSENT DATE

21. INTERVIEWER'S SIGNATURE

22. DATE

NOTES