Laureate Chemical Dependency Center

INTENSIVE OUTPATIENT PROGRAM

BIOPSYCHOSOCIAL ASSESSMENT

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PATIENT LABEL

Please complete this questionnaire and give it to your counselor on your first visit. This information will help your clinician gain an understanding of the problems for which you are seeking help and of other important events in your life.

YOUR NAME IN FULL	AGE	DATE OF BIRTH	MEDICAL RECORD NUMBER
WHO REFERRED YOU TO LAUREATE?			TODAY'S DATE

MOTIVATION FOR CHANGE

WHAT FACTOR(S) LED YOU TO SEEK CHEMICAL DEPENDENCY TREATMENT AT THIS TIME? *EXPLAIN*

☐ Legal problems ☐ Health problems ☐ Financial problems ☐ Other -
☐ Relationship problems ☐ School problems ☐ Work problems

PREVIOUS TREATMENT

TELL US ABOUT YOUR PREVIOUS MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT

DATE OF TREATMENT	SUBSTANCE ABUSE	MENTAL HEALTH	NAME OF TREATMENT PROVIDER OR CENTER	TYPE OF TREATMENT (Residential, Detox, Outpatient, etc.)	RESPONSE TO TREATMENT (How long did you stay sober?)

WHILE USING ALCOHOL OR DRUGS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING MENTAL HEALTH OR BEHAVIORAL PROBLEMS?

☐ Depression ☐ Anxiety ☐ Compulsive gambling ☐ Compulsive sex or pornography ☐ Drug dealing ☐ Eating disorder

SUBSTANCE USE HISTORY

SUBSTANCES	AGE FIRST USED	DATE LAST USED	CURRENT CRAVING INTENSITY (None, moderate or strong)	PATTERN OF USE (How much, how often)	
				PREVIOUS PATTERN	CURRENT PATTERN
				FREQUENCY AND QUANTITY	FREQUENCY AND QUANTITY
ALCOHOL (including beer and wine)					
DEPRESSANTS (Valium, Xanax, etc.)					
STIMULANTS (Speed, Meth, etc.)					
COCAINE (Powder, Crack, etc.)					
MARIJUANA (Any form)					
HALLUCINOGENS (Acid, Mushrooms, Ecstasy)					
INHALANTS (Poppers, paint, glue, etc.)					
OPIATES (Pain meds, heroin, etc.)					
NICOTINE (Smoked, smokeless, etc.)					
OTHER (Over-the-counter, etc.)					
OTHER (Over-the-counter, etc.)					
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CONSEQUENCES OF SUBSTANCE USE

Have you ever had work or school problems related to alcohol or drug use?	☐ Yes	☐ No
Has alcohol or drug use ever had a negative impact on any of your relationships?	☐ Yes	☐ No
Have you ever had legal charges related to your alcohol or drug use?	☐ Yes	☐ No
Has alcohol or drug use ever led to any medical conditions?	☐ Yes	☐ No
Has alcohol or drug use ever caused you any financial problems?	☐ Yes	☐ No

OBSTACLES TO RECOVERY

DO YOU BELIEVE ANY OF THE FOLLOWING WILL MAKE IT MORE DIFFICULT FOR YOU TO STOP USING ALCOHOL OR DRUGS?

- ☐ Living with someone who uses alcohol or drugs
- ☐ Experiencing a great deal of job stress
- ☐ Having strong cravings for alcohol or drugs
- ☐ Having friends who use alcohol or drugs
- ☐ Being depressed or anxious
- ☐ Having few or no hobbies or interests

DO YOU HAVE ANY COMMUNICATION DIFFICULTIES WHICH COULD AFFECT YOUR RECOVERY EFFORT (IE SPEECH, VISUAL, OR HEARING IMPAIRMENTS)? IF SO - WHAT?

DURING TREATMENT, WHAT SUPPORT SYSTEMS (FAMILY, FRIENDS, NEIGHBORS, CHURCH, ETC.) WILL BE AVAILABLE TO HELP YOU WITH YOUR SUBSTANCE ABUSE PROBLEM?

CHILDHOOD DEVELOPMENTAL HISTORY

PROBLEMS EXPERIENCED DURING CHILDHOOD OR ADOLESCENCE	*CHECK ONE* YES	NO	IF YES - *DESCRIBE*
Delayed speech			
Delayed motor development			
Excessive shyness			
Excessive aggression			
Hyperactivity			
Learning problems			
Poor peer relationships			
Alcohol or drug abuse			
Depression			
School failure / dropout			
Runaway behavior			
Illegal activities			
Sexual abuse			
Physical abuse			
Abusing someone sexually			
Abusing someone physically			

FAMILY HISTORY

LIST ANY FAMILY MEMBERS BELOW WHO HAVE BEEN TREATED FOR MENTAL HEALTH OR SUBSTANCE ABUSE PROBLEMS

FAMILY MEMBER (Parents, grandparents, siblings)	TYPE OF PROBLEM OR DISORDER	TYPE OF TREATMENT (Hospitalization, medication, etc.)

DESCRIBE ANY SIGNIFICANT CHILDHOOD EVENTS THAT YOU THINK MIGHT BE IMPORTANT TO UNDERSTAND YOUR CURRENT PROBLEM

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ENVIRONMENT AND HOME

MARITAL STATUS

☐ Single ☐ Married ☐ Living as married ☐ Divorced

SEXUAL ORIENTATION

WHO LIVES IN YOUR HOME WITH YOU?

LIST NAMES OF YOUR CHILDREN

WHO HAS CUSTODY?

WHAT CHILDCARE ARRANGEMENTS DO YOU HAVE?

HOW MANY CLOSE FRIENDS DO YOU HAVE?

ARE YOU SATISFIED WITH THIS NUMBER?

HAS THERE BEEN VIOLENCE / PHYSICAL / SEXUAL ABUSE IN YOUR CURRENT RELATIONSHIPS?

☐ Yes ☐ No

YOUR PAST RELATIONSHIPS?

☐ Yes ☐ No

IF THERE IS SIGNIFICANT INFORMATION REGARDING YOUR SEXUAL HISTORY - *LIST HERE*

VOCATIONAL, EDUCATIONAL AND MILITARY HISTORY

WHERE ARE YOU EMPLOYED?

JOB TITLE

DO YOU LIKE YOUR JOB?

☐ Yes ☐ No

HAVE YOU BEEN IN THE MILITARY?

☐ No ☐ Yes -

IF YES - *BRANCH*

HIGHEST RANK

TYPE OF DISCHARGE

HIGHEST LEVEL OF EDUCATION

☐ Did not complete high school ☐ Completed college ☐ Technical training

☐ Obtained GED ☐ Completed high school ☐ Completed graduate school

RELIGION AND SPIRITUAL ORIENTATION

IS SPIRITUALITY A SIGNIFICANT PART OF YOUR LIFE?

☐ Yes ☐ No

WHAT DENOMINATION ARE YOU AFFILIATED WITH - *IF ANY*

DO YOU ATTEND REGULARLY?

☐ Yes ☐ No

WHAT GIVES YOUR LIFE MEANING?

FINANCIAL AND LEGAL STATUS

CURRENT LEGAL PROBLEMS - *DESCRIBE*

PAST LEGAL CHARGES - *DESCRIBE*

CURRENT FINANCIAL PROBLEMS - *DESCRIBE*

LEISURE AND RECREATION

LIST ANY INTERESTS OR HOBBIES

WHAT SOCIAL ACTIVITIES DO YOU PARTICIPATE IN?

ETHNIC AND CULTURAL INFORMATION

WHAT IS YOUR ETHNIC GROUP?

☐ African American ☐ Asian ☐ Hispanic

☐ Native American ☐ Caucasian ☐ Other -

WHAT, IF ANY, CULTURAL BELIEFS DO YOU HAVE THAT COULD BE RELEVANT TO YOUR TREATMENT?

WHAT ARE YOUR STRENGTHS, SUCH AS TALENTS, SKILLS OR PERSONAL CHARACTERISTICS?

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BIOMEDICAL SCREENING

WHO IS YOUR PRIMARY CARE PHYSICIAN?	LIST YOUR PSYCHIATRIST - *IF ANY*

DESCRIBE ANY CHRONIC PAIN YOU MAY EXPERIENCE

CHECK ANY OF THE MEDICAL CONDITIONS BELOW WHICH YOU HAVE HAD

☐ Chronic headaches	☐ HIV / AIDS	☐ GYN problems	☐ Blood disorder
☐ Chronic stomach pains	☐ High blood pressure	☐ Weight gain	☐ Tuberculosis
☐ Numbness	☐ Chest pain	☐ Blackouts	☐ Hepatitis
☐ Eye disease	☐ Bronchitis	☐ Heart problems	☐ Venereal disease
☐ Erectile dysfunction	☐ Hearing loss	☐ Cirrhosis	☐ Weight loss

HOW LIKELY IS IT THAT ANY OF THE ABOVE ARE RELATED TO YOUR ALCOHOL OR DRUG USE?

WHICH OF THE FOLLOWING OCCUR WHEN YOU DISCONTINUE USING ALCOHOL OR DRUGS - *CHECK ALL THAT APPLY*

☐ Depressed mood	☐ Racing pulse	☐ Extreme anxiety	☐ Dilated pupils
☐ Nausea or vomiting	☐ Insomnia	☐ Seizures	☐ Diarrhea
☐ Sweating	☐ Hallucinations	☐ Fever	☐ Hand tremors

GOALS FOR TREATMENT

PLEASE INDICATE WHICH ONE OF THE FOLLOWING MOST APPLIES TO YOU AT THIS TIME

☐ I think that total abstinence from alcohol and drugs is the only answer for me, and I want to stop drinking and using completely.

☐ I think that total abstinence from alcohol and drugs may be necessary for me, but I am not sure. If I knew that controlled drinking and using were impossible for me, then I would want to stop drinking and using completely.

☐ I think that total abstinence is not necessary for me, but I would like to reduce my drinking and using to a “light social” non-problem level.

☐ I think that total abstinence is not necessary for me, but I would like to reduce my drinking and using to a “moderate social” non-problem level.

☐ I think that total abstinence is not necessary for me, but I would like to reduce my drinking and using to a “heavy social” non-problem level.

☐ I think that total abstinence is not necessary for me, and I see no need to reduce my drinking and using.

IS THERE ANY OTHER INFORMATION THAT YOU WANT STAFF MEMBERS TO KNOW ABOUT YOU?

HAVE YOU EVER ATTEMPTED SUICIDE?	DO YOU CONSIDER YOURSELF A HIGH RISK TO ATTEMPT SUICIDE IN THE FUTURE?
☐ Yes ☐ No	☐ Yes ☐ No

DO YOU CONSIDER YOURSELF OR ANY FAMILY MEMBER A SERIOUS THREAT TO DO HARM OR BE HARMED BY SOMEONE?

☐ Yes ☐ No

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FOR STAFF USE ONLY BELOW THIS LINE

PATIENT HAS BEEN INFORMED OF THE NEED AND BENEFIT OF FAMILY OR SIGNIFICANT OTHERS PARTICIPATION IN WEEKLY FAMILY GROUP?

☐ Yes

IF APPLICABLE, PATIENT MADE AWARE OF THE POSSIBLE RELATIONSHIP BETWEEN PATTERN OF SUBSTANCE USE AND IDENTIFIED MEDICAL CONDITIONS

☐ Yes

IF APPLICABLE, PATIENT INFORMED OF NEED FOR PHYSICAL EXAMINATION

☐ Yes

LEVEL OF CARE RECOMMENDATION

OUTPATIENT

☐ No withdrawal risk
☐ No biomedical complications
☐ No emotional / behavioral complications
☐ Cooperative but needs motivation
☐ Needs minimal support for abstinence
☐ Supportive recovery environment

INTENSIVE OUTPATIENT

☐ Minimal risk of severe withdrawal
☐ No or manageable biomedical conditions
☐ Mild emotional / behavioral conditions requiring monitoring
☐ Resistance moderate but requires structured program
☐ Likelihood of relapse without close monitoring and support
☐ Environment is non-supportive but patient can cope in structured program

INPATIENT

☐ Severe withdrawal requiring medical monitoring
☐ Requires inpatient diagnosis and treatment
☐ Dual diagnosis requires 24-hour psychiatric and addiction treatment

TREATMENT ACCEPTANCE LEVEL

☐ Withdrawal symptoms require medical treatment - referred to Inpatient
☐ Some resistance, requires structured program - referred to Intensive Outpatient Program
☐ Cooperative but needs motivating and monitoring strategies - referred to Outpatient

ADDITIONAL STAFF COMMENTS - IF APPLICABLE

REVIEWED BY - PRINT	CLINICIAN'S SIGNATURE	CREDENTIALS	DATE