MID-OHIO VALLEY FELLOWSHIP HOME

Client Assessment Form

Children _____ **Last use** _____ **CPS**_____

Date: _____ Time: _____ Assessment Taken By: _____

Caller's Name:_____ Agency (if applicable)_____

Address:_____

County_____

Relationship to Patient: _____Phone#_____

Client's Name:_____ Age: _____D.O.B.: _____

Client's Address: _____Phone# (H)_____ (W)_____

Current Residence (if other than above)_____ Phone#_____

Sex: M. F Marital Status: M S W D Sep. Employer:_____ Address:_____

SS #: _____ Client Pregnant? ☐ No ☐ Yes If Yes, how many months?_____

Are you a veteran? ☐ No ☐ Yes _____

SOURCE OF AWARENESS - HOW DID YOU HEAR ABOUT US?

☐ Phone Book ☐ Radio ☐ Word of Mouth_____

☐ Physician_____ ☐ Other_____

SUBSTANCE ABUSE HISTORY

1.) Information obtained from: ☐ Client ☐ Other_____

2.) Why do you want treatment now? (Why now? What is going on?) _____

_____

_____

3.) Are you currently using drugs? ☐ Yes ☐ No Are you currently using alcohol? ☐ Yes ☐ No

4.) Drug History: Have you used?

☐ **Alcohol** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/ month

Amount _____ Last Use _____ Drink(s) of Choice _____

☐ **Cocaine** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month

Amount _____ Last Use _____ Route _____

☐ **Heroin** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month

Amount _____ Last Use _____ Route _____

☐ **Marijuana** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month

Opiates

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

Benzos

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

5.) What is your drug of choice? _____

6.)How old were you when you had your first drink _____ Drugs? _____

7.)How long have you been using at this level? _____

8.) Have you ever tried to quit in the past? _____ How many times? _____

Longest time you quit _____

9.)In the last 6 months what is the longest period of time you have gone without using drugs or alcohol? _____

_____

10.)Previous inpatient treatment for drug/alcohol problems? ☐ Yes ☐ No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FOR HOW LONG?

11.)Have you ever had prior outpatient treatment for drug/alcohol problems? Yes No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FOR HOW LONG?

12.)Have you attended AA or NA or other support group? Yes No

MEDICAL HISTORY

1) When you stop drinking or using have you experienced any of the following?

tremors hallucinations audio/visual/tactile seizures agitation nausea/vomiting blackouts

delirium tremors insomnia sweats irritability mood swings muscle aches

other _____

2.) Have you ever been diagnosed with any of the following conditions?

high blood pressure cirrhosis hepatitis liver disease diabetes tuberculosis

heart problems _____ coronary artery disease pancreatitis breathing problems _____

difficulty walking GI bleeding renal failure inability to take oral meds

other medical conditions _____

3.)Have you been hospitalized for any of these conditions? Which ones? _____

4.)Do you have any disabilities, limitations or special needs? Yes No If yes, explain them:

_____

5.) Medical Doctor: _____ Ph# _____ Last Seen: _____

6.) What prescribed medicines are you currently taking ? ☐ None

NAME	DOSE	FREQUENCY	LAST TAKEN	REASON FOR

7.) Are you allergic to any medications? _____

Any Foods? _____ Other? _____

8.) Have you ever been diagnosed with a eating disorder? _____

If yes, please explain. _____

8a.) Do you feel your eating habits are healthy? _____

PSYCHIATRIC HISTORY

1.)Have you ever seen a psychiatrist or currently under the care of one now? ☐ Yes ☐ No If yes, please identify the name and date of psychiatrist: _____

2.)Have you ever been treated or hospitalized for any psychiatric problems? ☐ Yes ☐ No If yes, when, where, what for and for how long? _____

3.)Are you currently depressed? ☐ Yes ☐ No When you are depress what symptoms do you have?

☐ recent wt loss or gain (how much_____) ☐ insomnia ☐ sleeping all the time ☐ fatigue ☐ loss of energy

☐ feelings or worthlessness ☐ excessive guilt ☐ diminished ability to think or concentrate

☐ other symptoms described _____

4.)Are you currently suicidal? ☐ Yes ☐ No If yes, do you have a plan? ☐ Yes ☐ No If yes, what is the plan? _____

5.)Have you ever had suicidal thoughts? ☐ Yes ☐ No If yes, when? _____

Any past attempts? ☐ Yes ☐ No If yes, when and how? _____

6.)Have you ever displayed violent behavior? Yes No If yes, describe _____

_____

7.)Any homicidal thoughts? Yes No If yes, describe _____

_____

LEGAL INFORMATION

1.)Have you ever had any legal problems related to use of alcohol or drugs? (i.e., DUI, assault, burglary, theft)

Yes No If yes, describe _____

2.)Any current legal charges pending? Yes No If yes, explain _____

_____

3.)Have you ever been charged or convicted of Domestic Violence or Assaults or violent behaviors?

Yes No If yes, explain:

4.)Are you currently on Probation or Parole? Yes No If yes, list conviction(s) _____

_____

5.)Any scheduled hearing dates? _____

_____

OTHER

1.)What areas (other than remaining sober) would you like to work on while living here? _____

_____

2.)Are you currently in a significant relationship? Yes No If yes, explain. _____

_____

3.)Do you have children? Yes No Do you claim them on your Federal Tax Return? Yes No

If yes, how many and what ages? _____

_____

4.)Describe your family and your relationship with them: _____

Client's Name: _____

5.)What is the last grade you completed in school? _____

6.)How long would you be willing to live here if accepted? _____

Have you ever lived in or been interviewed for placement at another residential program? Yes No

If yes, where and when? _____

_____

8) If accepted, MOVFH charges a non-refundable processing fee of $100.00. How will I pay the $300.00 a month residential fee and this first months processing fee?

_____

9.) I understand that participating in this assessment I am stating that all information I have given MOVFH is the truth. I agree to provide MOVFH with all legal paperwork, court documents etc. False information of any kind could result in disqualification before acceptance or discharge after admittance. I have read or had this statement read to me and I agree to these conditions. Yes:_____ No: _____

OFFICE USE ONLY

Recommended for Residency _____Yes _____ No Anticipated Admission Date _____

By: _____
Staff Signature

Admission Date _____

Approved by _____
Patrice M. Pooler, Executive Director

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