Admissions / Biopsychosocial2

Please complete Clearly and Legibly

Client's Full Legal Name:		**Client's Address:**	
Client's Phone #:		**Email Address:**	
DOB & Age:		**Social Security #:**	
Marital Status:		**Gender Identity:**	
Sexual Identity:		**Ethnicity:**	
Primary Language:		**Religious Preference:**	

Primary Insurance:		**ID#:**
Secondary Insurance:		**ID#:**
Referral Source:		

Presenting Problem

Events/circumstances leading to assessment/admission (include the client's feeling(s) about being in treatment). Please share your account as to why you are in your current situation:

_____

_____

_____

_____

Does client need assistance technology? (ex. hearing amplifier, audio books): ☐ Yes ☐ No

_____

_____

☐ Yes ☐ No **Hearing Impairment** ☐ Yes ☐ No **Speech Impairment** ☐ Yes ☐ No **Vision Impairment**

☐ Yes ☐ No **Learning Disability** (If yes, expand):_____

☐ Yes ☐ No **Exposure to substance(s) in utero**? (If yes, expand): _____

_____

Is client currently employed? ☐ Yes ☐ No Employer Name?_____

Has addiction affected past or current employment?_____

_____

_____

Dimension 1- Acute Intoxication and/or Withdrawal Potential

☐ Yes ☐ No Current Risk for withdrawal and/or history of withdrawal symptoms? Describe withdrawal symptoms:

_____

_____

_____

_____

	Physical	Notes (Occurrence Frequency, Associated Substance)		Mental	Notes (Occurrence Frequency, Associated Substance)
☐	Vomiting		☐	Irritability	
☐	Nausea		☐	Anxiety	
☐	Increased Perspiration		☐	Depression	
☐	Seizures		☐	Mood Swings	
☐	Delirium Tremens		☐	Suicidal Ideation	
☐	Gastrointestinal Issues		☐	Hallucinations	
☐	Rapid Heart Rate		☐	Delusions	
☐	Changes in Appetite		☐	Paranoia	
☐	Body Aches		☐	Insomnia	
☐	Headaches		☐	Hypersomnia	
☐	Lethargy		☐	Cognitive Impairments	
☐	Poor Motor Control		☐	Confusion	
☐	History of Overdose		☐	Hostility / Aggression	
☐	Other: Click here to enter text.		☐	Poor Concentration	
☐	Other: Click here to enter text.		☐	Racing Thoughts	
☐	Other: Click here to enter text.		☐	Memory Issues	

☐ Yes ☐ No Client has a history of seizures (substance or non-substance related)? If yes, expand on date of last seizure and does client have a seizure disorder (If yes, does client take medications, when was the last seen by a physician):

_____

_____

_____

Dimension 2- Biomedical Conditions and Complications

☐ Yes ☐ No Client has experienced delays in development milestones (ex. walking, talking, toilet training, speech development) and/or a learning disability (ex. dyslexia, etc.) Identify development delay and/or learning disability:

_____

_____

☐ Yes ☐ No Client is using alternative heath approaches? Describe approaches (acupuncture, yoga, meditation, etc.):

_____

_____

☐ Yes ☐ No Client is pregnant? Include gestation and any prenatal care or lack of prenatal care:

_____

_____

_____

☐ Yes ☐ No History of high risk behaviors? (ex. unprotected sex, driving while intoxicated, IV use, etc.):

_____

_____

_____

_____

☐ Yes ☐ No Client has changes in sleeping pattern due to substance use? (If yes, please describe):

_____

_____

_____

☐ Yes ☐ No Client has changes in weight and/or eating patterns due to substance use? (If yes, please explain):

_____

_____

_____

☐ Yes ☐ No ADL (Activities of Daily Living) Client is able to complete person hygiene needs (shower independently, run water at a safe temperature, clean self, get in and out of the shower. Client is able to get around unassisted, able to maneuver stairs without assistance):

_____

_____

_____

☐ Yes ☐ No Client has a primary care provider (PCP)? (If yes, list provider name and location):

_____

_____

_____

☐ Yes ☐ No Client has had a physical in the last twelve months? (If yes, when and where):

_____

_____

_____

☐ Yes ☐ No Does client have any drug or food allergies? (If yes, expand):

_____

_____

Medication History/Current medication (Both medical and behavioral):

Medication	Dosage	Reason	Start Date	End Date	Efficacy	Prescriber

_____

_____

Communicable Disease Questionnaire:

Does the client have or have they ever had: (check boxes)

☐ Measles	☐ Mumps	☐ Rubella	☐ Chicken Pox
☐ Hepatitis	☐ HIV	☐ Tuberculosis	☐ MRSA
☐ Staph	☐ Other:		

☐ Yes ☐ No Has client been tested for communicable diseases (i.e. HIV, Hep C, STDs)?

☐ Yes ☐ No Is the client now under the care of a physician or taking any medication for a communicable disease?

_____

_____

_____

☐ Yes ☐ No Has the client had recent contact with someone with any of the above illnesses?

_____

_____

☐ Yes ☐ No Have you met with a physician in the last year for a physical?

_____

_____

Dimension 3- Emotional, Behavioral and Cognitive Conditions and Complications

☐ Yes ☐ No Client reports current or past psychiatric conditions and current or past symptoms? (If yes, provide previous diagnosis and treatment history):

_____

_____

Previous Treatment- Medical and Behavioral Health

Treatment Type	Conditions Treated	Facility Name	Admit Date	Discharge Status	Length of Sobriety Following

☐ Yes ☐ No Current behaviors, emotions or cognitive difficulties related to addiction? (If yes, please explain):

_____

_____

_____

☐ Yes ☐ No Client has current or past thoughts or attempts of self-harm and/or suicide? (If yes, please explain):

_____

_____

_____

_____

☐ Yes ☐ No Client has experienced, witnessed, or perpetrated abuse, neglect, violence, sexual assault or other traumatic experiences in their past? Does the client experience homicidal ideations?

_____
_____
_____
_____

☐ Yes ☐ No Client would consider mental health therapy? (If yes, is there a counselor preference?):

_____
_____

☐ Yes ☐ No Client would consider medications while at Rimrock?

_____
_____

☐ Yes ☐ No Does client currently have a mental health counselor? (If yes, do they want to return to that counselor?):

_____
_____

Dimension 4- Readiness to Change

☐ Yes ☐ No Client uses tobacco products (includes vaping, chewing, etc.)? If yes, describe use:

_____
_____

☐ Yes ☐ No Client identifies behaviors related to process addiction? (gambling, eating disorder, sexual addiction, codependency, video games):

_____
_____

Substance Use Matrix

SUBSTANCE	PAST 30 Days	AGE 1st Used	Route of Administration	Date of Last Use	Amount of Last Use
Alcohol – any use at all					
Alcohol – to intoxication					
Heroin					
Methadone					
Opiates					
Barbiturates					
Benzodiazepines					
Buprenorphine					

Sedatives/hypnotics/tranquilizers					
Cocaine					
Amphetamines					
Methamphetamines					
Cannabis					
Hallucinogens					
Inhalants					
Kratom					
Spice					
Other Drug:					

☐ Yes ☐ No Has client overdosed on drugs? (If yes, please explain):

_____

_____

Primary Drug of choice: _____

Based on the following criteria:

- ☐ using for a longer period of time or more than intended
- ☐ desire to cut down or attempts to control use
- ☐ spending a great deal of time in activities to obtain/use/recover from use
- ☐ cravings and/or strong desire to use
- ☐ use resulting in failure to fulfill major role obligations
- ☐ continued use despite persistent social or interpersonal problems caused or exacerbated by use
- ☐ having given up or reduced social/occupational/recreational activities in order to use
- ☐ recurrent use in physically hazardous situations
- ☐ continued use despite knowledge it causes/exacerbates physical/psychological problems
- ☐ experiencing a build-up of tolerance
- ☐ experiencing withdrawal during cessation

Secondary Drug of choice: _____

Based on the following criteria:

- ☐ using for a longer period of time or more than intended
- ☐ desire to cut down or attempts to control use
- ☐ spending a great deal of time in activities to obtain/use/recover from use
- ☐ cravings and/or strong desire to use
- ☐ use resulting in failure to fulfill major role obligations
- ☐ continued use despite persistent social or interpersonal problems caused or exacerbated by use

- ☐ having given up or reduced social/occupational/recreational activities in order to use
- ☐ recurrent use in physically hazardous situations
- ☐ continued use despite knowledge it causes/exacerbates physical/psychological problems
- ☐ experiencing a build-up of tolerance
- ☐ experiencing withdrawal during cessation

Dimension 5- Relapse/Continued Use Potential

☐ Yes ☐ No Client struggles with managing triggers, peer pressure and stress? (Identify struggles):

_____

_____

Describe the following areas and if the client has been negatively impacting by illness, addiction and/or mental health.

☐ Yes ☐ No Social? (Peers and social/leisure activities):

_____

_____

☐ Yes ☐ No Family?

_____

_____

☐ Yes ☐ No Education/Degree? (Indicate highest grade completed and/or degree earned.):

_____

_____

Dimension 6- Recovery Environment

☐ Yes ☐ No Client has a family history of addiction, mental illness and/or medical concerns? (If yes, identify family history.):

_____

_____

_____

_____

☐ Yes ☐ No Client has legal issues? (Probation, fines, CPS, pending court dates, or legal issues.):

_____

_____

_____

_____

☐ Yes ☐ No Client is a veteran? (Where deployed? How affected?):

_____

_____

☐ Yes ☐ No Client has cultural considerations for treatment? (Sweats, smudges, religious beliefs/customs, explain needs):

_____
_____

☐ Yes ☐ No Does the client have a spiritual belief and if yes, how has their addiction affected this?

_____
_____

Client's sober support (such as a 12-step program):

_____
_____
_____
_____

Describe current living situations: (If homeless, provide history):

_____
_____
_____
_____
_____

Describe discharge plans: (Where does client plan on going for continuing care?):

_____
_____
_____
_____

Legal Circumstances:
What facility are you currently incarcerated?

_____

Are you required to register as a violent or sexual offender? ☐ Yes ☐ No
Have you been sentenced to a Department of Corrections (DOC) placement? ☐ Yes ☐ No ☐ I don't know
If yes, please explain:

_____
_____
_____

Current Charges:

1. _____
2. _____
3. _____
4. _____
5. _____

Scheduled Sentencing Date: _____ Sentencing Judge: _____

Previous legal involvement? Jail/Prison? Jail last 30 days?

_____

_____

_____

Probation Officer: _____County: _____ Phone: _____

Attorney: _____ Firm/County: _____ Phone: _____

Signature:_____ **Date:**_____