Initial Screening

Demographics

Name:_____ Date of Birth:_____ Sex: ☐ M ☐ F

Last First MI

Today's Date:_____ Incarceration Date:_____ Scheduled Discharge Date:_____

Social Security #:_____ Ethnicity:_____

Address:_____ Phone #:_____

Street City State Zip Code

Precipitating Event:
Why are you seeking treatment at this time? Please share your account as to why you are here and what lead to your current legal involvement?

_____
_____
_____
_____

Dimension 1:
Current Use/Use History:

Type of Substance	Date Last Used	Amount Used/ Frequency	Route of Administration	Comments
Alcohol				
Heroin				
Methadone				
Opiates				
Barbiturates				
Sedatives				
Amphetamine				
Cannabis				
Hallucinogens				
Inhalants				
Tobacco				
Benzodiazepine				
Cocaine				
Other:_____				

Please identity and describe all withdrawal symptoms you are or have experienced when you've attempted to stop using drugs:

	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:		☐	Poor Concentration	
☐	Other:		☐	Racing Thoughts	
☐	Other:		☐	Memory Issues	
☒	Other:		☐	Other:	
☐	Other:		☐	Other:	
☐	Other:		☐	Other:	
☐	Other:		☐	Other:	

Dimension 2:
Medical Conditions:

Medical Condition	Physician/Facility	Medication Needed	Notes

	Present / Hx of:	Notes
☐	Current Physical Illness	
☐	Communicable Disease	

☐	Pregnancy	
☐	Risky Sexual Behavior	
☐	IV Drug Use	
☐	Needle Sharing	
☐	Dental Issues	
☐	Hearing Issues	
☐	Vision Issues	
☐	Disabilities	
☐	Head/Brain Injury	
☐	In-Utero Drug Exposure	

If you have medical condition, are you able to complete all activities of daily living? ☐ Yes ☐ No

If no, please explain:

_____

_____

_____

Does your condition require medical monitoring? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

How often do you check-in with your physician for medical conditions?

_____

*******Please sign and attach a Release of Information to any medical provider you have seen******

Dimension 3:

Identifying conditions in the following areas will not affect your opportunities with the True North Project. This information is used only to provide comprehensive care

Any mental health diagnosis? If so when did they receive this diagnosis and where:

Diagnosis	Physician/Facility	Medication	Notes

History of psychiatric treatment and/or hospitalizations? ☐ Yes ☐ No If yes, please fill out all areas below:

Facility Name	Year	Reason	Notes

Do you have a history of self-harm? ☐ Yes ☐ No If yes, please explain:
_____
_____
_____

Have you had any previous suicidal attempts and/or suicidal ideations? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____

Do you have a history of violence, fights, or harm to others? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____

Do you have a history of head injury? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____

Have you ever experienced or witnessed trauma, abuse, neglect, violence, or sexual assault? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____

*******Please sign and attach a Release of Information to any mental health provider you have seen******

Dimension 4:
Previous Evaluation/ Treatment for Substance Dependence:

Facility Name	Year	Complete/ Incomplete	Length of Sobriety Following Tx	Notes

What is your motivation to be sober?
_____

_____
_____
_____

On a scale of 1 – 5, with 1 being drug / alcohol use being a little bit of a problem to 5 being a serious problem, where do you rate your alcohol / drug problem? Please give explanation as to why you gave this rating:

_____
_____
_____

On that same scale of 1 – 5, how would you rate your willingness / readiness to change? Please give explanation as to why you gave this rating:

_____
_____
_____

What has kept you from getting sober or seeking treatment in the past?

_____
_____
_____

Please identify the negative consequences of your use.

_____
_____
_____

Do you struggle with any of the following:

☐ Gambling ☐ Codependency ☐ Compulsive/Restrictive Eating
☐ Compulsive Sexual Behaviors ☐ Shoplifting/Theft

If yes, please explain:

_____
_____

Primary Drug of Choice: _____

☐ Yes ☐ No 1. Have you used for a longer period of time or taken more than intended?
☐ Yes ☐ No 2. Have you wanted to cut down or attempted to control your use?
☐ Yes ☐ No 3. Do you spend a great deal of time in activities to obtain, use or recover from use?
☐ Yes ☐ No 4. Do you crave or have a strong desire to use?
☐ Yes ☐ No 5. Does your use result in a failure to fulfill major role obligations at work, school or home?
☐ Yes ☐ No 6. Do you have continued use despite having persistent or recurrent social or Interpersonal problems caused or exacerbated by the effects of use?
☐ Yes ☐ No 7. Have you given up or reduced social, occupational, or recreational activities in order to use?
☐ Yes ☐ No 8. Recurrent use in situations in which it is physically hazardous?
☐ Yes ☐ No 9. Do you continue to use with knowledge of having a persistent or recurrent physical problems that are likely to have been caused or exacerbated by you use?
☐ Yes ☐ No 10. Have you experienced tolerance?
☐ Yes ☐ No 11. Withdrawal Symptoms?

Secondary Drug of Choice: _____

☐ Yes ☐ No 1. Have you used for a longer period of time or taken more than intended?
☐ Yes ☐ No 2. Have you wanted to cut down or attempted to control your use?
☐ Yes ☐ No 3. Do you spend a great deal of time in activities to obtain, use or recover from use?
☐ Yes ☐ No 4. Do you crave or have a strong desire to use?

☐ Yes ☐ No 5. Does your use result in a failure to fulfill major role obligations at work, school or home?
☐ Yes ☐ No 6. Do you have continued use despite having persistent or recurrent social or Interpersonal problems caused or exacerbated by the effects of use?
☐ Yes ☐ No 7. Have you given up or reduced social, occupational, or recreational activities in order to use?
☐ Yes ☐ No 8. Recurrent use in situations in which it is physically hazardous?
☐ Yes ☐ No 9. Do you continue to use with knowledge of having a persistent or recurrent physical problems that are likely to have been caused or exacerbated by you use?
☐ Yes ☐ No 10. Have you experienced tolerance?
☐ Yes ☐ No 11. Withdrawal Symptoms?

Tertiary Drug of Choice: _____

☐ Yes ☐ No 1. Have you used for a longer period of time or taken more than intended?
☐ Yes ☐ No 2. Have you wanted to cut down or attempted to control your use?
☐ Yes ☐ No 3. Do you spend a great deal of time in activities to obtain, use or recover from use?
☐ Yes ☐ No 4. Do you crave or have a strong desire to use?
☐ Yes ☐ No 5. Does your use result in a failure to fulfill major role obligations at work, school or home?
☐ Yes ☐ No 6. Do you have continued use despite having persistent or recurrent social or Interpersonal problems caused or exacerbated by the effects of use?
☐ Yes ☐ No 7. Have you given up or reduced social, occupational, or recreational activities in order to use?
☐ Yes ☐ No 8. Recurrent use in situations in which it is physically hazardous?
☐ Yes ☐ No 9. Do you continue to use with knowledge of having a persistent or recurrent physical problems that are likely to have been caused or exacerbated by you use?
☐ Yes ☐ No 10. Have you experienced tolerance?
☐ Yes ☐ No 11. Withdrawal Symptoms?

*******Please sign and attach a Release of Information to any chemical dependency treatment programs you have attended******

Dimension 5:

What coping skills do you currently possess that will help you maintain sobriety?

_____
_____
_____

When do you find it most difficult to cope? (Ex. When stressed, when emotional, when vulnerable, etc.) Please be thorough in your response.

_____
_____
_____
_____

Do you struggle with peer pressure or feel compelled to use when others use alcohol/drugs around you? ☐ Yes ☐ No

_____
_____
_____

What do you think are your primary triggers to use alcohol/drugs?

_____
_____
_____

Do you feel you have any shame, guilt and/or grief? ☐ Yes ☐ No
Please explain:
_____
_____
_____

Are you involved in any sober activities/hobbies outside of incarceration? ☐ Yes ☐ No
Please explain:
_____
_____
_____

Do you have a family history of drug/alcohol abuse? ☐ Yes ☐ No
Please explain:
_____
_____
_____

Dimension 6:
How would you describe your relationship with your family?
_____
_____
_____

Do you have children? ☐ Yes ☐ No

Children:

Name	Age	Other Parent	Who has Custody

Do you have CPS/DFS involvement? ☐ Yes ☐ No

Name of CPS worker:_____

Please explain:
_____
_____
_____

Marital Status: ☐ Married ☐ Not Married Spouse's Name:_____

Current Status of Relationship:

_____

_____

Tell me about your living situation when not incarcerated:

Who do you live with? Is there use in the house? Would you return there following incarceration?

_____
_____
_____

Briefly describe your employment history:

_____
_____
_____

Briefly describe your education history:

_____
_____
_____

Legal

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 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: _____

*******Please sign and attach a Release of Information to any legal entities you are working with******

Are you currently and/or have you ever been involved in a 12-step or self-help program? ☐ Yes ☐ No
Please explain:

_____
_____
_____