

**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 NUMBER:
--	------------------	-----------------------------	--

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.

DBHR TARGET DATA ELEMENTS
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"/> DSHS Community Services Office	<input type="checkbox"/> Mental Health Provider	
<input type="checkbox"/> At Risk Youth (ARY/CHINS)	<input type="checkbox"/> Employer/EAP	<input type="checkbox"/> Other Alcohol/Drug Facility	
<input type="checkbox"/> Attorney	<input type="checkbox"/> First Steps or PPP Case	<input type="checkbox"/> Other Health Care Provider	
<input type="checkbox"/> BECCA Involved	<input type="checkbox"/> Gambling Facility	<input type="checkbox"/> Phone book	
<input type="checkbox"/> Court/Probation	<input type="checkbox"/> Gambling Retail	<input type="checkbox"/> Police	
<input type="checkbox"/> DCFS/CPS	<input type="checkbox"/> Group Care	<input type="checkbox"/> School/Education	
<input type="checkbox"/> Department of Corrections (DOC)	<input type="checkbox"/> 24 Hour Help line	<input type="checkbox"/> Self Help	
<input type="checkbox"/> Department of Licensing (DOL)	<input type="checkbox"/> Involuntary Commitment	<input type="checkbox"/> Self/Family	
<input type="checkbox"/> Detoxification Facility	<input type="checkbox"/> JRA	<input type="checkbox"/> Social Security Administration	
<input type="checkbox"/> Diversion	<input type="checkbox"/> Mass media	<input type="checkbox"/> Other:	
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"/> DSHS Community Services Office	<input type="checkbox"/> Mental Health Provider	
<input type="checkbox"/> At Risk Youth (ARY/CHINS)	<input type="checkbox"/> Employer/EAP	<input type="checkbox"/> Other Alcohol/Drug Facility	
<input type="checkbox"/> Attorney	<input type="checkbox"/> First Steps or PPP Case	<input type="checkbox"/> Other Health Care Provider	
<input type="checkbox"/> BECCA Involved	<input type="checkbox"/> Gambling Facility	<input type="checkbox"/> Phone book	
<input type="checkbox"/> Court/Probation	<input type="checkbox"/> Gambling Retail	<input type="checkbox"/> Police	
<input type="checkbox"/> DCFS/CPS	<input type="checkbox"/> Group Care	<input type="checkbox"/> School/Education	
<input type="checkbox"/> Department of Corrections (DOC)	<input type="checkbox"/> 24 Hour Help line	<input type="checkbox"/> Self Help	
<input type="checkbox"/> Department of Licensing (DOL)	<input type="checkbox"/> Involuntary Commitment	<input type="checkbox"/> Self/Family	
<input type="checkbox"/> Detoxification Facility	<input type="checkbox"/> JRA	<input type="checkbox"/> Social Security Administration	
<input type="checkbox"/> Diversion	<input type="checkbox"/> Mass media	<input type="checkbox"/> Other:	
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 (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

NOTES

DBHR TARGET DATA ELEMENTS
Assessment/Admission and Discharge

Assess Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

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? _____

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | YES | NO | IN NEED |
| 7. Currently under care for infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a traumatic injury that resulted in loss of consciousness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Currently under care for traumatic head 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

DBHR TARGET DATA ELEMENTS
Assessment/Admission and Discharge

Assess Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

SECTION IV: CLIENT MILESTONES (CONTINUED)

H. MENTAL/PSYCHOLOGICAL CONDITIONS (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?

- Yes 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)

- No/NA Unknown With Hospitalization 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"/> |
| For the next three items below, patient can have been under the influence of alcohol/drugs. | | |
| 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

DBHR TARGET DATA ELEMENTS
Assessment/Admission and Discharge

Assess Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

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): _____

NOTES

Assessment/Admission and Discharge

Assess Admit

AGENCY NUMBER	STAFF IDENTIFICATION
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:**
 a. How much money would you say you spent per week on gambling? \$ _____
 b. Number of gambling episodes per week _____

K. SUBSTANCE ABUSE

1. If administered a breath test, what were the results: _____

2. 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): _____

3. Does anyone in your immediate family or current living situation have an alcohol problem? Yes No

4. Does anyone in your immediate family or current living situation have a problem with drugs other than alcohol or tobacco? Yes No

5. Does anyone in your immediate family or current living situation have a gambling problem? Yes No

6. How many times in the last 30 days have you used alcohol to intoxication: _____ (ASI)

NOTES

DBHR TARGET DATA ELEMENTS
Assessment/Admission and Discharge

Assess Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

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 (can not 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

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

- | | |
|---|-------------------------------------|
| 2. Did you suggest client apply for DSHS Public Assistance?
<input type="checkbox"/> Yes <input type="checkbox"/> 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"/> CSO Out Station | <input type="checkbox"/> Pregnant/Parenting |
| <input type="checkbox"/> Adult Residential | <input type="checkbox"/> DOC - COM | <input type="checkbox"/> TANF (ESA) |
| <input type="checkbox"/> ATR – Access to Recovery | <input type="checkbox"/> DOC - Jail | <input type="checkbox"/> Tribe MOA (Title XIX) |
| <input type="checkbox"/> CA Out Station | <input type="checkbox"/> Gov2Gov (Non XIX) | <input type="checkbox"/> WASBIRT |
| <input type="checkbox"/> CDDA (COMM) | <input type="checkbox"/> Indian Health Services (IHS) | <input type="checkbox"/> Youth Treatment |
| <input type="checkbox"/> CDDA (LS) | <input type="checkbox"/> Local Sales Tax | |
| <input type="checkbox"/> Criminal Justice (CJ) | <input type="checkbox"/> Molina – Managed Care | |

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

DBHR TARGET DATA ELEMENTS
Assessment/Admission and Discharge

Assess Admit

AGENCY NUMBER	STAFF IDENTIFICATION
CLIENT NAME	

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 Outpatient | <input type="checkbox"/> Recovery House |
| <input type="checkbox"/> Group Care Enhancement | <input type="checkbox"/> Long-Term Residential | |
| <input type="checkbox"/> Housing Support Services | <input type="checkbox"/> Methadone/Opiate Substitution Treatment | |
| <input type="checkbox"/> Intensive Inpatient | <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"/> CSO Out Station | <input type="checkbox"/> Pregnant/Parenting |
| <input type="checkbox"/> Adult Residential | <input type="checkbox"/> DOC - COM | <input type="checkbox"/> TANF (ESA) |
| <input type="checkbox"/> ATR – Access to Recovery | <input type="checkbox"/> DOC - Jail | <input type="checkbox"/> Tribe MOA (Title XIX) |
| <input type="checkbox"/> CA Out Station | <input type="checkbox"/> Gov2Gov (Non XIX) | <input type="checkbox"/> WASBIRT |
| <input type="checkbox"/> CDDA (COMM) | <input type="checkbox"/> Indian Health Services (IHS) | <input type="checkbox"/> Youth Treatment |
| <input type="checkbox"/> CDDA (LS) | <input type="checkbox"/> Local Sales Tax | |
| <input type="checkbox"/> Criminal Justice (CJ) | <input type="checkbox"/> Molina – Managed Care | |

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