INTAKE: Self Alcohol/Drug Assessment

Name: ____ **Date:**______________________

Please answer all the following questions. All the information is kept in strict confidence and may not be disclosed without your permission. When completed, email form to your Jackson-Bibby location OR print and bring a copy to enrollment appointment.

1. At what age were you when you first took one or more drinks or used drugs? ________________________________
2. How old were you when you first became intoxicated or high?____
3. How many years have you been drinking or using?____
4. How often do you drink or use? ___ Daily ___ Weekly ___ Monthly ___ Other: ________________________________
5. What is the most positive or desirable effect of alcohol or drugs for you? ____________________________________
6. When was your last drink, or use? __________________ How much? ______________________________________
7. What particular situations or feelings would likely make you drink or use? ___________________________________
8. Have you had periods of not remembering events, during, or after the time you were drinking? ___________________
9. Have you had any medical problems directly related to drinking or using?____________________________________
10. How is your general health? ____
11. Do you feel that you have a drinking or drug problem impacting your life now? _______________________________
12. In what ways has your drinking or using caused you problems? ____
13. Do you consider your drinking or using to be alcoholic/addictive?____
14. What was your **B**lood **A**lcohol **C**ontent at the time of your arrest? _____ Do you feel you were in control? _________
15. Are you currently taking prescription medication? ______ lf so, what? _____________________________________
16. Have you used street drugs in the past? (cocaine, methamphetamine, pot, etc.) ____ lf so, what? _________________
17. Are you currently using drugs? _____ lf so, what?____
18. Have you attended counseling (marriage, family, Individual, alcohol/drug treatment)? _____If so, when?___________
19. Have you considered or been suggested to attend **AA/NA**? _____ If so, are you attending? _____________________
20. Is anyone in your family alcoholic or drug dependent? ______ lf so, who? ___________________________________
21. Legal History? (Current) ______________________________ (Past) _______________________________________
22. Current Age? _________________
23. Are you employed? ____________

AOD RESULTS DISCUSSED WITH CLIENT – TO BE SIGNED WITH COUNSELOR

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Client's Name: _________________________Signature:_________________________________Date:_______________

Counselor's Signature: ____

SIMPLE ASSESSMENT TOOL FOR AOD ABUSE

Name: ____ Date:_______________________

DIRECTIONS: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept confidential. Mark the response that best fits you. Answer the question in terms of your experiences **in the past 6 months**.

During the past 6 months...

1. Have you used alcohol or other drugs, such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants **in the past 6 months**?

___Yes ___ No

2. Have you felt that you use too much alcohol or other drugs **in the past 6 months**?

___Yes ___ No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs **in the past 6 months**?

___Yes ___ No

4. Have you gone to anyone for help because of your drinking or drug use, such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program **in the past 6 months**?

___Yes ___ No

5. Have you had any health problems **in the past 6 months**?

___ Had blackouts or other periods of memory loss?
___ Injured your head after drinking or using drugs?
___ Had convulsions, delirium tremens ("DTs")?
___ Had hepatitis or other liver problems?
___ Felt sick, shaky, or depressed when you stopped?
___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
___ Been injured after drinking or using?
___ Used needles to shoot drugs?
___ Experienced hallucinations?
If so, before drug use ___ ? After drug use ___ ?
___ None of the Above

6. Has drinking or other drug use caused problems between you and your family or friends **in the past 6 months?**

___Yes ___ No

7. Has your drinking or other drug use caused problems at school or work **in the past 6 months**?

___Yes ___ No

SIMPLE ASSESSMENT TOOL FOR AOD ABUSE, PAGE 2

8. Other than this present DUl, have you been arrested or had other legal problems, such as bouncing bad checks, driving while intoxicated, theft, or drug possession **in the past 6 months**?

___Yes ___ No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs **in the past 6 months**?

___Yes ___ No

10. Are you needing to drink or use drugs more and more to get the effect you want **in the past 6 months**?

___Yes ___ No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs **in the past 6 months**?

___Yes ___ No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break the rules, break the law, sell things that are important to you, or have unprotected sex with someone **in the past 6 months**?

___Yes ___ No

13. Do you feel bad or guilty about your drinking or drug use **in the past 6 months**?

___Yes ___ No

The next questions are about your Lifetime experiences.

14. Have you ever had drinking or other drug problems in your lifetime?

___Yes ___ No

15. Have any of your family members ever had a drinking or drug problem in your lifetime?

___Yes ___ No

16. Do you feel that you have a drinking or drug problem now in your lifetime?

___Yes ___ No

Participant's Signature: ____ Date Discussed:__________________