

**PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES  
COMPREHENSIVE PSYCHOSOCIAL EVALUATION**

|              |              |                |
|--------------|--------------|----------------|
| PATIENT NAME | PATIENT ID # | ADMISSION DATE |
|--------------|--------------|----------------|

**Chemical Dependence /Abuse Update:** *Please update the information below with any changes found since admissions assessment*

| Substance Type                               | Age of Onset | Frequency/Amount/Progression | Date of last use |
|--|--------------|------------------------------|------------------|
| Alcohol <input type="checkbox"/>             |              |                              |                  |
| Amphetamines <input type="checkbox"/>        |              |                              |                  |
| Cannabis <input type="checkbox"/>            |              |                              |                  |
| Cocaine <input type="checkbox"/>             |              |                              |                  |
| Hallucinogens <input type="checkbox"/>       |              |                              |                  |
| Inhalants <input type="checkbox"/>           |              |                              |                  |
| Nicotine <input type="checkbox"/>            |              |                              |                  |
| Opioids <input type="checkbox"/>             |              |                              |                  |
| PCP <input type="checkbox"/>                 |              |                              |                  |
| Sedatives/Hypnotics <input type="checkbox"/> |              |                              |                  |
| Other <input type="checkbox"/>               |              |                              |                  |

**Previous Treatment History:** *Please update with any information in addition to the admissions assessment.*

| Date | Treatment Providers | Completed Y/N | Signed Release Y/N |
|------|---------------------|---------------|--------------------|
|      |                     |               |                    |
|      |                     |               |                    |
|      |                     |               |                    |
|      |                     |               |                    |

**Previous Recovery/Abstinence History:** *Please list previous periods of sustained recovery/abstinence and methods of attainment.*

| DATE(S) | Methods of attainment (i.e., AA/NA; Smart Recovery; other self help; church; jail; ) |
|---------|--|
|         |  |
|         |  |
|         |  |
|         |  |

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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**II. Physical Health:**

**Medication(s):** *Please list additional medication information on backside of sheet as needed.*

| Medication | Purpose | Prescriber |
|------------|---------|------------|
|            |         |            |
|            |         |            |
|            |         |            |
|            |         |            |
|            |         |            |

**Current Medical History:**

| Provider(s) Name | Condition being Treated | Signed Release Y/N |
|------------------|-------------------------|--------------------|
|                  |                         |                    |
|                  |                         |                    |
|                  |                         |                    |
|                  |                         |                    |

**Physical Examination Information:**

No physical examination within the past year of the admission date, patient will be:

- Referred for a Medical Assessment - attach completed OASAS 822 Medical Assessment form.
- Referred for a Physical Examination to :
- Date of Exam appointment:
- Signed consent for release:    YES        NO

Physical Examination within the past year from admission date - or was admitted directly from another OASAS Certified Program - medical history and physical examination information are in the patient case record and have been reviewed by a medical staff member

**Communicable Disease Assessment:**  Attach completed OASAS 822 Communicable Disease Assessment Form.

Clinician's findings and conclusions in this functional area:

  
  
  
  
  
  
  
  
  
  

Patient's identified needs in this functional area and level of motivation:

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| <b>III. Mental Health History:</b> |         |            |
|------------------------------------|---------|------------|
| Medication                         | Purpose | Prescriber |
|                                    |         |            |
|                                    |         |            |
|                                    |         |            |
|                                    |         |            |
|                                    |         |            |

| <b>Mental Health Treatment:</b> |          |                         |                    |
|---------------------------------|----------|-------------------------|--------------------|
| Dates                           | Provider | Condition being Treated | Signed Release Y/N |
|                                 |          |                         |                    |
|                                 |          |                         |                    |
|                                 |          |                         |                    |
|                                 |          |                         |                    |
|                                 |          |                         |                    |
|                                 |          |                         |                    |

**Brief Mental Status Exam:**

**Orientation (please answer the questions below):**

|   |                              |                             |  |                              |                             |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Can the patient give his/her full name? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does patient know where he/she is?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient know the full date?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the patient know why he/she is attending the session? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Intellectual/mental ability (please answer the question below):**

Does the patient have the ability to develop and understand a treatment plan?  Yes     No

**Mood (indicate currently and on most days as given below):**

|            |                                  |                                    |             |                                  |                                    |         |                                  |                                    |
|------------|----------------------------------|------------------------------------|-------------|----------------------------------|------------------------------------|---------|----------------------------------|------------------------------------|
| happy      | <input type="checkbox"/> current | <input type="checkbox"/> most days | melancholic | <input type="checkbox"/> current | <input type="checkbox"/> most days | anxious | <input type="checkbox"/> current | <input type="checkbox"/> most days |
| sad        | <input type="checkbox"/> current | <input type="checkbox"/> most days | euphoric    | <input type="checkbox"/> current | <input type="checkbox"/> most days | angry   | <input type="checkbox"/> current | <input type="checkbox"/> most days |
| despondent | <input type="checkbox"/> current | <input type="checkbox"/> most days | elated      | <input type="checkbox"/> current | <input type="checkbox"/> most days | Other:  | <input type="checkbox"/> current | <input type="checkbox"/> most days |
| irritable  | <input type="checkbox"/> current | <input type="checkbox"/> most days | depressed   | <input type="checkbox"/> current | <input type="checkbox"/> most days |         |                                  |                                    |

**Lethality Assessment:**

Have you ever planned to kill yourself?  Yes     No

Do you have current thoughts about killing yourself?  Yes     No

*If yes please answer the below questions:*

How likely are you to act on these thoughts?

If yes to any current ideology – describe plan for immediate assessment and safety plan:

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| <b>Lethality (con't)</b>   |  |
|--|--|
| Have you ever planned to kill anyone else?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you currently planning to kill someone else?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <i>If yes please answer the below questions:</i>   |  |
| How likely are you to act on these thoughts:   |  |
| If yes to any current thoughts – describe plan for immediate assessment and safety plan: |  |
| Clinician's findings and conclusions in this functional area:                            |  |
| Patient's identified needs in this functional area and level of motivation:              |  |

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|   |  |                 |
|---|--|-----------------|
| <b>IV. Vocational/educational/employment Assessment:</b>  |  |                 |
| <b>Literacy Assessment: (based on Lisa Chow's 3 question assessment to determine health literacy, Family Medicine, 2004 Sep: 36(8):(588-94)</b>   |  |                 |
| On a scale of 1 to 5 with 1 being "never" and 5 being "always," how often do you have someone help you read important material or documents?  |  |                 |
| On a scale of 1 to 5 with 1 being "not at all" and 5 being "extremely," how confident are you filling out important forms yourself?   |  |                 |
| On a scale of 1 to 5 with 1 being "never" and 5 being "always," how often do you have problems learning about important information because of difficulty understanding written material? |  |                 |
| Assessment evaluation and recommendations:  |  |                 |
|   |  |                 |
| <b>Education History: (check all that apply)</b>  |  |                 |
| <input type="checkbox"/> High School Diploma; or <input type="checkbox"/> Highest Grade Completed   |  |                 |
| Name of High School:  |  |                 |
| Last year attended:   |  |                 |
| <input type="checkbox"/> GED  | Year completed:  |                 |
| <input type="checkbox"/> College  | <input type="checkbox"/> Highest Level or # of years Completed |                 |
| Degree  | Major  | Year Graduated  |
|   |  |                 |
|   |  |                 |
|   |  |                 |
| <input type="checkbox"/> Vocational School  | Subject:   | Year Completed: |
| <input type="checkbox"/> Other  |  |                 |
| <input type="checkbox"/> No formal education  |  |                 |
| What part of your educational experience made you feel good or proud?   |  |                 |
|   |  |                 |
| What did you struggle with in school?   |  |                 |
|   |  |                 |

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**Employment History:** *please list history for the past two years below*

| Dates | Employer | Position | Reason for Leaving |
|-------|----------|----------|--------------------|
|       |          |          |                    |
|       |          |          |                    |
|       |          |          |                    |
|       |          |          |                    |
|       |          |          |                    |
|       |          |          |                    |

Are you currently on disability?       Yes     No    If yes please answer the questions below:

Date approved: \_\_\_\_\_ Nature of disability: \_\_\_\_\_

What characteristics do you have that make you a good employee?

What difficulties have you had in a work environment?

How has your drug or alcohol use affected your employment?

At some point would you be interested in furthering your education or vocational opportunities?       Yes     No

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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|   |  |
|---|--|
| <b>V. Social/Leisure Assessment:</b>  |  |
| <b>Assessment of Adult Daily Living Skills (ADLS): On a scale of 1 to 10 with 1 being “<u>very difficult</u>” and 10 being “<u>very easy</u>” rate how well you complete the following tasks:</b> |  |
| How well are you able to cook for yourself and/or your family?  |  |
| Are you able to pay your bills on time?   |  |
| How difficult is it for you to balance your checkbook?  |  |
| How difficult is it for you to keep your living space clean?  |  |
| How difficult is it for you to get transportation?  |  |
| Are you able to take your medication(s) as prescribed?  |  |
| Are you able to use a washing machine and dryer?  |  |
| How difficult is it for you to take care of your personal hygiene (shower, deodorant, brush teeth)?   |  |
| Based on the above assessment please identify any areas where the patient would like to improve or learn new skills:  |  |
|   |  |
| <b>Social/Leisure Activities:</b>   |  |
| What do you do for fun or relaxation?   |  |
|   |  |
| Which of these activities have involved drugs or alcohol?   |  |
|   |  |
| Who do you go to when you need to talk things through?  |  |
|   |  |
| What would you say are your strengths as a person?  |  |
|   |  |
| What would you say are your weaknesses as a person?   |  |
|   |  |

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| <b>Community Recovery Support and Services:</b>   |                      |           |                          |                         |           |
|---|----------------------|-----------|--------------------------|-------------------------|-----------|
| <b>Please indicate which of the following meetings and/or services in which the patient has participated:</b> |                      |           |                          |                         |           |
| √   | Service              | Frequency | √                        | Service                 | Frequency |
| <input type="checkbox"/>  | Alcoholics Anonymous |           | <input type="checkbox"/> | Cocaine anonymous       |           |
| <input type="checkbox"/>  | Smart Recovery       |           | <input type="checkbox"/> | Narcotics Anonymous     |           |
| <input type="checkbox"/>  | Rational Recovery    |           | <input type="checkbox"/> | Gamblers Anonymous      |           |
| <input type="checkbox"/>  | S.O.S.               |           | <input type="checkbox"/> | Sex/Love Addicts (SLAA) |           |
| <input type="checkbox"/>  | Nar-Anon             |           | <input type="checkbox"/> | Al-anon                 |           |
| <input type="checkbox"/>  | CODA                 |           | <input type="checkbox"/> | Families Anonymous      |           |
| <input type="checkbox"/>  | Other                |           | <input type="checkbox"/> | Other                   |           |
| Of the services that you checked above which ones have you attended in the last 30 days?                      |                      |           |                          |                         |           |
| If you have stopped attending, what lead you to this decision?  |                      |           |                          |                         |           |
| Would you be open to returning?   |                      |           |                          |                         |           |
| Clinician's findings and conclusions in this functional area:   |                      |           |                          |                         |           |
| Patient's identified needs in this functional area and level of motivation:                                   |                      |           |                          |                         |           |



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**VI. Family Assessment:**

**Family of Origin: ( please fill in the following information)**

Describe growing up in your family:

How did your family solve problems?

How would describe your relationship with your parents? Siblings? Extended family?

What are your best and worst memories of growing up?

**Current Family Structure: ( please fill in the following information)**

| Name | Relationship | Age | Addicted? | Recovery Status |
|------|--------------|-----|-----------|-----------------|
|      |              |     |           |                 |
|      |              |     |           |                 |
|      |              |     |           |                 |
|      |              |     |           |                 |
|      |              |     |           |                 |
|      |              |     |           |                 |
|      |              |     |           |                 |
|      |              |     |           |                 |

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|  |   |
|--|---|
| <b>VI. Family Assessment (con't):</b>  |   |
| How would you describe the relationship with your partner/spouse/significant other?  |   |
| Have you ever hit, pushed, kicked or otherwise struck out at a partner in a relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been hit, pushed, kicked or otherwise struck in a relationship with a partner? <input type="checkbox"/> Yes <input type="checkbox"/> No   | Currently? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What role does/did alcohol and/or drugs play in your relationship with your partner/spouse/significant other?                                      |   |
| How would you describe the relationship with your children?  |   |
| What do you do well as a parent?   |   |
| What do you struggle with as a parent?   |   |
| Please describe any involvement you had with Child Protective Services:  |   |
| Would anyone in your family be interested in participating in your treatment?  | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Would you be interested in improving your parenting skills?  | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Clinician's findings and conclusions in this functional area:  |   |
| Patient's identified needs in this functional area and level of motivation:  |   |

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**VII. Legal Assessment:**

**Legal History: (please fill in the information below)**

| Date | Offense | Disposition | AOD Involved?                |                             |
|------|---------|-------------|------------------------------|-----------------------------|
|      |         |             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|      |         |             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|      |         |             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|      |         |             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|      |         |             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|      |         |             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you currently involved with:

|   |  |   |                               |
|---|--|---|-------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Parole | <input type="checkbox"/> Yes <input type="checkbox"/> No Probation | <input type="checkbox"/> Yes <input type="checkbox"/> No PINS | <input type="checkbox"/> None |
|---|--|---|-------------------------------|

|                 |         |
|-----------------|---------|
| Contact Person: | Phone # |
|-----------------|---------|

|          |        |        |      |
|----------|--------|--------|------|
| Address: | County | State: | Zip: |
|----------|--------|--------|------|

Signed Criminal Justice Consent for Release?  Yes  No

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

**VIII. Problem Gambling Assessment:**

If the patient answered yes to either of the two Lie-bet questions from the Admissions Assessment then a South Oaks Gambling Screen should be given to determine the need for further Problem Gambling Treatment Services.

**Results of SOGS:**

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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|   |                   |         |
|---|-------------------|---------|
| <b>IX. Ancillary Information:</b>   |                   |         |
| <b>Military Service:</b>  |                   |         |
| Did you, or a family member serve in the Military? <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates of Service: | Branch: |
| Where do/did you/they serve?  |                   |         |
| What do/did you/they do while in the service?   |                   |         |
| How has your <u>or someone else's</u> Military Service affected your life?                                  |                   |         |
| Are there areas of your Military experience that you would like to discuss further?                         |                   |         |
| Clinician's findings and conclusions in this functional area:   |                   |         |
| Patient's identified needs in this functional area and level of motivation:                                 |                   |         |
| <b>Spirituality/Religion:</b>   |                   |         |
| How would you describe your Spiritual and/or Religious beliefs?   |                   |         |
| In what way(s) is Spirituality and/or Religion important to you in your life?                               |                   |         |
| How do you see your beliefs helping you in your recovery from alcohol and/or substance abuse?               |                   |         |
| Is Spirituality an area that you would like to work on during your treatment?                               |                   |         |
| Clinician's findings and conclusions in this functional area;   |                   |         |
| Patient's indentified needs in this functional area and level of motivation:                                |                   |         |

## PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES COMPREHENSIVE PSYCHOSOCIAL EVALUATION

| <b>Traumatic Brain Injury (TBI) assessment: HELPS TBI Screening Tool</b>   |   |  |
|--|---|--|
| <p>Based on TBI screening tool was developed by M. Picard, D. Scarisbrick, R. Paluck, 9/91, International Center for the Disabled, TBI-NET, U.S.Department of Education, Rehabilitation Services Administration, Grant #H128A00022. The Helps Tool was updated by project personnel to reflect recent recommendations by the CDC on the diagnosis of TBI. See <a href="http://www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/diagnosis.htm">http://www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/diagnosis.htm</a>. This document was supported in part by Grant 6 H21 MC 00039-03-01 from the Department of Health and Human Services (DHHS) Health Resources and Services Administration, Maternal and Child Health Bureau to the Michigan Department</p> |   |  |
| <p><b>H</b> Have you ever <b>H</b>it your <b>H</b>ead or been <b>H</b>it on the Head? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>NOTE:</b> Prompt client/patient to think about all the incidents that may have occurred at any age, even those that did not seem serious: falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse; and also for service related injuries. TBI can also occur from violent shaking of the head, such as whiplash or being shaken as a baby or child.</p>   |   |  |
| <p><b>E</b> Were you ever seen in the <b>E</b>mergency room, hospital, or by a doctor because of an injury to your head? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>   |   |  |
| <p><b>L</b> Did you <b>L</b>ose consciousness or feel dazed or confused after experiencing any of the event(s) listed above? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>NOTE:</b> People with TBI may not lose consciousness but experience an “alteration of consciousness.” This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.</p>  |   |  |
| <p><b>P</b> Do you experience any of these <b>P</b>roblems in your daily live since you hit your head? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>   |   |  |
| <input type="checkbox"/> headaches   | <input type="checkbox"/> difficulty concentrating                 | <input type="checkbox"/> difficulty performing your job/school work            |
| <input type="checkbox"/> dizziness   | <input type="checkbox"/> difficulty remembering                   | <input type="checkbox"/> change in relationships with others                   |
| <input type="checkbox"/> anxiety   | <input type="checkbox"/> difficulty reading, writing, calculating | <input type="checkbox"/> poor judgment (being fired from job, arrests, fights) |
| <input type="checkbox"/> depression  | <input type="checkbox"/> poor problem solving                     |  |
| <p><b>NOTE:</b> Ask your client if s/he experiences any of the following problems, and ask when the problem presented. You are looking for a combination of two or more problems that were not present prior to the injury.</p>  |   |  |
| <p><b>S</b> Any significant <b>S</b>icknesses? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>NOTE:</b> Traumatic brain injury implies a physical blow to the head, but acquired brain injury may also be caused by medical conditions, such as: brain tumor, meningitis, West Nile virus, stroke, seizures. Also screen for instances of oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.</p>   |   |  |
| <p><b>Scoring the HELPS Screening Tool</b></p>   |   |  |
| <p>A HELPS screening is considered positive for a possible TBI when the following 3 items are identified:</p> <ol style="list-style-type: none"> <li>1.) An event that could have caused a brain injury (yes to H, E or S), <b>and</b></li> <li>2.) A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to L or E), <b>and</b></li> <li>3.) The presence of two or more chronic problems listed under P that were not present before the injury.</li> </ol> <p><b>NOTE:</b><br/>A positive screening is <b>not sufficient to diagnose TBI</b> as the reason for current symptoms and difficulties - other possible causes may need to be ruled out.</p>                                      |   |  |
| <p><b>Some individuals could present exceptions</b> to the screening results, such as people who do have TBI-related problems but answered “no” to some questions</p>  |   |  |
| <p>Consider positive responses within the context of the person’s self-report and documentation of altered behavioral and/or cognitive functioning</p>   |   |  |
| <p>Clinician’s findings and conclusions in this functional area;</p>   |   |  |

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**OTHER EMERGENT AREAS OF NEED:**

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

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**DSM-IV DIAGNOSIS**

**Based on information gathered in the above assessments please complete the following: (For both Abuse and Dependence diagnosis a maladaptive pattern of substance use, leading to clinically significant impairment or distress must be present)**

| <b>Dependence Criteria</b>  | <b>Primary Substance</b>     |                             | <b>Secondary Substance</b>   |                             | <b>Tertiary Substance</b>    |                             |
|---|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| <i>Please indicate the appropriate substance and ✓the corresponding criteria: (as manifested by three or more of the following occurring at any time in the same 12-month period)</i> |                              |                             |                              |                             |                              |                             |
| <b>Increased tolerance</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Withdrawal</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Use more or longer than intended</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Desire to control or unsuccessful efforts to control use</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Pre-occupation with acquiring the drug(s)</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Lifestyle change due to use</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Continued use despite consequences</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Abuse Criteria</b>   | <b>Primary Substance</b>     |                             | <b>Secondary Substance</b>   |                             | <b>Tertiary Substance</b>    |                             |
| <i>Please indicate the appropriate substance and ✓the corresponding criteria: (one or more criteria must have happened within the last 12 months)</i>                                 |                              |                             |                              |                             |                              |                             |
| <b>Recurrent failure to meet major role obligations</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Recurrent use Interferes with safety</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Recurrent substance Related Legal Problems</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Continued substance use despite persistent or recurrent social or interpersonal problems  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Please indicate specific diagnosis of alcohol related or psychoactive substance related disorder in accordance with the current version of the DSM:**

**AXIS I:**

|   |  |   |
|---|--|---|
| <b>PREPARED BY (IF OTHER THAN QHP):</b>           | <b>SIGNATURE:</b>  | <b>DATE (WITHIN 45 DAYS OF ADMISSION)</b> |
| <b>RESPONSIBLE Qualified Health Professional:</b> | <b>SIGNATURE: (Medical assessment/physical exam requirements must be met prior to QHP signature)</b> | <b>DATE (WITHIN 45 DAYS OF ADMISSION)</b> |
| <b>OTHERS PARTICIPANTS IN EVALUATION:</b>         | <b>SIGNATURE:</b>  | <b>DATE (WITHIN 45 DAYS OF ADMISSION)</b> |
| <b>OTHERS PARTICIPANTS IN EVALUATION:</b>         | <b>SIGNATURE:</b>  | <b>DATE (WITHIN 45 DAYS OF ADMISSION)</b> |
| <b>OTHERS PARTICIPANTS IN EVALUATION:</b>         | <b>SIGNATURE:</b>  | <b>DATE (WITHIN 45 DAYS OF ADMISSION)</b> |