2705

2705 Assessment

PROVIDENCE Health & Services

PARTNERSHIP FOR CHANGE
A Substance Use Treatment Program
At
Providence St Vincent Medical Center

_____
Last name, First Name

_____
Date of birth

BEHAVIORAL HEALTH/CDS ASSESSMENT PART 'A' PERSONAL HISTORY

ADMISSION DATA

Did you require emergency care prior to your arrival here? ☐ yes ☐ no

Emergency Contact

Name: _____

Relationship_____

Address: _____

_____

Phone: H)_____W)_____

Medical Providers: **Name and Phone number**

Primary care: _____

Psychiatrist:_____

Therapist: _____

Other: _____

Emergency Hospital Preference:_____

Emergency Dental Preference:_____

Allergies? ☐ yes ☐ no
(Food, medication, dust, pollen, etc)

Allergies	**Reactions**
_____	_____
_____	_____
_____	_____

☐ Latex ☐ Tape ☐ Iodine

Medications ☐ None
Including over-the-counter, herbals, psychotropics

Medication	Dose	Frequency

History of illness, surgeries, procedures, hospitalizations (including psychiatric), childbirth

When	Where	Why

MEDICAL and SURGICAL HISTORY

Do you have or have you ever had:

Circle those below that apply & write in others:

☐ YES ☐ NO **Eye, ear, nose, throat problems:**
(glaucoma; lens implants, dentures, loose teeth, dental caps or bridges; wear hearing aides, glasses, contacts or artificial eye)

☐ YES ☐ NO **Heart problems:**
(chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pacemaker, defibrillator)

☐ YES ☐ NO **Vascular problems:**
(high blood pressure, blood clots)

☐ YES ☐ NO **Lung problems:**
(asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)

☐ YES ☐ NO **Gastrointestinal problems:**
(hepatitis, cirrhosis, ulcers, hiatal hernia, intestinal bleeding, vomiting/diarrhea/constipation +24 hrs, heartburn)

☐ YES ☐ NO **Genitourinary problems:**
(OB/GYN, kidney disease/failure, prostate problems, incontinence, stress incontinence, painful urination, STDs, infections)

Women: is there any possibility you could be pregnant?
☐ YES ☐ NO ☐ LMP_____ ☐ Birth control_____
Date of last pap smear? _____ Results? _____
Birthing related complications? _____

☐ YES ☐ NO **Musculoskeletal problems:**
(back problems, broken bones of neck/back/face, limited range of motion, arthritis, TMJ)

☐ YES ☐ NO **Skin Problems:**
(rash, hives, bruise easily, open sores)

☐ YES ☐ NO **Neurological Problems:**
(seizures, paralysis/numb areas, stroke, weakness, dizzy spells, fainting, migraines, confusion, previous head injury)

☐ YES ☐ NO **Psychological condition:**
(anxiety, depression, bipolar, dementia, Alzheimer's)

☐ YES ☐ NO **Endocrine problems:**
(diabetes, thyroid)

☐ YES ☐ NO **Anemia/Unusual Bleeding problems:**

Cancer: ☐ YES ☐ NO
Type: _____

Immunizations:

Pediatric	☐ up to date	☐ unknown
Tetanus	☐ up to date	☐ unknown
Pneumonia	☐ up to date	☐ unknown
Influenza	☐ up to date	☐ unknown

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B. SUBSTANCE USE

Substance	Age at first use	Use in the last 30 days.	Pattern of use (including changes in the pattern.	Date of last use	Amount at last use	Use has negative consequences on…
Alcohol Beer, wine, hard liquor	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Amphetamine Meth, crystal, uppers, crank	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Caffeine Coffee, soft drinks	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Cannabis Pot, marijuana, hash	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Cocaine Coke, crack	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Nicotine	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None

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Substance	Age at first use	Use in the last 30 days	Pattern of use(including changes in the pattern)	Date of last use	Amount at last use	Use has negative consequences on…
Miscellaneous ☐ Ecstacy ☐ PCP ☐ Inhalants (Gas, nitrous) ☐ Hallucinogens (LSD, mushrooms)	☐ Never ☐ Never ☐ Never ☐ Never	☐ None ☐ None ☐ None ☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Heroin	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Prescription opiates Pain pills (e.g). Vicodin, codeine, oxycodone, ocxycontin, Percoset	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None
Sedatives Valium, Xanax, Librium	☐ Never	☐ None				☐ Health ☐ Finances ☐ Relationships ☐ Parenting ☐ Work/career ☐ Legal ☐ None

C. FAMILY HISTORY

Do any blood relatives have any of the following? (Write relation in 'who' column – e.g. brother, father, mother, etc)

	Who?	Who?	Who?	Who?
Heart disease				
Cancer				
Stroke				
Substance abuse problem				
Mental illness				
Diabetes				

Describe any other significant health problems in family.

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D. PAIN	Are you currently having pain? ☐ No ☐ Yes Pain location_____ Is your pain chronic? ☐No ☐ Yes Rate your pain using 0-10 with **0=no pain & 10=worst pain**. Circle a number 0 1 2 3 4 5 6 7 8 9 10 Describe your pain_____ Worst pain caused by_____ What relieves your pain?_____
E. NUTRITION	Do you follow a special diet? ☐ No ☐ Yes describe_____ Do you have any difficulty eating or chewing? ☐ No ☐ Yes describe_____ Unintentional weight loss of greater than 15 lbs. in the last 3 months? ☐ No ☐ Yes amount_____ Are you satisfied with your current weight? ☐ No ☐ Yes Do you feel you have a nutritional problem that prevents you from regaining your health? ☐ No ☐ Yes Describe_____ Have you ever made yourself vomit, used laxatives (purged) after eating? ☐ No ☐ Yes Have you ever been diagnosed with an eating disorder? ☐ No ☐ Yes
F. SLEEP	What hours do you normally sleep?_____ Do you nap during the day? ☐ No ☐ Yes Amount: _____ Do you have pre-bedtime rituals or use anything to help you sleep? ☐ No ☐ Yes If so, what are they?_____ Have you had any recent changes in your sleep patterns? ☐ No ☐ Yes If so, describe_____
G. SAFETY	Do you have concerns about your personal safety? ☐ No ☐ Yes Explain _____ Are you here today due to injury or illness related to partner violence? ☐ No ☐ Yes Have you ever been hit, kicked, punched or otherwise hurt by someone? ☐ No ☐ Yes Have you ever been forced to have sex? ☐ No ☐ Yes Do you feel unsafe in your current relationship? ☐ No ☐ Yes Is there a partner from a previous relationship that is making you feel unsafe now? ☐ No ☐ Yes Are you overly anxious/fearful? ☐ No ☐ Yes
H. SUPPORT	Would your family or support persons like more information regarding your treatment? ☐ Yes ☐ No Would you like your family or support persons involved in developing the plan for services here? ☐ Yes ☐ No If yes, whom_____ Would your family or support persons like information re: what to do in an emergency? ☐ Yes ☐ No Would you like information about support groups for you and your family? ☐ Yes ☐ No

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H. SUPPORT

Are you concerned about paying for food, medicine, transportation, etc? ☐ No ☐ Yes

Explain _____

Have you had any personal losses that may impact your care? ☐ No ☐ Yes

Are you able to contact emergency services when you need them? ☐ No ☐ Yes

Do you feel you have enough support from family, friends, church, etc? ☐ Yes ☐ No Describe _____

Are there spiritual practices you want us to know about? ☐ No ☐ Yes Describe_____

Are there cultural practices you want us to know about? ☐ No ☐ Yes Describe_____

I. INFECTIOUS DISEASE

Have you had HIV testing? ☐ No ☐ Yes When? _____ Why?_____ Results? _____

Are you sexually active? ☐ No ☐ Yes Do you use condoms? ☐ No ☐ Yes

Have you had a sexually transmitted disease? ☐ No ☐ Yes
☐ venereal warts ☐ herpes ☐ gonorrhea
☐ syphilis ☐ Chlamydia ☐ yeast
☐ other _____

Do you live or have you lived on the street or in a shelter? ☐ Yes ☐ No

In the past three years, have you travelled outside of the US? ☐ No ☐ Yes
(Except Canada, Australia, New Zealand, Japan, Western Europe, Great Britain)

In the past 12 months have you had a tattoo, ear/body piercing, ☐ No ☐ Yes
acupuncture or come into contact with someone else's blood?

Did you receive a blood transfusion before 1992? ☐ No ☐ Yes ☐ Don't know

Have you had sex with more than one person in the past six months? ☐ No ☐ Yes
(Any type of vaginal, rectal or oral contact without protection)

Have you ever injected drugs? ☐ No ☐ Yes Have you ever shared needles? ☐ No ☐ Yes

Have you ever been tested for Hepatitis C virus? ? ☐ No ☐ Yes When? _____ Results? _____

J. FUNCTIONING

1. **Mobility:**
   a.) A recent fall to the ground? ☐ No ☐ Yes_____
   b.) Need assistance with walking? ☐ No ☐ Yes_____
   c.) Difficulty going up/down stairs? ☐ No ☐ Yes_____
   d.) Difficulty getting in and out of a chair? ☐ No ☐ Yes_____
2. **Activities of daily living:**
   a.) Do you need assistance with personal hygiene, dressing, or cooking? ☐ No ☐ Yes
   Is so, describe_____
3. **Cognitive Function:**
   a.) Do you have any difficulty speaking, writing, reading, following directions or remembering things?
   ☐ No ☐ Yes Describe_____
   b.) Are familiar activities sometimes difficult to complete? ☐ No ☐ Yes_____
   c.) Do familiar places sometimes seem unfamiliar? ☐ No ☐ Yes_____
   d.) Have you experienced recent, frequent mood swings that surprise you? ☐ No ☐ Yes
4. **Medications:**
   a.) Are you able to take your medications without the help of others? ☐ No ☐ Yes
5. **Residence:** ☐ Home alone ☐ Home with others: who?_____
   ☐ No permanent residence ☐ Community facility & contact:_____

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K. LEARNING

Do you have concerns that may affect your learning or ability to participate in treatment? ☐ None

☐ Difficulty reading ☐ Memory Loss ☐ Difficulty hearing Interpreter needed? ☐ Yes ☐ No

☐ Non-English speaking ☐ English as a second language Interpreter needed? ☐ Yes ☐ No

☐ Learning disability Type: _____ ☐ Other _____

Do you learn better by? ☐ Reading ☐ Listening ☐ Watching ☐ Doing

Is there any health information you need? ☐ No ☐ Yes (Specify below)

☐ Advanced Directives ☐ Current Illness ☐ Diet ☐ Medication
☐ Exercise ☐ Stop Smoking Program ☐ Other_____

L. MISC/CPMS

Ethnicity:

☐ White/Non-Hispanic ☐ Black/Non-Hispanic ☐ Native American
☐ Alaskan Native ☐ Asian ☐ Southeast Asian
☐ Asian/Pacific Islander ☐ Hispanic/Mexican ☐ Hispanic/Puerto Rican
☐ Hispanic/Cuban ☐ Hispanic/Other ☐ Other race

Are you a US citizen? ☐ Yes ☐ No Religious preference _____

Marital status:

☐ Never married ☐ Married ☐ Living as married
☐ Separated ☐ Divorced ☐ Widowed

Have you served in the military? ☐ No ☐ Yes Branch _____
Current status: ☐ Active ☐ Reserves ☐ Discharged

M. TODAY'S GOALS

Who referred you here today?

What do you want from today's meeting?

Do you have urgent medical concerns? ☐ No ☐ Yes

Explain _____

Do you have urgent mental health concerns? ☐ No ☐ Yes

Explain _____

Do you have urgent environmental (living, work, social) concerns? ☐ No ☐ Yes

Explain _____

Do you have current or pending involvement with the legal system/DHS? ☐ No ☐ Yes

Explain _____

FORM COMPLETED BY:

☐ Patient _____ Date/Time: _____
Signature

☐ Family _____ Date/Time: _____ Relationship: _____
Signature

MD review _____ Date/Time: _____

Staff Reviewer: _____ **Date/Time:** _____