Kanawha Valley Fellowship Home

Client Assessment Form

Date:_____ Time:_____ Assessment Taken _____

Caller's Name:_____ Agency (if applicable)_____

Address:_____ County:_____

Relationship to Patient:_____Phone #_____

Client's Name:_____Age:_____ D.O.B.:_____

Current Residence (if other than above):_____
phone #:_____

Sex: M F Marital Status: M S W D Sep. Employer:_____ Address:_____

SS#:_____

SOURCE OF AWARENESS – HOW DID YOU HEAR ABOUT US?

__Phone Book __Radio Word of mouth _____

__ Physician _____ Other_____

SUBSTANCE ABUSE HISTORY

1.) Information obtained from: __Client __Other

2.) Why do you want treatment now? (Why not? What is going on?) _____

_____

3. Are you currently using drugs__Yes __No Are you currently using alcohol__ Yes __ No

4. Substance History:

__**Alcohol** __daily __3-5x/wk __wkends 1-8x/month __less than 1x/month

Amount_____ Last Use_____ Drink(s) of Choice _____

__**Cocaine** __daily__3x5/wk __wkends __1-8x/month __ less than 1x/month

Amount_____ Last Use_____ Drink(s) of Choice _____

__**Heroin** __daily 3x5/wk __ wkends __ 1-8x/month __ less than 1x/month

Amount_____ Last Use_____ Drink(s) of Choice _____

__**Marijuana** __daily 3x5/wk __ wkends __ 1-8x/month __ less than 1x/month

Amount_____ Last Use_____ Drink(s) of Choice _____

Client's Name: _____

Other

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

☐ _____ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month

Amount _____ Last Use _____ Route _____

5.) What is your drug of choice:_____ Last Used: _____

6.) How many years have you been using alcohol? _____ Drugs? _____

7.) How long have you been using at this level?_____

8.) Have you ever tried to quit in the past? _____ How many times? _____

Longest time you quit _____

9.) In the last 6 months what is the longest period of time you have gone without drugs or alcohol? _____

10.) Previous inpatient treatment for drug/alcohol problems? ☐ Yes ☐ No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FO HOW LONG?

11.) Have you ever had prior outpatient treatment for drug/alcohol problems? ☐ Yes ☐ No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FO HOW LONG?

Client's Name: _____

12.) Have attended AA or NA or other support group? ☐ Yes ☐ No

MEDICAL HISTORY

1.) When you stop drinking or using have you experienced any of the following?

☐ tremors ☐ hallucinations audio/visual/tactile ☐ seizures ☐ agitation ☐ nausea/vomiting ☐ blackouts
☐ delirium tremens ☐ insomnia ☐ sweats ☐ irritability ☐ mood swings ☐ muscle aches
☐ other _____

2.) Have you ever been diagnosed with any of the following conditions?

☐ high blood pressure ☐ cirrhosis ☐ hepatitis ☐ liver disease ☐ diabetes ☐ tuberculosis ☐ headaches
☐ heart problems _____ ☐ coronary artery disease ☐ pancreatitis ☐ breathing problems
☐ difficulty walking ☐ GI bleeding ☐ renal failure ☐ inability to take oral meds
☐ other medical conditions

3.) Have you ever been hospitalized for any of these conditions? Which one? _____

4.) Do you have any disabilities, limitations or special needs? ☐ Yes ☐ No If yes explain them: _____

5.) Medical Doctor: _____ Ph# _____ Last Seen: _____

6.) What prescribed medicines are you currently taking? ☐ None

NAME	DOSE	FREQUENCY	LAST TAKEN	REASON FOR

7.) Are you allergic to any medications? _____

Foods? _____ Other? _____

PSYCHIATRIC HISTORY

1.) Have you ever seen a psychiatrist or currently under the care of on now? ☐ Yes ☐ No

If yes, please identify the name and date of the psychiatrist: _____

2.) Have you ever been treated or hospitalized for any psychiatric problems? ☐ Yes ☐ No

If yes, when, where, what for and for how long? _____

_____

Client's Name: _____

3.) Are you currently depressed? ☐Yes ☐No If yes, do you have any of the following symptoms:

☐Recent wt loss or gain (how much _____) ☐insomnia ☐sleeping all the time ☐fatigue ☐loss of energy ☐feelings of worthlessness ☐excessive guilt ☐diminished ability to think or concentrate

other symptoms described _____

4.) Are you currently suicidal? ☐Yes ☐No If yes, do you have a plan ☐Yes ☐No If yes, what is the plan? _____

5.) Have you ever had suicidal thoughts? ☐Yes ☐No If yes, what? _____

Any past attempts? ☐Yes ☐No If yes, when and how? _____

6.) Have you ever displayed violent behavior? ☐Yes ☐No If yes, describe _____

_____

7.) Any homicidal thoughts? ☐Yes ☐ No If yes, describe _____

_____

LEGAL INFORMATION

1.) Have you ever had any legal problems related to use of alcohol or drugs? (i.e., DUI, assault, burglary, theft)

☐Yes ☐No If yes, describe _____

2.) Any current legal charges pending? ☐Yes ☐No If yes, explain _____

_____

3.) Have you ever been charged or convicted of Domestic Violence or Assaults or violent behaviors? ☐Yes ☐No If yes, explain: _____

_____

4.) Are you currently on Probation or Parole? ☐Yes ☐ No Of yes, list conviction(s) ___

_____

5.) Any Scheduled hearing dates? _____

_____

OTHER

1.) What areas (other than remaining sober) would you like to work on while living here? __

_____

2.) Are you currently in a significant relationship? ☐Yes ☐No If yes, explain. _____

_____

3.) Do you have an children? ☐Yes ☐No Do you claim them on your Federal Tax Return? ☐Yes ☐ No

If yes, how many and what ages? _____

4.) Describe your family and your relationship with them: _____

_____

Client's Name: _____

5.) What is the highest grade you completed in school? _____

6.) How long would you like to live here if accepted _____

7.) Have you ever lived in or been interviewed for placement at another halfway house?

Yes _____ No_____

If yes, where and when? _____ ____

8.) If accepted after 2 weeks would you be willing to pay $100.00 required residency fee to stay here?

_____

OFFICE USE ONLY

Recommended for Residency ___ Yes ___ No Anticipated admission date _____

By _____

Staff Signature

Admission Date _____

Approved By _____

DOCUMENTED NEGATIVE COVID 19 TEST_____

COVID VACINATION RECORD_____