



ATLANTA INTERVENTION NETWORK

Alcohol and Drug Clinical Evaluation

CONFIDENTIALITY: The information you give below will be held in strict confidence and will be used for establishing your file. Any misrepresented or false information places you at risk of being re-evaluated (at your cost) or discharged.

Date Evaluation Started: ____ / ____ / ____

Date Evaluation Completed: ____ / ____ / ____

Full Name: _____ Age: ____ Date of Birth: ____ / ____ / ____
First Middle Last MM DD YY

Place of Birth: _____ Gender/Sex: Male Female Race/Ethnicity: _____

Current Address: _____
Current Street Address City State Zip Code

Day Telephone Number: (____) ____ - ____ e-mail address: _____

Driver's License Number: _____ Social Security Number: ____ - ____ - ____

Completed Risk Reduction/DUI School: Yes No

If completed, the date was: ____ / ____ / ____

Risk Reduction Number: _____ Risk Reduction Completion Date: ____ / ____ / ____
Certificate of Completion MM DD YY

NEEDS Summary Score: ____ Religious Preference: _____ Place of Worship: _____

I. MARITAL STATUS

Single Living with an intimate partner Married? ____ years ____ months # of marriages: ____ Separated? ____ years ____ months

Divorced (Date(s): 1st: ____ / ____ to ____ / ____, 2nd: ____ / ____ to ____ / ____, 3rd: ____ / ____ to ____ / ____ Widow/Widower (Dates): ____ / ____
MM YY MM YY MM YY MM YY MM YY MM YY MM YY

Children: No Children

1) Boy Girl Age: ____ 2) Boy Girl Age: ____ 3) Boy Girl Age: ____ 4) Boy Girl Age: ____

5) Boy Girl Age: ____ 6) Boy Girl Age: ____ 7) Boy Girl Age: ____ 8) Boy Girl Age: ____

Step-Children:

1) Boy Girl Age: ____ 2) Boy Girl Age: ____ 3) Boy Girl Age: ____ 4) Boy Girl Age: ____

II. FAMILY BACKGROUND

Are your parents living? Father: Yes No Mother: Yes No

What does/did your father do for a living? _____ If deceased, what did he die from? _____

What does/did your mother do for a living? _____ If deceased, what did she die from? _____

Did your parents divorce? No Yes If yes, your age when they divorced ____ Did you have step-parents? No Yes

Did someone other than your parents raise you? No Yes If yes, who? _____

How many brothers and sisters do you have? ____ / ____ How many step-brothers and sister do you have? ____ / ____
Brother(s) Sister(s) Brother(s) Sister(s)

III. EDUCATION

High School Graduate, year ____ Attending High School Did not finish High School GED, year ____ Seeking a GED

College: AA BA BS Major: _____

Graduate School: MA MS PhD Major: _____

Technical/Vocational school/ trade or professional certification(s): _____
(e.g., certified electrician, licensed contractor, certified accountant)

IV. EMPLOYMENT

Employment full-time Employment part time Self-employed Homemaker Retired Disabled Student

History of Employment:

Position	Employer/Organization	Dates (e.g., Jan10 – Dec10)		Reason for Leaving
			Present	

Currently Unemployed For How Long? _____ Unemployment, no assistance Unemployment, public assistance
Month(s)/Year(s)

Reason for unemployment: _____

If never employed, reason for unemployment: _____

V. MILITARY EXPERIENCE

Have you served in the military? Yes No

If yes, branch of service: Army Navy Air Force Marines Coast Guard National Guard _____ Reserves

Date of Service: From ____/____ To ____/____ Rank at Discharge: _____ Job/Specialty: _____
MM YY MM YY

Type of Discharge: Honorable General General Under Honorable Conditions Medical Medical Dishonorable

Did you have any problems related to alcohol and/or drug(s) use or mental illness while in the military? Yes No

If yes, explain: _____

VI. FINANCIAL

Are you paying child support? No Yes If yes, is it Court ordered? No Yes Monthly payment \$ _____ If in arrears, how much? \$ _____

Have you ever declared bankruptcy? No Yes If yes, when? ____/____
MM YY

VII. PHYSICAL AND EMOTIONAL CHECKLIST

How often have you experienced each of the following in the last two months?

	Never	Occasionally	Fairly often	Very often		Never	Occasionally	Fairly often	Very often
Insomnia (trouble going to sleep)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless sleep (no deep or satisfying sleep)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uncontrollable temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping too much (more than 8 hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss (without dieting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of inferiority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling isolated from others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings that things are unreal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling tense all the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling depressed a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Having trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
“Flashbacks” (sudden, vivid, distracting memories)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unable to enjoy anything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ARREST(s) HISTORY (other than DUI)

# of Arrest	Date of Arrest (Month/Year)	Charge(s)	County	Convicted	Dismissed	Expunged
1 st	____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 nd	____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 rd	____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 th	____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 th	____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any pending charge(s)?: No Yes

If yes, list them: _____

EVALUATOR'S NOTES (Go to the next section)

X. ALCOHOL AND DRUG HISTORY

Please answer the following questions on the basis of how you have drank alcohol or used drugs In the past 10 years. If you have not been drinking for a length of time, there will be a space to list that in. We need to know how you have drank alcohol or used drugs in the past

In the past, did:

- ... your father drink Heavily Moderately Lightly Never drank
- ... your mother drink Heavily Moderately Lightly Never drank
- ...any of your brothers or sisters Heavily Moderately Lightly Never drank
- ...any of aunts and uncles Heavily Moderately Lightly Never drank

If you drank, where did you do most of your drinking? home bars parties friend's house Other: _____

Have you ever tried to stop drinking or drugging? No Yes

If yes, how long did you go without drinking: _____ Why did you stop? _____

Have you ever had an alcoholic or drug use evaluation before? No Yes

If yes, when? _____ Where? _____ Why was the evaluation done? _____

Have you ever been in an alcohol and/or drug-related halfway house? No Yes

If yes, when? _____ Where? _____

Ever been told by a doctor to stop drinking? No Yes Has anyone ever suggested to you that you should stop drinking? No Yes

Do you typically drink alone? No Yes Do most of your friends drink? No Yes

Have you ever attended an Alcoholics Anonymous (or CA, NA) meeting? No Yes If yes, was it Court-ordered? No Yes

Does your partner or roommate drink? No Yes If yes, (check one) Heavily Moderately Lightly Never drank

Have you ever been threatened about losing your job due to alcohol related problems? No Yes

In a one month (30 days) period, how many days would you typically drink? _____ days

Each time you drink, how much would you typically drink? _____ When did you have your last drink? _____
(e.g., one beer, six pack, pint)

Do you have hangovers? No Yes If yes, how often? _____ Last hangover? _____

In your lifetime, have you ever used: Alcohol Marihuana Amphetamines Methamphetamine Cocaine Crack Cocaine
 Opioids Herion Benzodiazepines Barbiturates LSD Ecstasy MDMA Inhalants Sport Drugs Other _____

SUBSTANCE (e.g., Alcohol, Marihuana, Meth)	AGE OF FIRST USE	Quantity	Age of Last Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever abused prescription drugs? No Yes If yes, which ones? _____

Have you ever failed a drug screen (e.g., at work, on probation, on parole)? No Yes

Have you ever sold drugs for profit or for your own use? No Yes

Do you think you have a problem with alcohol or drugs? **No problem** – 0 1 2 3 4 5 6 7 8 9 10 – **Very serious problem**
 Circle your response

Worst level of problem you reached while drinking or using drugs? **No problem** – 0 1 2 3 4 5 6 7 8 9 10 – **Very serious problem**
 Circle your response

What is your present goal concerning drinking and/or drugs?

- Total abstinence (no drinking)
- Cutting back
- Drinking the same amount
- Not driving when drinking

Have you participated in substance abuse treatment since the last DUI? No Yes

If yes, the name of the treatment program and facility: _____

Dates of treatment: from ____/____/____ to ____/____/____

Reason for termination of treatment: Completed Referred to another level of care Referred to another agency Early discharge

Please explain, if discharged early or transferred: _____

XII. Michigan Alcohol Screening Test (MAST)

Place an X in one box that best describes your answer to each question.	Yes	No
1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)?		
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?		
3. Does any near relative or close friend ever worry or complain about your drinking?		
4. Can you stop drinking without difficulty after one or two drinks?		
5. Do you ever feel guilty about your drinking?		
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
7. Have you ever gotten into physical fights when drinking?		
8. Has drinking ever created problems between you and a near relative or close friend?		
9. Has any family member or close friend gone to anyone for help about your drinking?		
10. Have you ever lost friends because of your drinking?		
11. Have you ever gotten into trouble at work because of drinking?		
12. Have you ever lost a job because of drinking?		
13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14. Do you drink before noon fairly often?		
15. Have you ever been told you have liver trouble such as cirrhosis?		
16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?		
17. Have you ever gone to anyone for help about your drinking?		
18. Have you ever been hospitalized because of drinking?		
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?		
20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?		
21. Have you been arrested more than once for driving under the influence of alcohol?		

XI. The Alcohol Use Disorders Identification Test (AUDIT): Self-Report Version
 Developed by: World Health Organization, Department of Mental Health and Substance Dependence

Place an X in one box that best describes your answer to each question.

1. How often do you have a drink containing alcohol?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2-4 times a month	<input type="checkbox"/> 2-3 times a week	<input type="checkbox"/> 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="checkbox"/> 1 or 2	<input type="checkbox"/> 3 or 4	<input type="checkbox"/> 5 or 6	<input type="checkbox"/> 7 to 9	<input type="checkbox"/> 10 or more
3. How often do you have six or more drinks on one occasion?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
9. Have you or someone else been injured because of your drinking?	<input type="checkbox"/> No		<input type="checkbox"/> Yes, but not in the last year		<input type="checkbox"/> Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input type="checkbox"/> No		<input type="checkbox"/> Yes, but not in the last year		<input type="checkbox"/> Yes, during the last year

XIII. DRUG ABUSE Screening Test (DAST)

Place an X in one box that best describes your answer to each question.

	Yes	No
1. Have you ever used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs?		
3. Do you abuse more than one drug at a time?		
4. Can you get through the week without using drugs (other than those required for medical reasons)?		
5. Are you always able to stop using drugs when you want to?		
6. Do you abuse drugs on a continuous basis?		
7. Do you try to limit your drug use to certain situations?		
8. Have you had "blackouts" or "flashbacks" as a result of drug use?		
9. Do you ever feel bad about your drug abuse?		
10. Does your spouse (or parents) ever complain about your involvement with drugs?		
11. Do your friends or relatives know or suspect you abuse drugs?		
12. Has drug abuse ever created problems between you and your spouse?		
13. Has any family member ever sought help for problems related to your drug use?		
14. Have you ever lost friends because of your use of drugs?		
15. Have you ever neglected your family or missed work because of your use of drugs?		
16. Have you ever been in trouble at work because of drug abuse?		
17. Have you ever lost a job because of drug abuse?		
18. Have you gotten into fights when under the influence of drugs?		
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20. Have you ever been arrested for driving while under the influence of drugs?		
21. Have you engaged in illegal activities to obtain drugs?		
22. Have you ever been arrested for possession of illegal drugs?		
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?		
25. Have you ever gone to anyone for help for a drug problem?		
26. Have you ever been in hospital for medical problems related to your drug use?		
27. Have you ever been involved in a treatment program specifically related to drug use?		
28. Have you been treated as an outpatient for problems related to drug abuse?		

STOP!!! DO NOT CONTINUE. The Clinical Evaluator will fill out sections XIV, XV, and XVI. STOP!!! DO NOT CONTINUE.

XIV. Additional Testing Instruments Narrative

Test Results and Summary

Name of Instrument: **SALCE/NEEDS Assessment** Score: _____ ASAM Level Recommendation: _____

Impressions/Recommendations: _____

Name of Instrument: **Michigan Audit Screening Test (MAST)** Score: _____

Impressions/Recommendations: _____

Name of Instrument: **Alcohol Use Disorders Identification Test (AUDIT)** Score: _____

Impressions/Recommendations: _____

Name of Instrument: **Drug Abuse Screening Test (DAST)** Score: _____

Impressions/Recommendations: _____

XV. ASAM Dimensions

ASAS Dimension 1: Alcohol or Substance Use Intoxication / Withdrawal Potential

Current ASAM Severity rating:
 Low Moderate High

ASAS Dimension 2: Biomedical Conditions and Complications

Current ASAM Severity rating:
 Low Moderate High

ASAS Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complication

Current ASAM Severity rating:
 Low Moderate High

ASAS Dimension 4: Readiness to Change

Current ASAM Severity rating:
 Low Moderate High

ASAS Dimension 5: Relapse, Continued Use or Continued Problem Potential

Current ASAM Severity rating:
 Low Moderate High

ASAS Dimension 6: Recovery/Living Environment

Current ASAM Severity rating:
 Low Moderate High

XVI. Clinical Impression and Recommendation

Clinical impressions in an interpretive summary:

ASAM Level of Care Recommended:

- Level I
- Level II.1
- Level II.5
- Level III.1
- Level III.5
- Level III.7
- Level IV
- No further treatment recommended

XVI. Clinical Evaluator's Professional Affirmation

I affirm the included information and attachments are an accurate presentation of the clinical evaluation I have conducted on the identified offender on the stated date. I understand that the records can be requested for review by the Department of Behavioral Health and Developmental Disabilities (DBHDD).

Printed Names of Clinical Evaluator (First, MI, Last) _____ Date: ____ / ____ / ____
 Clinical Evaluator # _____ MM DD YY

Signature of Clinical Evaluator _____ Credentials _____

Address _____ City _____ State _____ Zip Code _____

Day Telephone Number: (____) ____ - ____ Fax Number: (____) ____ - ____