

DIFFERENTIAL INTAKE ASSESSMENT

Date _____

Name _____ DOB: _____ Age: _____ Sex: F / M

Phone: (Home/Cell) _____ (Work) _____ Email _____

Address _____

Person Responsible for Fee Payment: _____ Phone: _____

Emergency Contact: Name _____ Phone _____

Address _____ Relationship _____

Current Offense _____ Arresting County _____ Blood Alcohol Level _____

Attorney _____

Phone: _____ Fax: _____ Email: _____

Did this offense occur in Colorado? _____ If not what state _____

Is your case unsupervised? Yes ___ No ___ Person /Agency Supervising your case: _____

Phone: _____ Fax: _____ Address: _____

Number of Past DUI/DWAI Offenses? _____ Number of Alcohol/Drug Related Accidents? _____

Other past Arrests/Offenses and Dates: _____

Do you have an Interlock Ignition unit installed in your vehicle? _____

How many years of school did you complete? GED _____ High School _____ College _____

Vocational/Trade School _____ Occupation or Trade _____ How long? _____

Are you a student now? _____ What grade are you in? _____

Employer _____ How long? _____

Employer's Address _____

How many jobs have you had in the last ten years? _____ Are you satisfied with your work? _____

What are your career/job goals? _____

Monthly Gross Income _____ Partner Employed _____ Number of Dependents _____

Military Service? _____ What Branch? _____ How long? _____

Were you in combat? _____ Injuries? _____ Disabled? _____

Current Living Status: Alone _____ Roommates _____ With Friends _____ With Family _____

Own your home _____ Renting _____ How long have you lived in this area? _____

Marital status: Single _____ Live-in Partner _____ Married _____ Divorced _____ Separated _____ Widowed _____

How many marriages or live-in relationships have you had? _____ Dates: _____

Are you currently in a relationship? _____ If so, for how long? _____

What are the current issues or problems in your primary relationship? _____

Are you pregnant? _____ Are you aware of the risks of substance use during pregnancy? _____

Would you like more information regarding this? _____

How do you and your partner resolve conflicts? _____

How many children do you have? _____ How many are living with you? _____

Please list name, age and gender of each of your children. _____

How do you discipline your children? _____

Your mother's name: _____ Age _____ Alive? _____ Cause of death: _____

Please describe her (personality traits): _____

Your father's name: _____ Age _____ Alive? _____ Cause of death: _____

Please describe him (personality traits): _____

Are your parents divorced or separated? _____ If so, your age at the time they separated _____

Names and ages of brothers and/or sisters: _____

How would you describe your childhood? _____

How were you disciplined as a child? _____

Was anyone in your family a heavy drinker or substance abuser? _____ Who? _____

How did this affect the family? _____

What is your sexual orientation? Heterosexual _____ Bisexual _____ Gay _____ Lesbian _____

What do you do for relaxation/recreation? _____

What is your current stress level: Low _____ Moderate _____ High _____

What are the current stressors in your life? _____

What is your current physical condition? _____

Please list any long term or chronic problems: _____

Are you currently under a doctor's care? _____ For? _____

Are you taking any medications? _____ If so, which medications? _____

_____ For how long? _____

Please list any serious illness or injuries in the past ten years (including accidents): _____

How many of the following have you or your partner ever had: Abortions _____ Dates _____

Miscarriages _____ Dates _____ Pregnancies _____ Dates _____

Have you ever experienced, or do you have a family history of, any of the following conditions?

Chronic headaches: ___ Dizziness: ___ Seizures: ___ Ulcers: ___ High blood pressure: ___ Diabetes: ___

Low blood sugar: ___ Heart problems: ___ Liver problems: ___ Memory loss: ___ Head injury: ___

Thyroid problems: ___ Shakes (morning after): Other: _____

Are you now, or have you ever been, in the care of a psychiatrist, psychologist or therapist? _____

If so, when? _____

_____ Length of treatment: _____

Have you ever been hospitalized for mental health reasons? If so, when? _____

Where? _____ Length of stay: _____

Reason for treatment? _____

Have you ever been in an alcohol, drug and/or anger control program? _____ If so, when? _____

What type(s) of program did you attend? Alcohol _____ Drug _____ Anger Control _____

Where? _____ Type of program: Inpatient _____ Outpatient _____

Ever had: Recurring nightmares? _____ Temper outbursts? _____ Mood swings? _____ Hallucinations? _____

How often do you feel depressed? Rarely _____ Sometimes _____ Often _____ Usually _____

Have you ever seriously considered suicide? _____ Dates: _____

By what method? _____

How do you express anger or frustration? Discuss _____ Throw things _____ Break things _____ Hitting _____ Yelling _____

Leave _____ Withdraw _____ Silence _____ Other: _____

Was there any violence in your family when you were growing up? _____

Was this alcohol or drug related? Please describe _____

Have you ever-lost control or become violent when angry? _____ If so, please describe: _____

Have you ever been the victim of: Assault? _____ Incest? _____ Rape? _____ Other: _____

If so, please describe: _____

Please describe yourself. Include strengths you possess and the issues you would like to improve upon or change.

If you are sober now, please answer the following questions for the period of time when you WERE drinking.

At what age did you start drinking regularly? _____ At what age did you have your first drink? _____

How many times per week do you drink? _____ How many times per month? _____

During what period of your life have you drunk the most heavily? _____

Number of drinks you consume per occasion: Minimum # _____ Maximum # _____ Usual # _____

What time of day do you usually drink? _____ How often do you get drunk? _____

Do you more often drink alone or with others? _____

Does alcohol have a more energizing or soothing effect on you? _____

Have you ever forgotten what happened while you were drinking? _____ How often? _____

Have you ever stopped drinking completely? _____ Have you ever tried to cut down? _____

What kind of alcohol do you usually drink? _____ When did you have your last drink? _____

I drink more than I intend _____ Sometimes _____ Always _____ Never _____

I like to get drunk _____ Sometimes _____ Always _____ Never _____

My drinking is under control _____ Sometimes _____ Always _____ Never _____

How would you classify your drinking? Light _____ Moderate _____ Heavy _____ Alcoholic _____

What drugs have you experimented with or used? Name of Drug: _____ Dates of Use: _____

Do alcohol or drugs help you: Feel less anxious _____ Feel numb _____ Forget _____ Sleep _____

Meet people _____ Cope better _____ Relieve Stress _____ Express Feelings _____ Have Sex _____

Have alcohol or drugs caused problems with: Family ___ Work ___ School ___ Legal ___ Financial ___ Relationships ___

Social ___ Anger/Violence ___ Other _____

Has anyone ever expressed concern about your drinking or drug use? _____ Who? _____

Have you ever felt your drinking or drug use was out of control? _____ Do you feel it is now? _____

How much would you estimate you spend on alcohol and/or drugs per month? \$ _____

Have you ever-injected drugs intravenously? _____ Do you use clean needles? _____

Do you use precautions against AIDS/HIV? _____ Condoms? _____

Your Rights as a Client Notice of Federal Confidentiality Rights Informed Consent

1. You are entitled to receive information about the methods of therapy, techniques, duration of therapy, and fees.
2. You may seek a second opinion from another therapist or you may terminate therapy at any time.
3. In a professional relationship, sexual intimacy is not appropriate and should be reported to the State Grievance Board.

Confidentiality of patient/client records maintained by this agency is protected by federal law. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying the patient, EXCEPT UNDER THE FOLLOWING CONDITIONS:

- The client consents in writing or signs a release;
- The disclosure is allowed or mandated by a court order;
- The disclosure is made to medical personnel in an emergency, or qualified personnel for research, audit, or program supervision;
- The disclosure is made to authorities based on information that the client has or has threatened to commit a crime;
- A report is made to authorities involving suspected child abuse or neglect (42 U.S.C. 290dd-3 & 42 CFR part 2, Fed. Regs.);
- A client is incapacitated or in immediate danger to himself or others by reason of mental illness or substance abuse; and
- The program has a duty to warn prospective victims of crimes that may be threatened by clients' statements or behaviors.

Treatment programs within the Boulder Alcohol Education Center (BAEC) are bound by federal and local regulations and guidelines regarding confidentiality, standards for ethical behavior and treatment of clients. If a client believes that his/her rights under these standards and guidelines have been violated, a complaint may be made to the director of the BAEC, John Gilbert Ph.D. If the complaint cannot be resolved with the agency, a grievance may be filed with the Colorado State Grievance Board.

I have read and understood the above and have been advised of my rights of confidentiality and ethical treatment by the staff of the BAEC. I consent to such evaluation, treatment, and follow-up contact as I and the staff of BAEC agree on. I understand that some information may be disseminated to the State of Colorado Alcohol and Drug Abuse Division for research purposes.

Signature of Individual: _____

Date: _____

Counselor's signature and credentials

Date: _____

Boulder Alcohol Education Center, 1525 Spruce Street, Suite 100, Boulder, CO 80302 303-444-6142

Board of Addiction Counselor Examiners, 1560 Broadway, Ste. 1350, Denver, CO 80202 303-894-7800

CO Dept of Human Services, Division of Behavioral Health, 3824 W. Princeton Cir, Denver, CO 80236 303-866-7400

Would you like a copy of this form? Yes No