|  |  |  |
| --- | --- | --- |
| **Person Served Information** | | |
| Person Served Name: | | Avatar ID Number: |
| **Person Served Address:** | | **Person Served Phone #:** |
| **Date of Birth:** Enter DOB | **Race/Ethnicity:** Enter Race/Ethnicity | |
| **Preferred Name:** Enter Preferred Name | **Preferred Pronouns:** Choose pronouns | |
| **Gender assigned at birth:** Choose gender | **Gender Identity:** Choose gender | |
| **Preferred Language:** Enter Language | **Interpreter Utilized?** Choose answer | |
| **Referral Source:** Provide details as to how/why person served enteredprogram | | |

|  |  |  |
| --- | --- | --- |
| **Provider Information** | | |
| **Program Name:** Enter Program Name | **Counselor/LPHA Name:** Enter Counselor/LPHA Name | |
| **Date:** Enter Service Date | **Start Time:** Start Time | **End Time:** End Time |
| **Additional Dates and Times (if applicable):** Enter Information | | |
| **Total Time:** Total Minutes for Service including Documentation time | | |

|  |
| --- |
| **Substance Use History**  (Use the + sign to the bottom right of this box for additional sections to document the history of multiple substances) |
| **Choose a substance Specify when necessary:**  **Age of First Use:**       **Number of Years Used:**       **Route of Use:**       **Date of Last Use:**  **Pattern of Use for this Substance Including Frequency/Amount/Quantity within the past 12 months:**  **DSM-5 Diagnostic Criteria: Answers to the following questions must link specifically to the substance identified above and have occurred within the past twelve (12) months. Please include dates within the detailed explanation.**  **1.** Have you taken the substance often and in larger amounts or over a longer period than you wanted?  Yes  No; If yes, please explain:  **2.** Do you have an ongoing desire or unsuccessful efforts to cut down or control your substance use?  Yes  No; If yes, please explain:  **3.** Do you spend a lot of time in activities trying to get the substance, use the substance or recover from its effects?  Yes  No; If yes, please explain:  **4.** Have you experienced cravings, strong desires or urges to use the substance?  Yes  No; If yes, please explain:  **5.** Have you been unable to fulfill major responsibilities and obligations at work, school or home due to ongoing substance use?  Yes  No; If yes, please explain:  **6.** Do you continue to use the substance although it has caused ongoing social or interpersonal problems or made existing problems worse?  Yes  No; If yes, please explain:  **7.** Have you given up or reduced your participation in important social, occupational or recreational activities because of your substance use?  Yes  No; If yes, please explain:  **8.** Do you frequently find yourself using the substance in physically dangerous situations?  Yes  No; If yes, please explain:  **9.** Do you continue to use the substance even though it has caused physical or psychological problems or made existing problems worse?  Yes  No; If yes, please explain:  **10.** Have you experienced tolerance, by either a need for increased amounts of the substance to become intoxicated or desired effect or a reduced effect when using the same amount of the substance?  Yes  No; If yes, please explain:  **11.** Have you experienced withdrawal, by either typical withdrawal symptoms from the substance or taking the substance, (or a closely related substance) to relieve or avoid withdrawal symptoms? (*Not applicable to Hallucinogen or Inhalant-Related Use Disorders*)  Yes  No; If yes, please explain: |

|  |
| --- |
| **Withdrawal Diagnostic Criteria** |
| Use the following section for **Alcohol Withdrawal**:  Not Applicable  Has your alcohol use recently reduced from previous heavy and prolonged use?  Yes  No; Please explain:  Have you experienced two (2) or more of the following within several hours to a few days after reduction of use? (A*utonomic hyperactivity, e.g., sweating or pulse rate greater than 100 bpm;* *Increased hand tremor; Insomnia; Nausea or vomiting; Transient visual, tactile or auditory hallucinations or illusions; Psychomotor agitation; Anxiety; Generalized tonic-clonic seizures)?*  Yes  No; Please explain:  Have any of the above signs or symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning?  Yes  No; Please explain:  Could the above signs or symptoms be attributed to another medical condition or better explained by another mental disorder, including intoxication or withdrawals from another substance?  Yes  No; Please explain: |
| Use the following section for **Cannabis Withdrawal**:  Not Applicable  Has your cannabis use recently reduced from previous heavy and prolonged use, usually daily or almost daily for at least a few months?  Yes  No; Please explain:  Have you experienced three (3) or more of the following within several hours to a few days after reduction of use? (*Irritability, anger or aggression; Nervousness or anxiety; Sleep difficulty, e.g., insomnia, disturbing dreams; Decreased appetite or weight loss; Restlessness; Depressed mood; At least one (1) of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills or headache)?*  Yes  No; Please explain:  Have any of the above signs or symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning?  Yes  No; Please explain:  Could the above signs or symptoms be attributed to another medical condition or better explained by another mental disorder, including intoxication or withdrawals from another substance?  Yes  No; Please explain: |
| Use the following section for **Opioid Withdrawal**:  Not Applicable  Has your opioid use recently reduced from previous heavy and prolonged use, usually several weeks or longer or administration of an opioid antagonist after a period of opioid use?  Yes  No; Please explain:  Have you experienced three (3) or more of the following within minutes to several days after reduction of use or administration of an opioid antagonist? (*Dysphoric mood; Nausea or vomiting; Muscle aches; Lacrimation or rhinorrhea; Pupillary dilation, piloerection or sweating; Diarrhea; Yawning; Fever; Insomnia)?*  Yes  No; Please explain:  Have any of the above signs or symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning?  Yes  No; Please explain:  Could the above signs or symptoms be attributed to another medical condition or better explained by another mental disorder, including intoxication or withdrawals from another substance?  Yes  No; Please explain: |
| Use the following section for **Sedative, Hypnotic, or Anxiolytics Withdrawal**:  Not Applicable  Has your sedative, hypnotic or anxiolytic use recently reduced from previous prolonged use?  Yes  No; Please explain:  Have you experienced two (2) or more of the following within several hours to a few days after reduction of use? *Autonomic hyperactivity, e.g., sweating or pulse rate greater than 100 bpm; Hand tremor; Insomnia; Nausea or vomiting; Transient visual, tactile, or auditory hallucinations, or illusions; Psychomotor agitation; Anxiety; Grand mal seizures)?*  Yes  No; Please explain:        Have any of the above signs or symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning?  Yes  No; Please explain:  Could the above signs or symptoms be attributed to another medical condition or better explained by another mental disorder, including intoxication or withdrawals from another substance?  Yes  No; Please explain: |
| Use the following section for **Stimulant Withdrawal**:  Not Applicable  Has your stimulant use (amphetamine-type substance, cocaine or other stimulant use) recently reduced from previous prolonged use?  Yes  No; Please explain:  Have you experienced a dysphoric mood or two (2) or more of the following physiological changes, developing within a few hours to several days after reduction of use? (*Fatigue; Vivid, unpleasant dreams; Insomnia or hypersomnia; Increased appetite; Psychomotor retardation or agitation)?*  Yes  No; Please explain:  Have any of the above signs or symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning?  Yes  No; Please explain:  Could the above signs or symptoms be attributed to another medical condition or better explained by another mental disorder, including intoxication or withdrawals from another substance?  Yes  No; Please explain: |
| Use the following section for **Other (or Unknown) Substance Withdrawal**:  Not Applicable  Has your other (or unknown) substance use recently reduced from previous heavy and prolonged use?  Yes  No; Please explain:  Have you experienced a substance specific syndrome (symptoms that have occurred together) shortly after reduction of the substance use?  Yes  No; Please explain:  Has the substance specific syndrome (symptoms that occur together) caused clinically significant distress or impairment in social, occupational, or other important areas of functioning?  Yes  No; Please explain:  Could the above signs or symptoms be attributed to another medical condition or better explained by another mental disorder, including intoxication or withdrawals from another substance?  Yes  No; Please explain:  Can this other (or unknown) substance be classified under any of the other substance categories (alcohol; cannabis; opioids; sedatives, hypnotics, or anxiolytics; stimulants)?  Yes  No; Please explain: |

|  |  |  |
| --- | --- | --- |
| **Counselor/LPHA Name Printed, Title:** | **Counselor/LPHA Signature:** | **Date:** |
| **LPHA/Medical Director Name Printed, Title:** | **LPHA/Medical Director Signature:** | **Date:** |