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| **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 |

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| **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 |

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| **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:       |

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| **Withdrawal Diagnostic Criteria** |
| Use the following section for **Alcohol Withdrawal**: [ ]  Not ApplicableHas 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 ApplicableHas 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 ApplicableHas 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 ApplicableHas 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 ApplicableHas 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 ApplicableHas 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:       |

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