



Life Skills Learning Center

CLIENT INFORMATION

Name of Client (please print) _____

Address _____
City State Zip

D.O.B. _____ Birth Sex: M or F Marital Status _____
(circle one) (single, married, divorced, widowed)

Gender Identity: _____

Race: (circle most predominate) Hispanic or Latino, American Indian or Alaskan Native, Black or African American, Asian, Native Hawaiian or other Pacific Islander, White

Email Address: _____

Primary Language: _____

Employment: (where and what do you do) _____

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No
(Cell number may be used for Telehealth/Zoom so please write legibly)

Work Phone: _____ May we leave a message? Yes No

What is your religious affiliation? _____

What is your highest level of schooling? _____

Are you currently on probation/parole? Y ___ N ___

CONVICTION(S)	DATE ARREST OCCURRED	WAS PROBATION/ PAROLE SUCCESSFULLY COMPLETED	DATES INCARCERATED (IF APPLICABLE)

Who is your parole/probation officer: _____

Please describe the most recent legal issues you have had (even if you are not on probation): _____

Why are you here today? (circle all that apply)

Counseling with Licensed Clinician (length to be determined)

Assessment (one appt. with counselor for recommendations)

Anger Management Class (8 weeks to complete)

Domestic Violence Offender Treatment Intervention Class (52 weeks to complete)

Parenting Class (9 weeks to complete)

EMERGENCY CONTACT INFORMATION

Name _____ Phone # _____

Relationship to you _____

Choose # 1 or # 2

1. I give consent for LSLC to contact this person only in case of a *medical emergency* _____.
(initial)

OR

2. I give consent for LSLC to speak to this person about any information in regards to my care or services _____.
(initial)

The consent to contact this person is valid for one year or until I notify LSLC to revoke it _____.
(initial)

I acknowledge that the above information is correct and that my confidentiality is protected.

Client Signature

Date

Life Skills Staff

Date

Client revoked consent on: _____

LSLC Staff: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

+ +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
 Somewhat difficult _____
 Very difficult _____
 Extremely difficult _____



MENTAL HEALTH/BEHAVIORAL HEALTH CLIENTS
(All Answers Are Completely Confidential)

Would you like a text reminder for upcoming appointments? (only for cell numbers) Yes No

1. Please report your current emotional state: (circle)

Depressed Suicidal Angry Agitated Hopeless Stressed

Other _____

2. Have you had any previous suicide attempts? Yes No

The date(s) of the most recent attempt: _____

3. Do you have someone you can safely talk to about anything? Yes No

4. Do you smoke? Yes No

5. Do you drink alcohol? Yes No

6. Do you use illegal drugs? Yes No Which one(s)? _____

7. If you answered yes to **Question 4, 5 or 6** do you struggle with dependency/addiction?

Yes No

8. Are you currently enrolled in mental health services with a licensed counselor *at another*

agency? Yes No If so, who with? (Agency and/or Counselor's Name) _____

9. Please identify ALL medications (prescription or over-the-counter) you are currently taking:

MEDICATIONS	DOSAGE/TIMES DAILY	USED FOR

10. Have you ever suffered a head or brain injury?_____ If so, please provide a date that it occurred and the circumstances:_____
- _____
11. What are the thoughts, feelings or behaviors that have been troubling you?_____
- _____
12. Do you have any mental health/behavior health issues in your family?_____
- _____
13. Do you have any trouble carrying out daily living activities such as eating, dressing, shopping?_____
- _____

I understand if I miss three (3) appointments in a row or I am continually a *No-Show*, I may be discharged from care_____.
(initial)

If at any time my clinician determines I am aggressive, threatening or presenting a safety issue, he/she may terminate my services at will_____.
(initial)

Client or Guardian Signature

Date



CLIENT RIGHTS FOR SERVICES

As a client, you have the right to:

- Select a professional counselor who meets your needs.
- Receive specific information about your counselor's qualifications, including education, experience, national counseling certifications, and state licensure.
- Obtain a copy of the code(s) of ethics your counselor must follow.
- Receive a written explanation of services offered, time commitments, fee scales, and billing policies prior to receipt of services.
- Understand your counselor's areas of expertise and scope of practice (e.g., career development, adolescents, couples, etc.).
- Ask questions about confidentiality and its limits as specified in state laws and professional ethical codes.
- Receive information about emergency procedures (e.g., how to contact your counselor in the event of a crisis).
- Ask questions about counseling techniques and strategies, including potential risks and benefits.
- Establish goals and evaluate progress with your counselor.
- Request additional opinions from other mental health assessment professionals.
- Understand the implications of diagnosis and the intended use of psychological reports.
- Obtain copies of records and reports.
- Terminate the counseling relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's conduct with the appropriate professional counseling organization or licensure board.

CLIENT RESPONSIBILITIES

In order for your counselor to provide the highest quality of services, it is important that clients:

- Adhere to established schedules. If you must miss an appointment, contact LSLC as soon as possible.

- Pay your bill in accordance with the billing agreements.
- Follow agreed-upon goals and strategies established in sessions.
- Inform your professional counselor of your progress and challenges in meeting your goals.
- Participate fully in each session to help maximize a positive outcome.
- Inform your counselor if you are receiving mental health services from another professional.
- Consider appropriate referrals from your counselor.
- Avoid placing your counselor in ethical dilemmas, such as requesting to become involved in social interactions or to barter for services.

WHAT TO DO IF YOU ARE DISSATISFIED

Remember that a counselor who meets the needs of one person may not meet the needs of another. If you are dissatisfied with the services of your counselor:

- Express concerns directly to the counselor, if possible.
- Seek the advice of the counselor's supervisor if the counselor is practicing in a setting where he or she receives direct supervision.
- Terminate the counseling relationship if the situation remains unresolved. Notify the Program Manager or Executive Director of your issue.
- Contact the appropriate state licensing board, national certification organization, or professional association if you believe the counselor's conduct to be unethical.

Having been informed of my rights and responsibilities as a client, I hereby give my consent for services:

Client Signature or Guardian

Date

LSLC Staff

Date

****Please inform staff if you would like a copy of these rights and responsibilities. A written copy of the full *Privacy Notice to Patients* and *Grievance Policy* can be provided upon request.****



1200 N. Thornton St., Suite H Clovis, NM 88101
Ph. 575-935-4411/Fax 575-935-0400
RELEASE OF INFORMATION

Client Name (Print) _____ DOB _____

Address _____
Street City State Zip

I hereby authorize (Agency Name) _____

Attention (Name & Title) _____

Phone Number _____ Fax Number _____

To release the following information for the purpose of coordination of care & treatment planning:

- Intake Information
Discharge Summary or Certificate of Completion
Psychiatric/Psychological Evaluation
Treatment Plan(s)
Recommendation Letter
School Records (report cards, discipline, teacher observations, IEP)
Diagnosis, Functional status, Prognosis
Medical Records from _____ to _____
Legal Records (excludes attorney/client privilege)
Psychosocial Assessment
Domestic Violence/Anger Assessment
Placement History
Substance Abuse/Alcohol Assessment (protected under 42 CFR Part 2)
Chronological Offense Records
Probation/Parole Agreement
Court Orders
Consultation/Dialogue (phone, in-person, secure email, fax)
Referral Information/Service Plan
Fees/Balance Owed
Educational Tests/Evaluations
Attendance/Progress Reports
Other _____

*****MH/BH Psychotherapy Notes (actual notes excluded as defined in 45 CFR 164.501)

The information shall be released to (Agency Name) _____

Attention (Name & Title) _____

Phone Number _____ Fax Number _____

PROHIBITION ON REDISCLOSURE: Federal Law & State Regulations prohibit further disclosure of this information to any Persons or Agency without securing another proper written authorization for that purpose.

This is valid for one (1) year after the date of this signature or until either party terminates in writing. I expressly understand and agree that no legal responsibility or liability of any nature shall be to the respondent, the agency or its employees in acting upon this authorization and request.

Signature of Client _____

Date _____

Signature of Parent/Legal Guardian (if applicable) _____

Date _____

Signature of Life Skills Staff (Witness) _____

Date _____



Life Skills Learning Center phone: 575-935-4411 Fax: 575-935-0400

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Insurance companies require the client to complete the PCP Release form

To authorize release of information to physicians, other than my PCP, please complete a general release form: 'Consent for Release'

Name of Client (last, first, MI)

Client's Social Security Number

Client's Date of Birth

1. Please check one of the following:

- NO, I DO NOT give consent to release information to my Primary Care Physician (Please skip to section 3)
YES, I DO give consent to release information to my Primary Care Physician (PCP) named below (If you check yes the Counselor will communicate with the named physician and/or send treatment plan and/or progress notes of therapy as agreed upon by the client and Counselor.)

2. If you checked YES, please complete the following:

I hereby give my informed consent for Life Skills Learning Center to:

(check all that apply)

- Talk with Physician
Release written documentation regarding my treatment to

Primary Care Physician

Address

Phone () - Fax () -

3. Client Authorization: I understand

- This authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization.
My refusal to release records will not affect my ability to obtain treatment.
If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be re-disclosed.

Signature of Client (Or responsible Party if Client is a Minor)

Date

Printed Name (last, first, MI)

Relationship to Client

Witnessed by: LSLC staff

Date



FINANCIAL AGREEMENT
CONSENT FOR RELEASE OF PROTECTED HEALTH
INFORMATION
FILING INSURANCE

Client Name: _____

If I have insurance coverage with a Managed Care Organization that Life Skills Learning Center is *credentialed with*, I authorize LCLS to release personal health information (PHI) contained in my client record and to complete claims on my behalf.

The information authorized to be released shall include, but is not limited to, demographic information, behavioral health history, diagnosis or treatment, progress notes and/or information about drug or alcohol abuse. I waive any privilege pertaining to such confidential information. Life Skills Learning Center, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. This agreement will remain in effect while I am a client at LSLC.

I also understand (if applicable), I am responsible for any co-pays and/or deductibles. I will pay at the time services are rendered unless other arrangements have been made. If unpaid co-pays/deductibles become excessive, LSLC reserves the right to refuse service until such time payment is made. If I lose my insurance coverage or change carriers, I am responsible for notifying LSLC.

I understand I may request a copy of this agreement.

Insurance Co. _____ Member # _____

Client Signature or Guardian: _____ Date: _____

LSLC Staff: _____ Date: _____



FINANCIAL AGREEMENT

Assessment

Client Name: _____

The agreed upon fee is:

- > ___ Assessment - \$75.00 (Self-Pay)
(This fee is not billable to insurance). Please submit cash, money order or credit card. This is due at the time of appointment.
> ___ Assessment - \$75.00 (Curry County Grant)
(This fee is not billable to insurance).

Once I complete one of the required self-reporting assessments/screenings tools, I will be required to make an appointment and meet with a licensed clinician. The information I report during my intake is not complete UNTIL I meet with one of the clinicians. If the clinician recommends counseling services, I can submit my insurance information (if applicable) for future appointments.

I understand this agreement will expire one year from date of signature.

Client Signature or Guardian: _____ Date: _____

Client Printed Name: _____ Date: _____

LSLC Staff: _____ Date: _____



Telehealth Informed Consent Form

I (**print name**) _____ consent to engaging in telehealth with Life Skills Learning Center as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning and therapy. Telehealth will occur primarily through Interactive audio, video, telephone and/or audio/video communications.

I understand I have the following rights with respect to telehealth:

- 1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
- 2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
- 3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Life Skills Learning Center that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my counselor believes I would be better served by other interventions I will be referred to a mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my counselor, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of ZOOM video-conferencing is HIPPA compliant, but that may have issues with Wi-Fi connectivity. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my counselor, and all of my questions regarding the above matters have been answered to my approval.

6) I understand If I chose to utilize Life Skills Learning Center homebased telehealth services, continuation of this service is at the discretion of the counselor in that it is conducive to the delivery of value-added, quality, up to 60 minute sessions. Factors that influence the success and continued delivery of homebased telehealth services include, but are not limited to: level of distractions within my home, my internet connectivity (dependability/speed) and my equipment (charged phone, computer, microphone/ camera quality). I understand my counselor will determine if he/she believes I would be better served by accessing services through the main office, and will discuss this with me as deemed necessary.

I further understand that I must be PHYSICALLY PRESENT within the state of NEW MEXICO to engage in telehealth services with Life Skills Learning Center.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, I am in a life threatening or emergency situation, and/or I am abusing drugs or alcohol and am not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

Client Signature or Guardian

Date

LSLC Staff

Date

National Strategy for Suicide Prevention (NSSP)

"Embedding Suicide Screening in a Holistic, Recovery Oriented System of Care"

Suicidal? In Crisis? Need Help NOW?

- Call 9-1-1 or go to the local hospital Emergency Room
- National Lifeline: 1-800- SUICIDE (1-800-784-2433)
- The New Mexico Crisis and Access Line (NMCAL): 1-855-NMCRISIS (1-855-662-7474)
- Veteran's Crisis Line: 1-800-273-8255 (Press 1)
- LGBT Youth Suicide Hotline: 1-866-4-U-TREVOR
- Agora Crisis Center: 1-866-HELP-1-NM (505-277-3013)
- CrisisTEXT LINE: Text "GO" to 741-741

Other Important Numbers

- Statewide Child Abuse Hotline: 855-333-SAFE (7233) or #SAFE from a cell phone
- New Mexico Domestic Violence Hotline: 1-800-773-3645 (Statewide)
- New Mexico Poison Information Center: 1-800-432-6866
- Runaway/Suicide Adolescent Hotline (National Switchboard): 1-800-621-4000

"There are a thousand reasons to live this life, everyone of them sufficient"

- Marilynne Robinson

In collaboration with New Mexico Behavioral Health Services Division (NM BHSD) and funding by a grant from Substance Abuse and Mental Health Services Administration (SAMHSA)



Life Skills Learning Center

INFORMATION

CRISIS CARD

I (print name) _____, acknowledge I have received the *Crisis Card* with emergency numbers for after-hours care. If I require information about additional resources, they will be provided to me upon request.

Client Signature or Guardian

Date

NO-SHOW FEES AND CANCELATIONS

If I (print name) _____, cannot attend my scheduled appointment with Life Skills Learning Center and DO NOT call to reschedule or cancel at least 24 hours in advance, I understand LSLC has the right to charge me for a no-show fee.

The first missed appointment will be a warning and I will not be charged the fee. If I miss two appointments, I agree to pay the \$25.00 "no-show" fee. If I miss three appointments, I agree I will pay the required fees (\$50.00 total) BEFORE I can return for another appointment. If I fail to pay, I understand I could be dropped as a client.

This fee is my responsibility and my insurance will not be charged.

I am also not allowed to have excessive cancelations. The clinician's time is valuable and I cannot repeatedly cancel my appointments. I understand it is at my clinician's discretion what qualifies as "excessive" and I will be notified if I can continue to schedule or I will be dropped as a client.

If I am ordered to attend counseling, the referring agency or my probation officer will be notified of ALL no-shows and cancelations.

Client Signature or Guardian

Date

*LSLC takes cash, money orders and credit cards over the phone.

ADS

Instructions

The questions in this questionnaire are numbered. Match the number of the question with the number on your answer sheet. All questions should be answered on your answer sheet. Skipped or unanswered questions are scored negatively. Do not skip any questions.

This questionnaire measures truthfulness. Do not give false information. Your records may be checked to verify the information provided.

Drinking refers to beer, wine and other liquors. Drugs refer to both prescription and nonprescription (illegal) drugs.

When you understand these instructions – begin.

Section 1

Answer the following questions **True** or **False**. When a statement is true put an X under **T** for True. When a statement is false put an X under **F** for False on your answer sheet.

1. Sometimes I worry about what other people think or say about me.
2. I am concerned about my drinking.
3. I have been told I have a drug problem.
4. There are times when I am very unhappy.
5. I often drink more or use more drugs than I intended.
6. I have used nonprescription or illegal drugs more than I should.
7. It bothers me when I am overlooked or ignored by people I know.
8. My drinking is more than just a little or minor problem.
9. Smoking marijuana helps me settle down, relax and feel good.

10. There have been times when I have been jealous or resentful of others.
11. When I drink a lot my personality changes and I seem like a different person.
12. There are times when I am really depressed.
13. When offered drugs, I may or may not use them. It depends on how I feel at the time.
14. I was not caught for some of the things I have done that were wrong.
15. I have been told I have a drinking problem.
16. My use of drugs has threatened my happiness and success in life.
17. There are times when I am concerned that others may not approve of me.
18. Within the last five years, I have had two or more blackouts (memory losses) after drinking.
19. I have gone to Narcotics Anonymous (NA) or Cocaine Anonymous (CA) meetings because of my drug problem.
20. I spend a lot of time getting alcohol and/or drugs, using them and recovering from their effects.
21. There are times when I really worry about my responsibilities and happiness.
22. I am a recovering alcoholic. I have an alcohol-related problem, but do not drink anymore.
23. I have tried to cut down or stop using drugs, but I still use them.
24. I have been embarrassed or worried about mistakes I have made.
25. I have been in a chemical dependency treatment program for my drug problem.
26. There are times when I get very discouraged.
27. Last year, drinking was a problem for me.
28. I have lied to people about my use of drugs -- either minimizing how much I use, or hiding the fact that I use drugs at all.

29. I do not always tell the whole truth when asked about my money (finances) or personal life.
30. I am worried that I might have a drinking problem.
31. I have gone to someone for help about my drug related problem.
32. I have given up important social, occupational and/or recreational activities because of my alcohol and/or drug abuse.
33. There are times when I get frustrated and really angry.
34. My drinking is a serious problem.
35. I have used drugs like marijuana, crack, ice, cocaine, amphetamines, barbiturates or heroin within the last year.
36. My alcohol and/or drug use has resulted in absences from school and/or work, or poor work performance due to hangovers.
37. There have been times when I have had a job but did not want to go to work.
38. Within the last year, my family has been concerned about my drinking.
39. I have neglected my children or household duties and responsibilities because of my alcohol and/or drug use.
40. There have been times I have felt guilty about using drugs.
41. I have had to use more alcohol and/or drugs to get as high as I did in the past.
42. I have done things when angry or mad that I regret.
43. I have continued my alcohol and/or drug use despite recurrent arguments or fights with family members about my substance use.
44. There are times when I really worry about myself and my future.
45. I need help to overcome my drinking problem.
46. In the last year, using drugs has been a problem for me.
47. Within the last year, I have had intense desires or cravings for my substance (alcohol/drugs) of choice.
48. There have been times when I have been concerned about my sex life.
49. I have lied to people about my drinking--either minimizing how much I really drink, or hiding the fact that I drink at all.
50. I have a drug abuse or drug-related problem.
51. Sometimes I get angry and upset at myself.
52. I have asked for help with my drinking or alcohol-related problem.
53. I am in treatment for a drug problem.
54. There are times when I am concerned that others may think badly of me.
55. I have a drinking problem.
56. I continue to use drugs despite family arguments about my drug use.
57. I have been treated (counseling, outpatient or inpatient treatment) for a drinking problem.
58. I am a recovering drug abuser. I have not used drugs for at least a month, but I have a drug related problem.
59. There are times when I am really down, depressed and discouraged.
60. I have been told I am an alcoholic.
61. I get upset when others criticize me.
62. I have attended Alcoholics Anonymous (AA) meetings for help with my drinking.
63. I am dependent on drugs and may be addicted to them.
64. I continue to drink or use drugs even though I am aware of the harmful effects of repeated alcohol and/or drug use.
65. I use and sometimes abuse drugs.

Section 2

Rate yourself on the next series of statements. Put an **X** under the number (1, 2, 3 or 4) that applies to you **now**. Use the following rating scale.

- | | |
|------------------|-------------------------|
| 1. Rare or Never | 3. Often |
| 2. Sometimes | 4. Very Often or Always |

66. Exercise/Physical Activity
67. Positive Attitude/Outlook
68. Dissatisfied with Life
69. Good Sense of Humor/Laugh
70. Anxious/Worried/Fearful

71. Depressed/Discouraged
72. Insomnia/Trouble Sleeping
73. Satisfied with Self/Like Self
74. Financially Stable/Responsible
75. Enthusiastic/Involved in Life

76. Tension/Stress/Nervous
77. Fatigued/Tired/Sluggish
78. Directly Deal with Problems
79. Emotionally Upset/Crying
80. Angry/Hostile with Others

81. Lonely/Unhappy
82. Able to Handle Life's Problems
83. Nervous/Unable to Relax
84. Patient/Tolerant/Understanding
85. Can't Make Decisions/Indecisive

86. Work/Job Satisfaction
87. Admit My Errors/Mistakes
88. Bored/Restless/Uninterested
89. Accept Constructive Criticism
90. Trust My Own Judgment

91. Stomach Problems/Acidity
92. Difficulty with Others/Conflict
93. Adaptable/Adjustable
94. Marital/Family Problems
95. Self-Reliant/Independent

Section 3

Select the answer to each of the following statements that is accurate for you. Put an **X** under the number (1, 2, 3 or 4) that applies to you **now**.

96. My repeated alcohol and/or drug use has resulted in:
 1. Absences or poor performance at school or work
 2. My neglecting children and/or household duties and responsibilities
 3. Both 1 and 2
 4. None of the above

97. I have repeatedly used alcohol and/or drugs:
 1. In physically hazardous or dangerous situations like swimming, boating or skiing
 2. Before driving or operating machinery
 3. Both 1 and 2
 4. None of the above

98. My repeated alcohol and/or drug use has resulted in:
 1. Substance-related legal problems
 2. Alcohol and/or drug-related arrests
 3. Both 1 and 2
 4. None of the above

99. I have continued alcohol and/or drug use despite persistent or recurrent:
 1. Social and interpersonal problems
 2. Arguments or fights with my family about my substance use
 3. Both 1 and 2
 4. None of the above

100. I have:
 1. Had serious physical, social, emotional and/or mental problems due to my use of alcohol and/or drugs
 2. Continued to use alcohol and/or drugs even though I know they cause serious problems for me
 3. Both 1 and 2
 4. None of the above

101. Within the last year I have noticed:
 1. I use a lot more alcohol or drugs to get intoxicated or high
 2. I do not get intoxicated or high when I use the same amount of alcohol or drugs that I used in the past
 3. Both 1 and 2
 4. None of the above

102. I have had withdrawal symptoms like trouble sleeping, tremors, sweating, headaches, nausea or vomiting:
1. After reducing alcohol and/or drug use
 2. When I stopped heavy alcohol or drug use
 3. Both 1 and 2
 4. None of the above
103. With regard to alcohol or drug use, I:
1. Use them to avoid withdrawal symptoms
 2. Take more alcohol and/or drugs to relieve or reduce withdrawal symptoms
 3. Both 1 and 2
 4. None of the above
104. When drinking or using drugs I often:
1. Use more (larger amounts) than I intended
 2. Use over a longer period than I intended
 3. Both 1 and 2
 4. None of the above
105. I have tried but I cannot:
1. Reduce, cut down or control my use of alcohol and/or drugs
 2. Stop using alcohol and/or drugs
 3. Both 1 and 2
 4. None of the above
106. With regard to alcohol and/or drugs, I:
1. Spend a lot of time obtaining or getting alcohol or drugs
 2. Spend a lot of time taking or recovering from alcohol or drug use
 3. Both 1 and 2
 4. None of the above
107. I have been high, drunk or have had withdrawal symptoms after using alcohol and/or drugs:
1. Before or during school, work or important family functions
 2. While driving a vehicle (car, truck or machinery)
 3. Both 1 and 2
 4. None of the above
108. I have:
1. Cut down or stopped doing many of the things I used to do because of alcohol and/or drugs
 2. Spent more time using alcohol and/or drugs and less time with my family or friends
 3. Both 1 and 2
 4. None of the above
109. How would you describe your drinking?
1. A serious problem
 2. A moderate problem
 3. A mild or slight problem
 4. No problem
110. How much motivation or desire do you have for alcohol rehabilitation, treatment or help?
1. I want help (highly motivated)
 2. Undecided (some motivation)
 3. Handle it myself (little motivation)
 4. No need
111. How many different treatment programs for alcohol problems have you been enrolled in?
1. One
 2. Two or three
 3. Four or more
 4. None
112. Recovering means having an alcohol or drug problem, but not using or abusing them anymore. I am a recovering:
1. Alcoholic
 2. Drug abuser
 3. Both 1 and 2
 4. None of the above
113. How would you describe your drug use?
1. A serious problem
 2. A moderate problem
 3. A mild or slight problem
 4. No problem
114. How many different treatment programs for drug problems have you been enrolled in?
1. One
 2. Two or three
 3. Four or more
 4. None
115. How much motivation or desire do you have for drug rehabilitation, treatment or help?
1. I want help (highly motivated)
 2. Undecided (some motivation)
 3. Handle it myself (little motivation)
 4. No need
116. My substance of choice or preferred substance is:
1. Alcohol
 2. Drugs
 3. Both alcohol and drugs
 4. None of the above

ADScreen

COMPLETE THE FOLLOWING INFORMATION

First Name: _____
Please Print

Middle Name or Initial: _____

Last Name: _____

Last 4 Digits of Your SSN: _____

Age: _____ Sex: _____

Date of Birth: ____ / ____ / ____
Month Day Year

Race/Ethnicity: _____

Education (highest grade completed): _____

Marital Status: _____
Married / Single / Divorced / Widowed

Today's Date: ____ / ____ / ____
Month Day Year

In the following, number means the total number in your lifetime.

1. Number of **alcohol**-related (not DUI/DWI) arrests: _____

2. Number of **drug**-related (not DUI/DWI) arrests: _____

3. Number of DUI/DWI arrests: _____

4. Diagnosed an Alcoholic: Yes: No:

5. Diagnosed Drug Dependent: Yes: No:

6. Diagnosed Substance Dependent: Yes: No:

Section 1

If a statement is **True** put an **X** under T for **True**. If a statement is **False** put an **X** under F for **False**.

	T	F		T	F
1.	_____	_____	33.	_____	_____
2.	_____	_____	34.	_____	_____
3.	_____	_____	35.	_____	_____
4.	_____	_____	36.	_____	_____
5.	_____	_____	37.	_____	_____
6.	_____	_____	38.	_____	_____
7.	_____	_____	39.	_____	_____
8.	_____	_____	40.	_____	_____
9.	_____	_____	41.	_____	_____
10.	_____	_____	42.	_____	_____
11.	_____	_____	43.	_____	_____
12.	_____	_____	44.	_____	_____
13.	_____	_____	45.	_____	_____
14.	_____	_____	46.	_____	_____
15.	_____	_____	47.	_____	_____
16.	_____	_____	48.	_____	_____
17.	_____	_____	49.	_____	_____
18.	_____	_____	50.	_____	_____
19.	_____	_____	51.	_____	_____
20.	_____	_____	52.	_____	_____
21.	_____	_____	53.	_____	_____
22.	_____	_____	54.	_____	_____
23.	_____	_____	55.	_____	_____
24.	_____	_____	56.	_____	_____
25.	_____	_____	57.	_____	_____
26.	_____	_____	58.	_____	_____
27.	_____	_____	59.	_____	_____
28.	_____	_____	60.	_____	_____
29.	_____	_____	61.	_____	_____
30.	_____	_____	62.	_____	_____
31.	_____	_____	63.	_____	_____
32.	_____	_____	64.	_____	_____
			65.	_____	_____

Section 2

Rate yourself on the next series of statements. Put an **X** under the number (1, 2, 3 or 4) that applies to you **now**. Use the following rating scale.

1. Rare or Never	3. Often
2. Sometimes	4. Very Often or Always

	1	2	3	4
66.	_____	_____	_____	_____
67.	_____	_____	_____	_____
68.	_____	_____	_____	_____
69.	_____	_____	_____	_____
70.	_____	_____	_____	_____
71.	_____	_____	_____	_____
72.	_____	_____	_____	_____
73.	_____	_____	_____	_____
74.	_____	_____	_____	_____
75.	_____	_____	_____	_____
76.	_____	_____	_____	_____
77.	_____	_____	_____	_____
78.	_____	_____	_____	_____
79.	_____	_____	_____	_____
80.	_____	_____	_____	_____
81.	_____	_____	_____	_____
82.	_____	_____	_____	_____
83.	_____	_____	_____	_____
84.	_____	_____	_____	_____
85.	_____	_____	_____	_____
86.	_____	_____	_____	_____
87.	_____	_____	_____	_____
88.	_____	_____	_____	_____
89.	_____	_____	_____	_____
90.	_____	_____	_____	_____
91.	_____	_____	_____	_____
92.	_____	_____	_____	_____
93.	_____	_____	_____	_____
94.	_____	_____	_____	_____
95.	_____	_____	_____	_____

Section 3

Select the answer to each of the following statements that is accurate for you. Put an **X** under the number (1, 2, 3 or 4) that applies to you **now**.

	1	2	3	4
96.	_____	_____	_____	_____
97.	_____	_____	_____	_____
98.	_____	_____	_____	_____
99.	_____	_____	_____	_____
100.	_____	_____	_____	_____
101.	_____	_____	_____	_____
102.	_____	_____	_____	_____
103.	_____	_____	_____	_____
104.	_____	_____	_____	_____
105.	_____	_____	_____	_____
106.	_____	_____	_____	_____
107.	_____	_____	_____	_____
108.	_____	_____	_____	_____
109.	_____	_____	_____	_____
110.	_____	_____	_____	_____
111.	_____	_____	_____	_____
112.	_____	_____	_____	_____
113.	_____	_____	_____	_____
114.	_____	_____	_____	_____
115.	_____	_____	_____	_____
116.	_____	_____	_____	_____

Thank you for your cooperation!

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