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: _____ (First Middle Last) Age: ____ Date of Birth: ____/____/____ (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: _____ (Certificate of Completion) Risk Reduction Completion Date: ____/____/____ (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: ____/____ (MM YY) to ____/____ (MM YY), 2nd: ____/____ (MM YY) to ____/____ (MM YY), 3rd: ____/____ (MM YY) to ____/____ (MM YY) ☐ Widow/Widower (Dates): ____/____ (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? ____ (Brother(s)) / ____ (Sister(s)) How many step-brothers and sister do you have? ____ (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? _____ Month(s)/Year(s) ☐ Unemployment, no assistance ☐ Unemployment, public assistance

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 ____/____ (MM YY) To ____/____ (MM YY) Rank at Discharge: _____ Job/Specialty: _____

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
Insomnia (trouble going to sleep)	☐	☐	☐	☐
Restless sleep (no deep or satisfying sleep)	☐	☐	☐	☐
Sleeping too much (more than 8 hours)	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐
Weight loss (without dieting)	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐
Feeling isolated from others	☐	☐	☐	☐
Loneliness	☐	☐	☐	☐
Low sex drive	☐	☐	☐	☐
Sadness	☐	☐	☐	☐
"Flashbacks" (sudden, vivid, distracting memories)	☐	☐	☐	☐

	Never	Occasionally	Fairly often	Very often
Stomach problems	☐	☐	☐	☐
Uncontrollable temper	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐
Feelings of inferiority	☐	☐	☐	☐
Feelings of guilt	☐	☐	☐	☐
Feelings that things are unreal	☐	☐	☐	☐
Feeling tense all the time	☐	☐	☐	☐
Feeling depressed a lot	☐	☐	☐	☐
Having trouble breathing	☐	☐	☐	☐
Unable to enjoy anything	☐	☐	☐	☐

Have you ever been admitted in a hospital? ☐No ☐Yes If yes, your age, what for, how long? _____

_____

Did you take any medication? ☐No ☐Yes If yes, what types? _____

Have any of your family members had depression, Post Traumatic Stress Disorder, bi-polar disorder, "nerves", attention deficit disorder or any similar type illness? ☐No ☐Yes If yes, who and what types of illnesses did they have? _____

_____

In your lifetime:

- Have you seriously thought about harming yourself? ☐No ☐Yes If yes, how close did you come? _____
- Have you seriously tried to harm yourself? ☐No ☐Yes If yes, how close did you come? _____
- Have you seriously tried to harm others? ☐No ☐Yes If yes, how close did you come? _____

Has anyone in your family committed suicide? ☐No ☐Yes If yes, who? _____

IX. LEGAL HISTORY

ARREST(s) HISTORY (**other than DUI**) List all of your arrest:

# of Arrest	Date of Arrest (Month/Year)	Charge(s)	County	Convicted	Dismissed	Expunged
1st	____/____			☐	☐	☐
2nd	____/____			☐	☐	☐
3rd	____/____			☐	☐	☐
4th	____/____			☐	☐	☐
5th	____/____			☐	☐	☐

Any pending charge(s)?: ☐No ☐Yes If yes, list them: _____

DUI HISTORY

Date of most recent DUI: ____/____ (*MM YY*) BAC Level: _____ ☐ BAC Unknown ☐ Refused the breathalyzer

What happened? _____
(*Reason for being stopped and what happened afterwards*)

_____

Other DUIs	Date of DUI (Month/Year)	BAC Level	BAC Unknown	Refused BAC
	1.____/____		☐	☐
	2.____/____		☐	☐

Other DUIs	Date of DUI (Month/Year)	BAC Level	BAC Unknown	Refused BAC
	3.____/____		☐	☐
	4.____/____		☐	☐

Any pending DUI ☐ No ☐ Yes If yes, arrest date: ____/____ (*MM YY*) BAC Level: _____ ☐ BAC Unknown ☐ Refused

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

In my **lifetime,** I ☐ have never used alcohol. *If you **have never** used alcohol, go to the next section.*

I ☐ have used alcohol. *If you have used alcohol (including trying it out), fill out the following:*

How old were you the 1st time you used? _____ How much did you use the 1st time/who was with you? _____

Where were you when you used the 1st time? _____ When did you have your last drink? _____
(e.g., home, bar, friend's home, party, etc…)

Where do you do most of your drinking? ☐ home ☐ bars ☐ parties ☐ friend's house ☐ Other: _____

Currently, in a 30 day period, how many days would you typically drink? _____ How much do you use each time? _____
Day(s) *(e.g., 3 beers, 2 glasses of wine, 3 drinks, etc…)*

What was the most you drank at one time? _____ What was the longest time you went without drinking? _____
(e.g., 6 pack, bottle, etc…)

Why do you drink? _____ How many drinks does it take to feel the effects of the alcohol? _____
(e.g., social, relax, taste, feeling, etc…) *(e.g., 1 beer, 2 glasses of wine, 3 drinks, etc…)*

Describe your tolerance level _____ Why? _____
(low, moderate, or high)

Have you ever attended a detoxification program? ☐ no ☐ yes If yes, explain: _____

Have you ever attended a treatment program? ☐ no ☐ yes If yes, explain: _____

Do you have hangovers? ☐ No ☐ Yes If yes, how often? _____ Last hangover? _____
MM / YR

Do you have withdrawals? ☐ No ☐ Yes If yes, how often? _____ Last hangover? _____
MM / YR

Do you have blackouts? ☐ No ☐ Yes If yes, how often? _____ Last hangover? _____
MM / YR

Do you have cravings? ☐ No ☐ Yes If yes, how often? _____ Last hangover? _____
MM / YR

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 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

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

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

Have you ever attended an Alcoholic Anonymous meeting? ☐ No ☐ Yes If yes, was it Court-ordered? ☐ No ☐ Yes

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?		

Total: _____

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?	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 2-3 times a week	☐ 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 to 9	☐ 10 or more
3. How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ 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?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ 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?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ 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?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ 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?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
9. Have you or someone else been injured because of your drinking?	☐ No		☐ Yes, but not in the last year		☐ 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?	☐ No		☐ Yes, but not in the last year		☐ Yes, during the last year

Total: _____

In my **lifetime,** I ☐ have never used drugs. *If you **have never** used drugs, go to the next section*

I ☐ have used and or experimented with drugs. *If you have used drugs (including trying it out), fill out the following:*

Substance	Age of first use	Used 1-5 times	Used 5-20 times	Used daily in the past	Age of last use	Still using
Marihuana						
Crack Cocaine						
Powder Cocaine						
Methamphetamines						
Benzodiazepines						
Codeine						
Heroin						
LSD						

Substance	Age of first use	Used 1-5 times	Used 5-20 times	Used daily in the past	Age of last use	Still using
Ecstasy						
Xanax						
Amphetamines						
Barbiturates						
MDMA						
Morphine						
Opioids						
Valium						

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

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?		
Total: _____		

Circle your response

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**

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: _____

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_____ Client's Signature

_____ Printed Name

Date: _____ / _____ / _____ MM DD YY

STOP!!! DO NOT CONTINUE. The Clinical Evaluator will continue from here. STOP!!! DO NOT CONTINUE.

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

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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?		
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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?		
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27. Have you ever been involved in a treatment program specifically related to drug use?		
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Total: _____		

Circle your response

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☐ 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: _____

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