# Admissions Assessment & Intake Evaluation

## SECTION 1 — CLIENT INFORMATION

Client Name: _____ Date of Birth: _____ dd / mm / yyyy

Age: _____ Gender: _____

Preferred Pronouns: _____ Address: _____

Phone: _____ Name of Emergency Contact: _____

Relationship with Emergency Contact: _____ Phone Number of Emergency Contact: _____

Date of Assessment: _____ dd / mm / yyyy Date of Admission: _____ dd / mm / yyyy

## SECTION 2 — PRESENTING PROBLEM & REASON FOR ADMISSION

Describe the primary concerns leading the client to seek services:

Client perception of the problem:

Duration & pattern of symptoms:

## SECTION 3 — SUBSTANCE USE HISTORY (REQUIRED BY DCF FOR SUD, PHP, IOP, OP)

Has the client used substances in the past 12 months?

◯ Yes ◯ No

**Alcohol**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

Consequences:

**Cannabis**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

Consequences:

**Opioids (Rx or illicit)**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

Consequences:

**Stimulants**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

Consequences:

**Benzodiazepines**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

Consequences:

**Hallucinogens**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

Consequences:

**Nicotine / Vaping**

First Use Age: _____ Last Use Date: _____ dd / mm / yyyy

Frequency: _____ Amount: _____

Route: _____

**Consequences:**

**Other**

**Specify other substance:** _____ **First Use Age:** _____

**Last Use Date:** _____ dd / mm / yyyy **Frequency:** _____

**Amount:** _____ **Route:** _____

**Consequences:**

History of overdose?

◯ Yes ◯ No

History of withdrawal symptoms?

◯ Yes ◯ No

**If yes, describe:**

**Medication-Assisted Treatment History:**

- ☐ Suboxone
- ☐ Methadone
- ☐ Vivitrol
- ☐ None

**Details:**

## SECTION 4 — ASAM 6-DIMENSION PRE-SCREEN (REQUIRED FOR PLACEMENT)

**DIMENSION 1: Acute Intoxication & Withdrawal Risk**

Current use?

◯ Yes ◯ No

Withdrawal symptoms present?

◯ Yes ◯ No

History of medically managed withdrawal?

◯ Yes ◯ No

**Notes:**

**DIMENSION 2: Biomedical Conditions**

Any chronic medical issues?

◯ Yes ◯ No

Pain concerns?

◯ Yes ◯ No

**Notes:**

**DIMENSION 3: Emotional / Behavioral / Cognitive Conditions**

Diagnosed MH conditions?

◯ Yes ◯ No

Recent SI/HI?

◯ Yes ◯ No

Trauma history?

◯ Yes ◯ No

**Notes:**

**DIMENSION 4: Readiness to Change**

Stage of change:

◯ Pre-contemplation ◯ Contemplation ◯ Preparation ◯ Action

**Notes:**

**DIMENSION 5: Relapse / Continued Use Potential**

High-risk behaviors?

◯ Yes ◯ No

Past relapses?

◯ Yes ◯ No

**Notes:**

**DIMENSION 6: Recovery Environment**

Safe housing?

◯ Yes ◯ No

Supportive family/friends?

◯ Yes ◯ No

**Notes:**

ASAM Provisional Level Recommended:

◯ OP ◯ IOP ◯ PHP ◯ Residential (if referred out)

## SECTION 5 — MENTAL HEALTH HISTORY

**Past diagnoses:**

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ OCD
- ☐ Bipolar
- ☐ Psychosis
- ☐ ADHD
- ☐ Eating Disorder
- ☐ Other

Prior hospitalizations:

◯ Yes ◯ No

**If yes, list dates/facilities:**

Self-harm or suicide history:

◯ No history ◯ Past self-harm ◯ Past suicide attempt(s)

**Details:**

**Current psychiatric symptoms:**

- ☐ Mood changes
- ☐ Panic
- ☐ Trauma flashbacks
- ☐ Dissociation
- ☐ Obsessions/Compulsions
- ☐ Disordered eating
- ☐ Sleep disturbance

Details:

## SECTION 6 — MEDICAL & PSYCHIATRIC INFORMATION

Primary Care Physician: _____ Psychiatrist: _____

Current Medications (medical & psychiatric):

Allergies:

Medical Conditions:

- [ ] Diabetes
- [ ] Seizures
- [ ] Asthma
- [ ] Cardiac
- [ ] Thyroid
- [ ] Chronic pain
- [ ] Other

Last physical exam date: _____ dd / mm / yyyy

## SECTION 7 — FAMILY, SOCIAL & DEVELOPMENTAL HISTORY

Family mental health or substance use history?

Current living situation:

- ◯ Independent
- ◯ With parents
- ◯ Group home
- ◯ Homeless
- ◯ Recovery residence

Details:

**Social supports:**

- [ ] Partner
- [ ] Friends
- [ ] Faith community
- [ ] Sponsor
- [ ] None

**Relationships:**

## SECTION 8 — LEGAL HISTORY (DCF REQUIRED)

Select applicable:

○ No legal issues ○ Probation ○ Court-ordered treatment ○ Pending charges

**Details:**

## SECTION 9 — RISK ASSESSMENT (DCF REQUIRED)

**Suicide Risk**

Currently suicidal?

○ Yes ○ No

Past attempts?

○ Yes ○ No

**Plan or intent?**

**Homicide/Violence Risk**

Any current intent to harm others?

○ Yes ○ No

**Abuse/Exploitation Screening**

**Any history of?**

- [ ] Physical abuse
- [ ] Sexual abuse
- [ ] Neglect
- [ ] Domestic violence

Is client safe today?

○ Yes ○ No

## SECTION 10 — FUNCTIONAL ASSESSMENT

Daily living functioning:

◯ Good ◯ Moderate impairment ◯ Severe impairment

**Notes:**

**Employment / School**

**Status:** _____ **Barriers:** _____

## SECTION 11 — TREATMENT GOALS (CLIENT STATED)

**Specify below:**

## SECTION 12 — ADMISSION DECISION & SERVICE PLAN

Recommended Level of Care:

◯ PHP ◯ IOP ◯ OP

**Admitting Diagnosis (Provisional):**

**Services recommended:**

- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Case Management
- ☐ Medication Management
- ☐ Urine Drug Screening
- ☐ Family Therapy
- ☐ Crisis Planning

Safety Plan Completed?

◯ Yes ◯ No

## SECTION 13 — INFORMED CONSENT & RIGHTS REVIEWED

**Check to confirm completion:**

- ☐ HIPAA privacy
- ☐ Client rights and responsibilities
- ☐ Grievance procedure
- ☐ Program rules
- ☐ Safety & emergency procedures
- ☐ Consent for treatment
- ☐ Release of information (if applicable)

## SECTION 14 — SIGNATURES

Client Signature:

**Date:** _____ dd / mm / yyyy

Guardian Signature (if minor):

**Date:** _____ dd / mm / yyyy

Assessor / Intake Coordinator:

**Date:** _____ dd / mm / yyyy **Credentials:** _____