RECOVERY FOR LIFE TREATMENT CENTER

228 N. Lynnhaven Rd. Suite 118
Virginia Beach, VA 23452

ASSESSMENT AND TREATMENT PLAN

408942001 (SNOMED-CT) PREVENTION ASSESSMENT
Assessment based on the ASI Index, DSM-5, DAST, AUDIT, and ASAM Dimensions

A 2-hour notice is required for all cancellations. Please note that a $25 fee will be added to your account in the event of a no-show on your part.

REGISTRATION - GENERAL INFORMATION

Today's Date _____	Session Began: Session Ended:	Number of minutes:
Last Name:	**First Name:**	
DOB: (Date of Birth)	Current Age:	Veteran __ Yes, __ No
Street Address	City:	
State	Zip:	
Cell Phone #		How long have you lived at this address? _____ years
Home Phone #		
Work Phone #		
Email Address		
Emergency Contact		Phone #
Employer Name		Phone #

REFERRING / REPORTING AGENCY

☐ CHESAPEAKE BAY ASAP ☐ PROBATION ☐ PARENTS ☐ SELF ☐ EMPLOYER

CASE MANAGER / P.O.	PHONE #
FAX#	EMAIL

CHIEF COMPLAINT – DIAGNOSIS:

The reason why I'm here:

What have you done so far to solve it?

PERSONAL STATUS		OFFICE USE ONLY
GENDER IDENTITY		**UDS __ passed __ failed for ___ sessions**
RACE IDENTITY		**___ DSM-5 ___ AUDIT ___ DAST ___ ASAM**
MARITAL STATUS		**Dual D? SUD +**

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

ANY PRESCRIBED MEDICATIONS

Name:	Amount:	Frequency:
Name:	Amount:	Frequency:
Name:	Amount:	Frequency:

CHECK ANY ISSUES THAT APPLY TO YOU PERSONALLY

☐ DEPRESSION	☐ MARRIAGE	☐ ALCOHOL	☐ SEX	☐ INSOMNIA	☐ OTHER
☐ INTERNET	☐ GAMBLING	☐ WORK	☐ FOOD	☐ PORNOGRAPHY	
☐ ANXIETY	☐ ANGER ISSUES	☐ VIOLENCE	☐ DRUGS	☐ INTERNET	

MY TREATMENT GOAL, WHAT I WOULD HOPE TO GET FROM TREATMENT

GOAL _____

EDUCATIONAL BACKGROUND

My highest degree education

Professional certifications

ARREST HISTORY

Have you been in a controlled environment in the last 30 days? How many?

ARREST DATES	EXPLAIN ANY ARRESTS (IF D.U.I. - LIST BLOOD ALCOHOL CONTENT (BAC)	
	Reason: (BAC)	Details:
	Reason: (BAC)	Details:
	Reason: (BAC)	Details:
	Reason: (BAC)	Details:

TYPES OF SUBSTANCE USERS

We have identified the following types, or categories of substance users. Please check the one(s) you identify with most.

__ **SOCIAL/CONTROLLED USER (no diagnosis, early education)** *"I always get a sober driver."*	This person never uses substances alone and never drives or operates anything motorized while impaired, but always gets a sober driver. They only drink or use randomly and limits the amounts.
__ **EPISODIC/PROBLEM USER due to emotional distress or celebration, (mild)** *"I drank more than five (for men) or four (for women) or more drinks in a day more than once within the last year." "I use for emotional reasons when I'm stressed or have a serious loss."*	They may go for long periods of time without drinking / using, but on this occasion, chose not to. When they drink / use, they have a reason for it. They may drink / use to reward good behavior, when something goes wrong, or on a special occasion. When they are in an "episode," they don't keep count of much they drink or use. (stress, an argument, to feel better, loss of loved one, etc.)
__ **PROBLEMATIC, MODERATELY FUNCTIONING (moderate)** *"I have made some poor choices as a result of drinking alcohol and/or ingesting altering substances." "Substance use is causing dysfunction in my life."*	This person has a problem with drinking alcohol or ingesting altering substances. (Any arrest, DUI/DWI is a problem). They have gotten a 2nd or 3rd substance-related driving arrest (DWI/DUI) for any reason and/or a BAC (Blood Alcohol Content) of .15 or higher or THC of 5 milliliters or higher. They may have refused the breathalyzer for any reason; I don't know what my BAC was." (Virginia- informed consent).
__ **SEVERE PROBLEMATIC, LOW FUNCTIONING (severe)** *"I often drink/use because I need to, or I might get sick.*	People are telling this person that they need help. Drinking / using has caused serious dysfunction at home, work, or school. They may feel they can't stop. It has taken over a year to deal with their issues.

MEDICAL/MENTAL HEALTH HISTORY

How many days have you experienced medical problems in the last 30?

	Please Explain in the column below
☐ Do you have any ongoing health concerns?	
☐ Previously diagnosed with a mental health disorder?	
☐ Psychiatric hospital stay for any reason?	
☐ Previous counseling for any reason.	
☐ Other than substance (alcohol/drug) use, has your behavior ever caused problems?	
☐ Have you ever attempted to hurt yourself or attempted to complete suicide?	
☐ Do you have any history of trauma?	
☐ Have you suffered any significant deaths/losses?	
☐ How is your current physical health?	Explain ☐ good ☐ poor ☐ bad
☐ Current sleep patterns.	Explain ☐ good ☐ poor ☐ bad

FAMILY HISTORY OF SUBSTANCE ABUSE

Parents ☐ yes ☐ no	Grandparents ☐ yes ☐ no
Siblings ☐ yes ☐ no	

MY SUBSTANCE ABUSE HISTORY

Alcohol	Age I first used	Date I last drank _____
Marijuana	Age I first used	Date I last used _____
Stimulants (cocaine, crack, amphetamine, Adderall)	Age I first used	Date I last used _____
Opiates (heroin, codeine, fentanyl, hydrocodone, Vicodin)	Age I first used	Date I last used _____
Other	Age I first used	Date I last used _____

How long was your last period of voluntary abstinence?

EMPLOYMENT STATUS

☐ full-time ☐ part-time ☐ unemployed ☐ other

☐ professional ☐ sales ☐ management ☐ other My financial income in the last year:

RELIGIOUS PREFERENCE

Religious affiliation _____ Level of activity _____

Are you comfortable with talking about the 12 steps of AA, spirituality, and God in your recovery? __ Yes __ No
If not, please explain _____

DIAGNOSTIC QUESTIONNAIRE (adapted from the DSM-5)

(Please check the box(es) below for substances you have used)

☐ ALCOHOL ☐ MARIJUANA ☐ COCAINE ☐ OPIATES ☐ STIMULANTS ☐ OTHER

IN THE LAST YEAR, DID THE ABOVE SUBSTANCE (S) MAKE YOU.
(Note, if you did not complete ASAP or treatment previously, answer the questions about the time of most use)

Please check and explain any descriptions that apply to you and your substance use.

☐ **YES.** Sometimes I have used more (__ alcohol and or __ illegal drugs) than I meant to for a longer period of time than I planned on. *(Example: "I was going to have a beer with friends for an hour and shoot pool. Ended up drinking 3 beers and was there for 4 hours.")*

If yes, please explain. _____

☐ **YES.** I have tried to (or wanted to) cut down on or control the amount of my (alcohol / illegal drugs) use but didn't or felt I couldn't. *(Example: "I've stopped drinking for weeks, even months, but picked back up later.")*

If yes, please explain. _____

☐ **YES.** I have spent too much time and/or money getting (alcohol / illegal drugs), using them, and recovering from their effects (hangovers, etc.). *(Example: "Drinking/using has wasted a lot of my time and costs me too much!")*

If yes, please explain. _____

☐ **YES.** I have experienced cravings or urges to use (alcohol / illegal drugs). *(Example: "Often, when I haven't drank/used for a while, I just feel like a drink or a little bit of drugs would help me feel a lot better.")*

If yes, please explain. _____

☐ **YES.** My __ home, __ work, or __ school life has been negatively affected by my use (alcohol / illegal drugs). "I've shown up late, missed family events or meetings because of use. *(Example: "Family members say I'm just not there for them like I used to be.")*

If yes, please explain. _____

☐ **YES.** I have experienced withdrawal symptoms after stopping my use. *(Example: "I felt sick, had headaches, shakiness, dizziness, sweaty, heart palpitations, etc. after I stopped use.")*

If yes, please explain. _____

☐ **YES.** Even though my (alcohol / illegal drugs) use has caused relationship problems, I have continued to use. *(Example: "My parents, spouse, girlfriend, etc. get upset over my use. We have argued about it.")*

If yes, please explain. _____

☐ **YES.** Because of my (alcohol / illegal drugs) use, I have given up on or reduced my involvement in certain hobbies, sports, social events, occupational, or recreational activities. *(Example: "I don't play sports, enjoy hobbies, etc. like I used to because of my use.")*

If yes, please explain. _____

☐ **YES.** Even though (alcohol / illegal drugs) put me in danger, I used anyway. *(Example: "I got a DUI, I drove any type of vehicle after drinking/using, or operated machinery, made risky choices, etc.")* How many times did you drive/operate a vehicle, boat, machinery, etc. after drinking alcohol in the last year and did not get caught? _____

If yes, please explain _____

☐ **YES.** Despite realizing that my (alcohol / illegal drugs) use was causing physical and/or psychological problems (or making such problems worse), I continued to use. *(Example: "It has complicated issues like diabetes, blood pressure, ADD, depression, etc.")*

If yes, please explain. _____

☐ **YES.** I consistently needed more of the substance (alcohol / illegal drugs) to get the same effect/high. *(Example: "I used to get a buzz from 3 drinks, now it takes me 5 to feel the same way.")*

If yes, please explain. _____

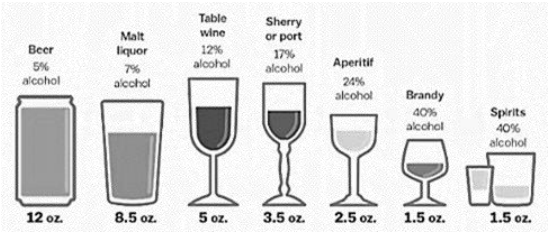
☐ **YES**. I have used drugs and/or alcohol to ease difficulties with emotions, relationships, or as a stress reliever? (because of a death in the family, financial problems, work stress or other stressors)

If yes, please explain. _____

TOTAL: ____ The previous questions were adapted from the DSM-5 developed by the American Psychiatric Association. These questions helped you identify the type and severity of problems and physical symptoms related to your use of alcohol or other drugs over the last year. (DSM-5 = MLD4-5)

ALCOHOL USE DISORDERS IDENTIFICATION TEST (A.U.D.I.T.)

Questions about your ALCOHOL use in the last year or <u>when you were drinking</u>. If you have not gone to treatment when you were expected to, then answer for the time when you were drinking the most. (place your answer's number under "score")



Remember, a serving is 12 oz. beer = 4 oz. glass of wine = 1.5 ounces of liquor

Place the number that best describes your alcohol use in the gray column at the right	0	1	2	3	4	SCORE 0-4
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	
How many drinks do you have on a typical day when you're drinking? (12 oz. beer = 4 oz wine = 1.5 ounces liquor)	1 or 2	3 or 4	5 or 6	7,8 or 9	10 or more	
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

How often in the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session the night before? (eye opener)	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, in the last year	
Has a relative, friend, doctor (or any another health worker) been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year	
TOTAL						

DAST: DRUG ABUSE SCREENING TEST

For Substance Use (other than alcohol).	CHECK IF YES
1. Have you used drugs other than those prescribed for medical reasons?	☐
2. Have you abused prescription drugs? (borrowed someone's prescription, bought someone's medication, taken more than the standard dose, etc.)	☐
3. Do you use more than one substance at a time? (alcohol plus marijuana, for example)	☐
4. Do you struggle with stopping drug use even if you want to?	☐
5. Have you had "blackouts" or "flashbacks" because of drug use?	☐
6. Do you ever feel bad about your drug abuse?	☐
7. Does your spouse/significant other (or parents) ever complain about your involvement with drugs?	☐
8. Has drug abuse ever created problems between you and your spouse/significant other (or parents)?	☐
9. Have you ever lost friends because of your use of drugs? (i.e. certain people no longer want to associate with you because you use).	☐
10. Have you ever neglected your family or missed work because of your use of drugs?	☐
11. Have you ever been in trouble at work because of drug abuse?	☐
12. Have you ever lost a job because of your drug abuse?	☐
13. Have you gotten into fights when under the influence of drugs?	☐
14. Have you engaged in illegal activities to obtain drugs? (bought, sold, distributed, or stolen for drugs, etc.)	☐
15. Have you ever been arrested for possession of illegal drugs?	☐
16. Have you ever experienced withdrawal symptoms because of drug use?	☐
17. Have you had medical or mental health problems because of use (memory loss, lack of focus, depression, hepatitis, convulsions, or bleeding, etc.)?	☐
18. Have you ever gone to anyone for help for a drug problem?	☐
19. Have you ever been involved in a treatment program specifically related to drug use?	☐
TOTAL BOXES CHECKED	

CLIENT STATEMENTS ASSESSMENT

Questions about your ALCOHOL or SUBSTANCE use in the last year when you were drinking/using. If you have not gone to treatment when you were supposed to, then answer for the time when you were drinking/using the most. If your answer is YES, put a 10 in the right column. If it is a NO, leave it blank.

STATEMENT		A YES = 10
"I realize I have an alcohol or other substance abuse **problem.** (Getting a DUI is a problem)."		
"I have had serious **consequences** from drinking/substance use." (arrest, jail, health, etc.)		
"I had an offense before this one within the last **6 years.**" (DUI, drunk in public, etc.)		
"I drank/used while I was in treatment or on probation." (i.e. since enrolling in ASAP program)		
"I have been to a **detox, treatment**, or a medical program before." (due to substance abuse).		
"My BAC was a **0.15** or higher." (or I refused the breathalyzer)		
"I've had one or more **non-driving** conviction/offense." (drunk in public, or other substance-related).		
"I had an **interlock violation**, or positive reading on a breathalyzer device or drug screen during ASAP."		
"I got another alcohol or other drug-related conviction/offense." (during the ASAP probationary period).		
"I have been using a substance that can be **addicting**." (has the potential to lead to dependence).		
"I didn't **complete** my treatment assessment as instructed by VASAP."		
"I didn't **complete treatment** as required by a prior treatment provider."		
"People around me at **home** drink/use."		
"People around me at **work** drink/use while at work."		
"My life seems **dysfunctional** (out of control) from drinking/using."		
"I shouldn't have to stop drinking/using. No one can tell me I can't have a drink/use drugs."		
"I get/feel **defensive** when confronted about my use."		
"I have an **emotional reason** to use." (loss of a family member, bad mood, bad day, etc.)		
"I began alcohol / altering drug use at ___ years of age." (if under 21, write in a score of **10**)		
"Drinking/using has created **other health issues**."		
TOTAL		

Note about cannabis use: It is considered while an individual is in the VASAP and ASAT program, they are on probation. Marijuana may NOT be used unless prescribed by a true health practitioner. It is both disrespectful and unacceptable for any participant to attend groups under the influence of any altering substances (at least 6 hours before group medical marijuana must cease).

COMPLETE ABSTINENCE AGREEMENT

You, The Client, must acknowledge that there will be complete abstinence from alcohol and all mind mood-altering substances (unless prescribed) while in treatment.

_____ _____

Signed Date

RECOVERY FOR LIFE TREATMENT CENTER

228 N. Lynnhaven Rd. Suite 118
Virginia Beach, VA 23452

INFORMED CONSENT FORM
AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

My Name: _____ Date of birth: _____

This document is to act as a set agreement for an approved payment plan based upon policy set by to Recovery For Life / Affordable Substance Abuse Treatment.

I understand that I am financially responsible for any copayment, cost share and/or deductible determined by my insurance carrier. In addition, I am responsible for any services deemed to be a non-covered benefit or if there is a lapse of coverage at the time medical services are rendered. Your benefits may vary based on the services provided. Should your account become delinquent and collection actions occur, you will be responsible for payment of all charges incurred as well as all collection agency costs and attorney fees up to 33 1/3%.

I authorize the release of any medical information necessary for the processing of my medical claims. I hereby authorize my insurance company to pay benefits directly to Recovery For Life (R4L) /Affordable Substance Abuse Treatment (ASAT).

Signature _____ Date _____

Printed Name _____

(PLEASE NOTE: WE ARE REQUIRED TO HAVE YOUR SIGNATURE)

Do we have your permission to leave a message regarding any test results or appointments on a voice machine at your home or mobile phone? ___ Yes ___ No

Do we have your permission to discuss any medical conditions or treatments and or leave a message with any household members? ___ Yes ___ No

Do we have your permission to share information regarding any treatment, attendance, urine screen results or appointments on a voice machine, email or text with the following individuals you may choose? ___ Yes ___ No

☐ I understand that by writing in or typing my name, I am electronically signing this document.

Signature _____ Date _____

Printed Name _____

RECOVERY FOR LIFE TREATMENT CENTER

228 N. Lynnhaven Rd. Suite 118
Virginia Beach, VA 23452

PATIENT FINANCIAL RESPONSIBILITY AND OBLIGATION FORM

DOB		Phone #

This is to certify that I am authorizing the release of my medical records. Please forward them to:

Office Name		
Office Address		
Office Contact #		
Office Fax#		

☐ PRETRIAL, PROBATION OFFICER		
☐ ASAP CASE MANAGER		
☐ ATTORNEY		
☐ FAMILY MEMBER		
☐ EMPLOYER		
☐ ASAT CASE MANAGEMENT	ASAT/Recovery for Life Team	757-456-0093
☐ OTHER		

Signature _____ Date _____

Printed Name _____

RECOVERY FOR LIFE TREATMENT CENTER

228 N. Lynnhaven Rd. Suite 118
Virginia Beach, VA 23452

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
GROUP #	GROUP #
MEMBER #	MEMBER #
SUBSCRIBER	SUBSCRIBER
SS#	SS#
DOB	DOB

Due to the many changes in insurance policies, it is no longer an easy task to keep up with everyone's insurance policies. Although we tried to stay aware of these changes it is not always possible. Therefore, we urge you as the patient to check with your insurance company regarding your coverage and if you need a referral. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred.

To assist you in finding out if you have coverage, the insurance company has a customer support number on the back of your insurance card. Some insurance plans require referrals to see a specialist from your primary care physician or primary care manager. If your insurance company requires such a referral, it is your responsibility to obtain and provide the referral to our office prior to being seen. Failure to do so may result in your either having to reschedule your appointment or except full responsibility for payment. In addition, all insurance companies require you to see physicians that participate with that said company. It is you, the patient's, responsibility to verify with the insurance that we are a participating provider.

If you happen to cancel or don't show up to your scheduled appointment time you may be charged a $25 no-show fee for follow-up patients. After three no-call, no-show appointments you will not be able to reschedule.

All past due balances must be paid at the time of service unless you have arranged a payment plan with the office.

☐ I understand that by typing my name, I am electronically signing this document.

Signature _____ Date _____

Printed Name _____

RECOVERY FOR LIFE TREATMENT CENTER

228 N. Lynnhaven Rd. Suite 118
Virginia Beach, VA 23452

CONSENT TO REPORT TO AGENCIES AND INDIVIDUALS
MEDICAL RELEASE OF INFORMATION

Patient Name		
DOB		Phone #

This is to certify that I am authorizing the release of my medical records. Please forward them to:

Office Name		
Office Address		
Office Contact #		
Office Fax#		

☐ PRETRIAL, PROBATION OFFICER		
☐ ASAP CASE MANAGER		
☐ ATTORNEY		
☐ FAMILY MEMBER		
☐ EMPLOYER		
☐ ASAT CASE MANAGEMENT	ASAT/Recovery for Life Team	757-456-0093
☐ OTHER		

RECOVERY FOR LIFE TREATMENT CENTER

228 N. Lynnhaven Rd. Suite 118
Virginia Beach, VA 23452

HIPAA PRIVACY OF PATIENT HEALTH CARE INFORMATION

Because there can be questions of privacy when healthcare information is transmitted electronically the Congress has established an all-inclusive sweeping privacy law called the **Health Information Privacy an Portability Act (HIPPA)** to be administered by the Department of Health and Human Services the act establishes standards for health care providers in obtaining and disclosing your personal health information. Although such information exchange has been routine in the past and even though we have never had a problem, the law mandates that you must now give specific written consent to continue these traditional communications relating to your personal health information and to facilitate payment.

We fully respect the privacy of your records, and we will continue to do all we can to make them secure and to protect their confidentiality. In order to provide the best possible health care and or to help third parties involved with payment for your account, we routinely share and request pertinent health information only with your other medical caregivers and with other concerned parties such as relatives and others involved in account payment such as insurers. We may, from time to time, need to confirm or discuss appointments or to discuss care related concerns on your home answering machine or directly to those answering your home phone or to phone callers identifying themselves as a relative or concerned party. This may also occur by cell phone if it has been listed.

In the course of your treatment, we sometimes have to disclose or receive your personal health information from other treatment-related facilities such as labs, durable medical equipment companies, pathologists for radiologists that might not be required to obtain your consent to release to us reports relating to your personal health, drug screens, etc.

HIPPA allows you to consent or refuse to the use of or disclosure of your personal health information as described above but concept or refusal must be in writing. HIPPA does recognize the necessity of information exchange for the optimum patient care and it has provided for denial of treatment if you choose not to consent. If you choose to give consent by signing this document you have the future right to revoke or restrict part or all of this personal health care information agreement but you may not revoke or restrict actions that have already been taken that relied on this or a previously signed consent of course you personally have the right at any time to access any information we have in your personal health records. Your signature below indicates your consent.

☐ Recovery for Life prohibits discrimination against its clients on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information.

☐ If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone ***else,*** please call 911 for assistance. Your signature below indicates consent for us to help you and/or members your family.

☐ I understand that by typing my name and continuing this assessment evaluation, I am electronically signing this document.

Signature _____ Date _____

Printed Name _____