Middlesex DUIL Program

Probation Officer:_____ Court:_____ Date completed:_____

1. First Name: **Middle Initial:** **Last Name:** **Suffix:**

2. Highest Grade Completed:

- ☐ ~~blank~~
- ☐ High school diploma/GED
- ☐ College degree or higher
- ☐ No formal education
- ☐ Some schooling, no high school
- ☐ Some college
- ☐ Other credential (degree, certificate)
- ☐ Some high school
- ☐ Associates degree

3. Gender: Male ☐ Female ☐ Transgender ☐ other _____

4. Birth Date: *mm* / *dd* / *yyyy*

5. SSN:

PERSONAL INFORMATION / ADDRESS

- ☐ Live in a home, apt, group / sober home etc.
- ☐ Homeless (no permanent place to live / shelter)
- ☐ Near Homeless (unstable living arrangements)

6a. Address

Street Address: Unit:

City/Town: State: Zip code:

6b. Is this your Primary Address? Yes ☐ No ☐

ALTERNATE NAME Section

If client has an alternate name, complete the following:

7a. First Name: **Middle Initial:** **Last Name:**

7b. Name Type: Alias ☐ Nickname ☐ Known by ☐ Married Name ☐ Maiden Name ☐ Name at Birth ☐ Prior Marriage Name ☐

DEMOGRAPHICS - CULTURAL CHARACTERISTICS

8a. Are you Spanish / Hispanic / Latino? Yes ☐ No ☐ ***If 'no,' go to Question 9***

8b. If you are Spanish / Hispanic / Latino, which of the following ethnicities best describes you?

_____ Central American	_____ Mexican, Mexican American	_____ South American
_____ Cuban	_____ Puerto Rican	_____ Unknown
_____ Dominican	_____ Salvadoran	_____ Other, specify

9. What is your primary Ethnicity / Ancestry? *(select only one)*

_____ African	___ Chinese	_____ Latin American Indian
_____ African American	___ Eastern European	_____ Middle Eastern
_____ American	___ European	_____ Portuguese
_____ Asian Indian	___ Filipino	_____ Russian
_____ Brazilian	___ Haitian	_____ Thai
_____ Cambodian	___ Japanese	_____ Vietnamese
_____ Cape Verdean	___ Korean	_____ Unknown
_____ Caribbean Islander	___ Laotian	_____ Other, specify _____

10. What is your race*? (check all that apply)*

_____ American Indian/Alaskan Indian	___ Native Hawaiian or Pacific Islander
_____ Asian	___ White
_____ Black, African American	___ Other, specify: _____

11. In what language do you prefer to read or discuss materials?

_____ American Sign Language	___ Haitian Creole	_____ Russian
_____ Cambodian (Khmer)	___ Hmong	_____ Spanish
_____ Cape Verdean Creole	___ Korean	_____ Vietnamese
_____ Chinese	___ Laotian	_____ Other, specify _____
_____ English	___ Portuguese	

HOUSEHOLD CHARACTERISTICS Section

12. Number of Adults in Household: *(if you are Homeless, enter 1)*	**13. Number of Children Living in Household** *(children under 19)***:** *(all children currently living in the household whether or not related)*
14a. Current Income: $ _____	**14b. Income Frequency:** ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

15. Source of Income: *(Check all that apply)*

_____ Wages/Salary	_____ Veterans Disability Payment	_____ Retirement - Social Security
_____ Child Support	_____ Private Disability Payment	_____ Retirement/Pension - Private
_____ Alimony	_____ Public Assistance - TANF	_____ Veterans Pension
_____ Disability	_____ Public Assistance - General	_____ Non-employment Cash Income
_____ Disability - SSI	_____ Unemployment Compensation	_____ None
_____ Disability - SSIDI	_____ Workers Compensation	_____ Other

16. Employment at the time of Enrollment

Please circle the number which applies to your employment status

1 Full-time Employment – Working 35 hours or more each week, including active duty members of the uniformed services.
2 Part-time Employment – Working fewer than 35 hours each week.
3 Unemployed-Looking for Work – Looking for work during the past 30 days or on layoff from a job.
4 Unemployed-Not Looking for Work – Not looking for work during the past 30 days.
5 Not in labor Force-Student
6 Not in labor Force-Retired
7 Not in labor Force-Disabled
8 Not in labor Force-Homemaker
9 Not in labor Force-Other

17. Marital Status:

☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Partnership

INSURANCE Section

18. Insurance:

☐ **Uninsured** ☐ **MC** (Medicaid / Mass Health / MBHP ☐ **MP** (Medicare – Over 65-some disabled) ☐ **VA** Veterans Administration

☐ **HM** Private HMO – through employment or client pay ☐ **CI** Private Insurance – through employment or client pay with no subsidy ☐ **OT** Other - Includes State subsidy – Connect Care / Health Safety Net

Insurance Company Name *Not required if uninsured*:	**Policy Number:** *If Insurance Type is **MC**, the Mass Health Number, which begins with "100", must be entered.*

19. Is this your Primary Insurance? Yes ☐ No ☐

If you have additional insurance coverage, complete the following.

20. Additional Insurance: *Note: Uninsured is not an option under additional insurance.*

☐ **MC** Medicaid / Mass Health / MBHP ☐ **MP** Medicare –Over 65-some disabled ☐ **VA** Veterans Administration

☐ **HM** –Private HMO – through employment or client pay ☐ **CI** Private Insurance – through employment or client pay with no subsidy) ☐ **OT** Other - Includes State subsidy – Connect Care / Health Safety Net)

Insurance Company Name:	**Policy Number:** *If Insurance Type is **MC**, the Mass Health Number, which begins with "100", must be entered.*

1. & 2. blank

3. Do you own or rent a home, apartment, or room? ☐Yes ☐No

4. Are you Chronically Homeless? ☐Yes ☐No

5. ZIP Code of Last Permanent Address:

6. Where did you stay last night?

1☐ Emergency shelter
2☐ Transitional housing for homeless persons
3☐ Permanent housing for formerly homeless
4☐ Psychiatric hospital or other psych. facility
5☐ Substance abuse treatment facility or detox
6☐ Hospital (non-psychiatric)
7☐ Jail, prison or juvenile detention facility
8☐ Room, apartment, or house that you own or rent
9 ☐ Staying or living with a family member
10☐ Staying or living with a friend
11☐ Room, apartment, or house to which you cannot return (future return can be uncertain)
12☐ Hotel or motel paid for without emergency shelter voucher
13☐ Foster care home or foster care group home
14☐ Place not meant for habitation
15☐ Other_____
88☐

7a. Do you consider yourself to be transgender? ☐ Yes ☐ No

7b. If you answered Yes, please specify: ☐ Male to Female ☐ Female to Male ☐ Other, specify_____

8. Do you consider yourself to be: ☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Other, specify _____

9. Blank

10. Referral:
Were you referred by the Dept. of Probation or are you considered a self-admit? ____ PO ___ Self Admit

11. Self Help:

Please circle the code number that relates to the Frequency of Attendance at Self-Help Programs. Example: AA, NA, SMART recovery

Code		**Code**	
01	No attendance in the past month	05	16-30 times in past month (4 or more times per week)
02	1-3 times in past month (less than once per week)	06	Some attendance
03	4-7 times in past month (about once per week)	~~99~~	
04	8-15 times in past month (2 or 3 times per week)		

12. Blank

13.* Please *answer Yes or No to a. through i.

a. Student	☐Yes ☐No	f. Probation	☐Yes ☐No
b. Pregnant	☐Yes ☐No	g. Parole	☐Yes ☐No
c. Postpartum	☐Yes ☐No	h. Federal Probation	☐Yes ☐No
d. Veteran/ Any Military Service	☐Yes ☐No	i. Federal Parole	☐Yes ☐No
e. Prison	☐Yes ☒No		

14. Do you have children? ☐Yes ☐No

14 a. Number Children Under 6: ☐

14 b. Number of Children 6-18: ☐

14 c. Children Over 18: ☐

14 d. Are any of the children Native American Indian race? 1 ☐ Yes 2 ☐ No

15. Are you the primary caregiver for any children? ☐ Yes ☐ No

~~**16. blank**~~

17. Number of days worked in the past 30 days? ☐☐

18. Where do you usually live? (*Where have you spent / slept most of the time over the last 12 months?)*

1 ☐ House or apartment
2 ☐ Room / boarding or sober house
3 ☐ Institution
4 ☐ Group home/treatment
5 ☐ Shelter / mission
6 ☐ On the streets
~~7 ☐~~
~~88 ☐~~

19. Who do you live with? (*Check all that apply***)**

☐ Alone ☐ Child 6-18 ☐ Spouse/Equivalent ☐ Other Relative

☐ Child under 6 ☐ Child over 18 ☐ Parents ☐ Roommate/Friend

20. Use of mobility aid: **(***Check all that apply)* ☐ None ☐ Cane ☐ Crutches ☐ Walker ☐ Manual Wheelchair ☐ Electric Wheelchair

21. Vision Impairment
Please circle

None: Normal Vision
Slight: vision can be or is corrected with glasses/lenses
Moderate: "Legally blind" but having some minimal vision
Severe: No usable vision

none slight moderate severe

22. Hearing Impairment
Please circle

None: Normal hearing
Slight: Hearing is or can be adequately corrected with amplification,(hearing aid)
Moderate: Hard of hearing, even with amplification
Severe: Profound deafness

none slight moderate severe

23. Self-care / ADL Impairment

None: No problem accomplishing ADL skills such as bathing, dressing and other self-care

none / slight

Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant

24. Developmental Disability

none slight

25. Prior Mental Health Treatment ☐ No history ☐ Counseling ☐ One hospitalization ☐ More than one hospitalization

26. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition? 1 ☐ Yes 2 ☐ No ~~88 ☐ R 99 ☐ U~~

27. List the number of prior admissions to each substance abuse treatment modality
(0 - 5 admissions, '5' = 5 or more) **Do** *not count the DUIL Program*

☐ Detox	☐ Outpatient	☐ Drunk Driver	☐ Other
☐ Residential	☐ Opioid	☐ Section 35	

28. Are you currently receiving Medication Assisted Treatment? ☐ Yes ☐ No
If Yes, answer Q28a -28c. If No, skip to Q29

28a. Are you receiving Methadone Treatment *If Yes skip to Q29* ☐ Yes ☐ No

28b. Are you receiving Suboxone or Vivitrol Treatment? *Select Below*

☐ Buprenorphine (Suboxone) ☐ Extended release injectable naltrexone (Vivitrol)

28c. Is your Suboxone or Vivitrol prescription for alcohol use disorder, opioid use disorder, or both?

☐ Alcohol Use Disorder ☐ Opioid Use Disorder ☐ Both

29. Currently receiving services from a state agency: (*Check all that apply***)**

☐ None	☐ DMH do *you have* a *case mgr.?*_____	☐ DTA *e.g. food stamps*	☐ MCDHH *MA Commission for Deaf*
☐ DCF *was DSS*	☐ DDS *was DMR*	☐ MRC *Mass Rehab Commission*	☐ Other _____
☐ DYS *youth services*	☐ DPH *e.g. HIV/STD; not BSAS tx.*	☐ MCB *Commission for Blind*	

30. Have you been arrested in the last 30 days? ☐ Yes ☐ No

(Section 35 is not an arrest, it is a civil commitment)

If so, Number of arrests in the past 30 days? ☐

	31. Please complete the Substance Misuse, Nicotine / Tobacco Use & Gambling History **Use the code chart below to answer the last three columns on the right** **DO NOT list prescribed or OTC medications that you take according to instructions.**	Have You Ever Misused / Bet		Your Age of First Use- Bet	Last Use of substances -or Bet Use code below	Frequency of Last Use or Bet Use code below	Route of Administration Use Code below
		Y	N				
A	**Alcohol** *For **Alcohol**, enter first age of **intoxication***						
B	**Cocaine**						
C	**Crack**						
D	**Marijuana / Hashish**						
E	**Heroin**						
F	**Prescribed Opiates** *Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.*						
G	**Non-prescribed Opiates** *Non-medical use of pharmaceutical opiates which were not prescribed for the client*						
H	**PCP**						
I	**Other Hallucinogens**						
J	**Methamphetamine**						
K	**Other Amphetamines**						
L	**Other Stimulants**						
M	**Benzodiazepines**						
N	**Other Tranquillizers**						
O	**Barbiturates**						
P	**Other Sedatives / Hypnotics**						
Q	**Inhalants**						
R	**Over the Counter**						
S	**Club Drugs**						
V	**Fentanyl**						
U	**Other**						
X	**Nicotine/Tobacco** *Includes cigarettes, cigars, chewing tobacco, inhalers*						
Y	**Gambling** *Includes any of the types listed in Q.33a*						**N/A**
Z	**K2/Spice or Other Synthetic Marijuana**						

Code	Last Use of Substances or bet		Code	Frequency of Last Use of substances or bet		Code	Route of Administration of substances
1	12 or more months ago		1	Less than once a month		1	Oral (swallow and/or chewing)
2	3-11 months ago		2	1-3 times a month		2	Smoking
3	1-2 months ago		3	1-2 times a week		3	Inhalation
4	Past 30 days		4	3-6 times a week		4	Injection
5	Used in last week		5	Daily		5	Other
			99	Unknown		6	Electronic Devices/Vaping

Have you ever used tobacco? ☐ Yes ☐ No

32a. If currently smoking cigarettes / Number of cigarettes currently smoked per day

Indicate the number of cigarettes, not the number of packs 1 pack = 20 cigarettes _____

32b. Do you have an interest in stopping nicotine/tobacco use:

1 ☐ No

2 ☐ Yes, Within 6 Months

3 ☐ Yes, Within 30 days

4 ☐ Does Not Apply (already stopped)

33a Types of last regular gambling *(check all that apply*) ***NONE*** _____

☐ Lottery -Scratch Tickets	☐ Slot Machines	☐ Sports Betting	☐ Stock Market
☐ Lottery - Keno	☐ Casino Games	☐ Bingo	☐ Internet Gambling
☐ Lottery/Numbers Games	☐ Card Games	☐ Dog/Horse Tracks, Jai Alai	

33b. Have you ever thought you might have a gambling problem, or been told you might? ☐ Yes ☐ No

34. What do you consider your primary substance of choice?

Please rank substances by entering a corresponding letter for substances listed in **Question 31.**

(*If no secondary or tertiary substance, leave blank)*

Primary Substance ☐ Secondary Substance ☐ Tertiary (third) Substance ☐

35. Needle use?

0 ☐ Never
1 ☐ 12 or more months ago
2 ☐ 3 to 11 months ago
3 ☐ 1 to 2 months ago
4 ☐ Past 30 days
5 ☐ Last week

36. Have you had any overdoses in your lifetime? ☐ Yes ☐ No *(If No, skip to Q37)*

36a. How many overdoses have you had in your lifetime? ☐

36b. How many overdoses have you had in past year? ☐

37. Have you ever witnessed an overdose? ☐

38. Date of most recent DUI arrest

_____/_____/_____

39. Referring Court:

_____

40. BAC this arrest: ☐

41. Lifetime number of arrests for DUI: ☐

42. Lifetime number of DUI convictions: ☐

EMERGENCY CONTACT - CONSENT TO RELEASE INFORMATION

In Case of Emergency

I, _____ DOB _____ hereby authorize

PRINT Client Name

the **Middlesex DUIL Program** to release information about my involvement in the program to the persons, agency or provider listed below:

_____

PRINT Name and telephone number of **Primary** person / agency / provider Relation to client

_____

PRINT Name and telephone number of **Secondary** person / agency / provider Relation to client

The purpose of this release is: Emergency notification

The information to be disclosed:

- ✓ Dates of Service
- ✓ Presence in Program
- ✓ The Occurrence & Nature of an Emergency & Current Known Location of Individual.

I understand that my records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records 42CFR part 2 and/or 45 CFR Part 164, and cannot be released or re-released without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires 90 days from the date this consent was signed, unless otherwise specified below:

_____

(specify the date, event or condition upon which this consent expires, not to exceed 90 days)

_____ _____ _____

Client signature Print name Date

_____ _____ _____

Staff witness signature Print name Date

Middlesex DUIL Program | PO Box 149, Tewksbury, MA 01876
Tel: 978-863-0048 | **Fax**: 978-863-9914 | DUIL@MHSAinc.org
MHSAinc.org

Middlesex DUIL Program **Client Health Assessment**

Name: _____ **Date form completed:** _____
(please print)

Please answer the following questions as accurately as possible.

If any answers below are YES please explain

1	Have you had medical concerns with your heart, either currently or in the past?	Yes	No
2	Have you had concerns with high blood pressure, either currently or in the past?	Yes	No
3	Do you have difficulty breathing, such as shortness of breath, COPD, emphysema etc?	Yes	No
4	Have you ever suffered from dizziness or fainting spells?	Yes	No
5	Have you ever been told you have a problem with your liver or pancreas?	Yes	No
6	Have you ever suffered from withdrawal symptoms (e.g., sweating, pain, nausea, shaking)?	Yes	No
7	Have you ever suffered a seizure?	Yes	No
	If yes, was it alcohol related?	Yes	No
8	Have you ever been diagnosed with any psychological condition? Example: anxiety, depression, bipolar, schizophrena, autism etc.	Yes	No
9	If # 8 is No, do you think you may suffer from a psychological condition?	Yes	No
10	Do you currently or have you ever had thoughts of suicide?	Yes	No
11	Have you ever attempted suicide? If so, when?	Yes	No
12	Are you currently seeing a psychiatrist, psychologist or counselor? If yes, reason for seeing them and length of time you have been seeing them.	Yes	No
13	Have you seen a psychiatrist, psychologist or counselor in the **past**? If yes, reason for seeing them and length of time you saw them.	Yes	No

Middlesex DUIL Program **Client Health Assessment continued**

If any answers below are YES please explain

14	Have you ever suffered from any type of head trauma?	Yes	No
15	Do you have any learning disabilities?	Yes	No
17	Do you have any type of eating disorder?	Yes	No
18	Do you have any dental concerns?	Yes	No
19	Have you, in the past year, had any type of major surgery?	Yes	No
20	Have you been hospitalized in the past year for either **physical or psychiatric reasons?** If yes, please list date(s) and reason(s).	Yes	No
21	Do you have a regular or primary care physician?	Yes	No
22	When was the last time you saw a doctor? Please list the date and reason.		
23	Do you have any medical or psychological or other concerns that you feel would hinder your success in participating in the program?	Yes	No
24	Please write anything else that you feel is important for your counselor know about you that might be relevant to your treatment at DUIL.		
25	Are you actively involved in aftercare? If yes, please list where and for how long	Yes	No

Family & Substance Use

1 Who raised you? If parents were divorced, how old were you?

2 How many brothers and sisters do you have?

3 Is there anyone in your family who struggles with addiction? If yes, How are they related?

The following questions refer to your primary substance use

4 When was your heaviest period of alcohol or substance use?

List ages, how often, how much? What do you drink / use?
(e.g., Age 25 - 35, 6 to 10 beers, 3 to 5 times per week.)

5 Describe your most current drinking pattern or substance use.
How much, how often, and what do you drink / use?

6 Has there ever been a period in your adult life when you did not drink or use? Yes No
If yes, when and for how long?

7 When was your last drink / substance use?

8 What and how much did you drink / use?

_____ _____
signature of client *date*

Middlesex DUIL Program

Medical and Insurance Information

_____
Print name

Primary Care Physician:

PCP Name: _____ ☐ Do not have a Primary care physician

Phone #: _____ ☐ Don't know or am unsure of phone #

City/Town: _____

Medical Insurance Coverage:

I currently have medical insurance coverage: YES ☐ NO ☐ If Yes, provide details below:

If covered by more than one plan, list Primary Coverage first.

Insurance Carrier/Plan: _____
(Such as: Mass Health, Medicare, Blue Cross/HMO Blue, etc.)

Member ID #: _____

I also have secondary medical insurance coverage: YES ☐ NO ☐ If Yes, provide details below:

Insurance Carrier / Plan: _____

Member ID #: _____

Middlesex DUIL Program

Prescription and Over the Counter (OTC) Medications

Name: _____ Date form completed:_____

Please list all allergies (food, medicines and any other.)

On the chart below, please record the name of each medication you are currently taking, the dosage and frequency, and any special instructions (e.g., with food, etc.

For each medication, place a check mark under the time(s) you wish to take it that is closest to the time you normally take it.

Medication	7:00	Noon	5:00 PM	9:30 PM
(example) **Atenolol, 20 mg, 1 tab, 2 times a day**	√			√
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

(Over, if needed)

Medication List (cont.)

Your Name: _____ Date: _____

Medication	7:00	Noon	5:00 PM	9:30 PM
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				