SAN BERNARDINO COUNTY
Behavioral Health
621 East Carnegie Drive, Suite 210, San Bernardino | Phone: 800-968-2636 • Fax: 909-381-2172
www.SBCounty.gov

Reset

Substance Use Disorder and Recovery Services Intake Assessment

Demographic Information		
Client Name:		Client ID:
DOB:	Self-Identified Gender:	
Admission Date:	Intake Date:	Discharge Date:

Program:
- ☐ Adult Drug Court
- ☐ Juvenile Drug Court
- ☐ Residential Treatment
- ☐ Perinatal Residential Treatment
- ☐ Withdrawal Management
- ☐ Intensive Outpatient Treatment
- ☐ Perinatal Treatment
- ☐ Narcotic Treatment Program
- ☐ Outpatient Treatment
- ☐ Recovery Services

Referral Source:
- ☐ CalWORKs
- ☐ Children & Family Services
- ☐ Employer
- ☐ Family Law
- ☐ IEHP
- ☐ Molina
- ☐ Mental Health
- ☐ Parole
- ☐ Probation
- ☐ Primary Care Physician
- ☐ Self
- ☐ Other:

Presenting problem, why client is seeking treatment: Include current symptoms, functional impairment, severity, duration and problems to daily living *(e.g. Unable to work, school, peers, social relationships, family, parenting, living arrangement/problems, health, self-care and legal)*

Name:	
DOB:	
Chart #:	
Program:	

621 East Carnegie Drive, Suite 210, San Bernardino | Phone: 800-968-2636 • Fax: 909-381-2172
www.SBCounty.gov

Results of Alcohol / Drug Use

Have you experienced the following as a result of alcohol and/or drug use?

☐ Blackouts	☐ Decrease in tolerance	☐ Nausea
☐ Feeling Depressed	☐ Periods of remorse	☐ Delirium Tremens
☐ Feeling Anxious	☐ Malaise-not feeling good	☐ Suicidal thoughts
☐ Binge Drinking	☐ Vomiting	☐ Attempted Suicide
☐ Dizziness	☐ Diarrhea	☐ None

Substance Use History

Substance:	Age first used:	Age/date last used:
Route of Administration:	How much a day did/do you use:	Do you consider your use a problem? ☐ Yes ☐ No

Substance:	Age first used:	Age/date last used:
Route of Administration:	How much a day did/do you use:	Do you consider your use a problem? ☐ Yes ☐ No

Substance:	Age first used:	Age/date last used:
Route of Administration:	How much a day did/do you use:	Do you consider your use a problem? ☐ Yes ☐ No

Substance:	Age first used:	Age/date last used:
Route of Administration:	How much a day did/do you use:	Do you consider your use a problem? ☐ Yes ☐ No

Substance:	Age first used:	Age/date last used:
Route of Administration:	How much a day did/do you use:	Do you consider your use a problem? ☐ Yes ☐ No

Primary drug within last 12 months:	Frequency of use in the last 12 months:
Counselor's comments:	

1. In the past seven (7) days, what types of drugs, including alcohol have you used? *(Type of drug and route of administration)*

Explanation:

2. In the past year, what types of drugs, including alcohol, have you used? *(Type of drug and route of administration)*

Explanation:

This confidential information is provided to you in accordance with State and Federal laws and regulations including, but not limited to, applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.	Name:	
	DOB:	
	Chart #:	
	Program:	

Substance Use Disorder Previous Treatment History			
Have you ever been in substance use disorder treatment? *(mark all that apply)*		☐ Yes	☐ No
☐ Residential Treatment Level 3.1	Dates:		
☐ Residential Treatment Level 3.3	Dates:		
☐ Residential Treatment Level 3.5	Dates:		
☐ Residential Treatment Level 3.7	Dates:		
☐ Residential Treatment Level 4	Dates:		
☐ Withdrawal Management Level 1	Dates:		
☐ Withdrawal Management Level 2	Dates:		
☐ Withdrawal Management Level 3.2	Dates:		
☐ Withdrawal Management Level 3.7	Dates:		
☐ Withdrawal Management Level 4	Dates:		
☐ Outpatient Services Level 1	Dates:		
☐ Intensive Outpatient Treatment Level 2.1	Dates:		
☐ Narcotic Treatment Program	Dates:		
☐ Recovery Services	Dates:		
☐ Partial Hospitalization	Dates:		
If other:			
If other:			

3. Have you ever taken medication [methadone, buprenorphine (suboxone)] to manage cravings? *(Please explain)* ☐ Yes ☐ No

4. What is the longest period of time that you have gone without using alcohol and/or drugs?

Health Questionnaire
A component of a client SUD assessment requires medical/psychiatric/psychological history; SUD Treatment Programs must utilize the DHCS Form 5103 health questionnaire (most recent version) to obtain this information. The health questionnaire is a client's self-assessment of their health status. The health questionnaire shall be completed and signed prior to the client's admission to the program and filed in the client's file. Appropriate SUD Treatment Program staff shall review each completed health questionnaire.

Children and Family Services (CFS) Involvement	
CFS Worker:	Phone Number:
County:	Office:

Criminal Record:			
Charges/Convictions:	Date Arrested:	Arrest Location:	Sentence:

This confidential information is provided to you in accordance with State and Federal laws and regulations including, but not limited to, applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.	Name:	
	DOB:	
	Chart #:	
	Program:	

Probation Parole				
Are you on Probation?	☐ Yes	☐ No	Probation Officer Name:	Phone:
Are you on Parole?	☐ Yes	☐ No	Parole Officer Name:	Phone:

5. Do you have any current legal problems/warrants? (*If yes, please explain)* ☐ Yes ☐ No

Explanation:

6. Have you been mandated to have an assessment completed or to enter treatment? ☐ Yes ☐ No

Explanation:

Emergency Contact		
Emergency Contact Name:		Phone:
Emergency Contact Address:		
City:	State:	Zip:

Emergency Contact Name:		Phone:
Emergency Contact Address:		
City:	State:	Zip:

Household Members		
Names of Persons Residing with You:	Relationship To You:	Age:

Children			
Name:	Sex:	DOB:	Status: (w/mother, foster care, etc.):

This confidential information is provided to you in accordance with State and Federal laws and regulations including, but not limited to, applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.	Name:	
	DOB:	
	Chart #:	
	Program:	

Family Health History	
Health History:	Relationship to you:
Comments:	

Social/Recreational History

7. Are there potential barriers to your recovery? *(e.g., financial, transportation, relationships, etc.) (Please specify)* ☐ Yes ☐ No

Explanation:

8. What high risk situations are created by your use of alcohol and/or drugs? *(e.g., driving under the influence, caring for minor children, working with machinery, heavy equipment, etc.) (Please describe)*

Explanation:

9. Are you aware of what triggers you to use alcohol and/or drugs? ☐ Yes ☐ No

Please check off any triggers that may apply: *

☐ Strong Cravings	☐ Work Pressure	☐ Mental Health	☐ Relationship Problems; including; friends or family
☐ Difficulty Dealing with Feelings	☐ Financial Stressors	☐ Physical Health	☐ School Pressure
☐ Environment	☐ Unemployment	☐ Chronic Pain	☐ Peer Pressure

10. How do you spend your free time?

Explanation:

11. How often do you engage in your free time activities?

Explanation:

Name:	
DOB:	
Chart #:	
Program:	

12. Have you given up activities you used to enjoy as a result of your alcohol and/or drug use? (*If yes, what activities)* ☐ Yes ☐ No

Explanation:

13. How many close friends would you say you have?

14. How many of those close friends use alcohol and/or drugs regularly?

15. Are friends supportive of abstinence, not using or drinking? (*If yes, how?)* ☐ Yes ☐ No

Explanation:

16. How close are you to your family of origin?

Explanation:

17. When was your last contact with your family of origin?

18. Is there a family history of substance use disorder in your family of origin? ☐ Yes ☐ No

Explanation:

19. Do you live in a safe environment/safe home? (*If no, please explain)* ☐ Yes ☐ No

Explanation:

20. Do you feel safe in your environment? ☐ Yes ☐ No

Please rate your response from 1-5, the higher the number, the safer you feel: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

21. Are your living arrangements supportive of non-use? (*If no, please explain)* ☐ Yes ☐ No

Explanation:

Gambling		
Do you gamble on a regular basis?	☐ Yes	☐ No
Have you ever felt the need to bet more and more money?	☐ Yes	☐ No
Have you ever had to lie to people important to you about how much you gamble?	☐ Yes	☐ No

This confidential information is provided to you in accordance with State and Federal laws and regulations including, but not limited to, applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.	Name:	
	DOB:	
	Chart #:	
	Program:	

Educational History

22. What is the highest level of education completed? ☐ Elementary School ☐ Middle School ☐ High School ☐ College

Explanation:

23. Do you have a GED or High School Equivalency Diploma? ☐ Yes ☐ No

24. Have you completed any training or technical education? (*If yes, please explain the training/technical education)* ☐ Yes ☐ No

Explanation:

25. Did your alcohol and/or drug use negatively affect your educational goals and/or activities? ☐ Yes ☐ No

Explanation:

Employment and Financial Status History

26. Do you have a source of income? (*If yes, mark all boxes that apply)* ☐ Yes ☐ No

- ☐ Employment
- ☐ Self-Employment
- ☐ Odd Jobs *(recycling, panhandling)*
- ☐ CalWORKs
- ☐ Social Security Disability
- ☐ Spousal Support
- ☐ State Disability
- ☐ Workers Compensation
- ☐ Unemployment benefits
- ☐ Supplemental Security Income (SSI)
- ☐ Child Support
- ☐ Other *(If other please explain below)*

Explain:

27. What do you do for work?

Explanation:

28. What jobs have you held in the last 6 months?

Explanation:

Name:	
DOB:	
Chart #:	
Program:	

29. Primary Occupation:

30. Length of time at current employment:

31. Last fulltime employment:

32. Do your available funds support your basic needs? ☐ Yes ☐ No

33. Which of the following employment/school problems have you ever experienced due to alcohol and/or drug use?

☐ Absenteeism	☐ Used/Drank at work/school
☐ Fired	☐ Diminished Productivity
☐ Suspended/Leave of Absence	☐ Quit
☐ Physical Hazards	☐ None

34. Have you ever lived in poverty? ☐ Yes ☐ No

Explanation:

35. Do you feel that alcohol and/or drug use by you or others impacted this living condition? ☐ Yes ☐ No

Explanation:

36. Has your alcohol and/or drug use impacted your finances in a negative way? ☐ Yes ☐ No

Explanation:

Name:	
DOB:	
Chart #:	
Program:	