



Department of Behavioral Health  
 Substance Use Disorder and Recovery Services

**DBH-SUDRS CalOMS Annual Update**

<b>First Name</b>		<b>Last Name</b>	
<b>Counselor Name</b>		<b>Date</b>	
<b>Client ID</b>		<b>Reporting Unit</b>	

<b>CalOMS Annual Update</b>			
<b>Annual Update Date</b>			
Please enter the day the annual update is completed MM/DD/YY			
<b>Current First Name</b>			
Please enter the client's current first name if different from the birth name			
Please enter "99904" if the client is unable to provide an answer			
<b>Current Last Name</b>			
Please enter the client's current last name if different from the birth name			
Please enter "99904" if the client is unable to provide an answer			
<b>Social Security Number</b>			
Please enter the client's social security number			
Please enter "99900" to indicate that the client declines to state their social security number			
Please enter "99904" to indicate that the client is unable to answer			
<b>Zip Code at Current Residence</b>			
Please enter the client's current zip code			
Please enter "00000" to indicate that the client is homeless and update the <b>Current Living Arrangements</b> on the <b>Family/Social Data</b> section accordingly			
Please enter "99900" to indicate that the client declines to state their ZIP code			
Please enter "99904" to indicate that the client is unable to answer			
<b>Disability</b>			
Please select the client disability by checking appropriate box(es):			
<input type="checkbox"/> None	<input type="checkbox"/> Other	<input type="checkbox"/> Visual	<input type="checkbox"/> Declined to state
<input type="checkbox"/> Hearing	<input type="checkbox"/> Client unable to answer	<input type="checkbox"/> Speech	<input type="checkbox"/> Mobility
<input type="checkbox"/> Mental	<input type="checkbox"/> Developmentally Disabled		
<b>Record to be Submitted</b>			
Please select the annual update record to be submitted by checking appropriate box:			
<input type="checkbox"/> None	<input type="checkbox"/> Other	<input type="checkbox"/> Visual	<input type="checkbox"/> Declined to state
<b>Annual Update Number</b>			
Please enter the annual update number			
*If a user overrides the Annual Update Number, when doing the Cal-OMS Submission, the Annual Update number used will be whatever the user entered. If no change is made to the Annual Update Number, when doing the subsequent Cal-OMS Submission the Annual Update Number will increase.			

<b>Consent</b>	
Please select <b>Yes or No</b> if the client has given consent to be contacted in the future by checking appropriate box:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Alcohol and Drug Use</b>			
<b>Primary Drug</b>			
Please select the client's primary drug of use by checking appropriate box(es):			
If <b>Other (Specify)</b> is selected, enter the name of the client's primary drug in the <b>Primary Drug Name</b>			
<b>Ask:</b> What is your primary alcohol or other drug problem?			
<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Barbiturates
<input type="checkbox"/>	Ecstasy	<input type="checkbox"/>	Heroin
<input type="checkbox"/>	Marijuana/ Hashish	<input type="checkbox"/>	Methamphetamines
<input type="checkbox"/>	None	<input type="checkbox"/>	Other (specify) _____
<input type="checkbox"/>	Other Amphetamines	<input type="checkbox"/>	Other Club Drugs
<input type="checkbox"/>	Other Opiates and Synthetics	<input type="checkbox"/>	Other Stimulants
<input type="checkbox"/>	Over-the-Counter	<input type="checkbox"/>	Oxycodone/OxyContin
<input type="checkbox"/>	Tranquilizer (Benzodiazepine)	<input type="checkbox"/>	Cocaine/Crack
<input type="checkbox"/>		<input type="checkbox"/>	Inhalants
<input type="checkbox"/>		<input type="checkbox"/>	Non-Prescription Methadone
<input type="checkbox"/>		<input type="checkbox"/>	Other Hallucinogens
<input type="checkbox"/>		<input type="checkbox"/>	Other Tranquilizers
<input type="checkbox"/>		<input type="checkbox"/>	PCP
<b>Primary Drug Frequency</b>			
Please enter the drug use frequency			
<b>Ask:</b> How many days in the past 30 days have you used your primary drug of abuse? _____			
<b>Primary Drug Route of Administration</b>			
Please select the client's primary drug route by checking appropriate box:			
<b>Ask:</b> What usual route of administration do you use most often for your primary drug of abuse?			
<input type="checkbox"/>	Oral	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	Injection (IV or intramuscular)	<input type="checkbox"/>	None or Not Applicable
<input type="checkbox"/>		<input type="checkbox"/>	Inhalation
<input type="checkbox"/>		<input type="checkbox"/>	Other
<b>Secondary Drug</b>			
Please select the client's secondary drug of use by checking appropriate box:			
If <b>Other (Specify)</b> is selected, enter the name of the client's secondary drug in the <b>Secondary Drug Name</b>			
<b>Ask:</b> What is your secondary alcohol or other drug problem?			
<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Barbiturates
<input type="checkbox"/>	Ecstasy	<input type="checkbox"/>	Heroin
<input type="checkbox"/>	Marijuana/ Hashish	<input type="checkbox"/>	Methamphetamines
<input type="checkbox"/>	None	<input type="checkbox"/>	Other (specify) _____
<input type="checkbox"/>	Other Amphetamines	<input type="checkbox"/>	Other Club Drugs
<input type="checkbox"/>	Other Opiates and Synthetics	<input type="checkbox"/>	Other Stimulants
<input type="checkbox"/>	Over-the-Counter	<input type="checkbox"/>	Oxycodone/OxyContin
<input type="checkbox"/>	Tranquilizer (Benzodiazepine)	<input type="checkbox"/>	Cocaine/Crack
<input type="checkbox"/>		<input type="checkbox"/>	Inhalants
<input type="checkbox"/>		<input type="checkbox"/>	Non-Prescription Methadone
<input type="checkbox"/>		<input type="checkbox"/>	Other Hallucinogens
<input type="checkbox"/>		<input type="checkbox"/>	Other Tranquilizers
<input type="checkbox"/>		<input type="checkbox"/>	PCP
<b>Days of Secondary Drug Use in the Last 30 Days</b>			
Please enter the drug use frequency			
<b>Ask:</b> How many days in the past 30 days have you used your secondary drug of abuse? _____			
<b>In the Secondary Drug Route of Administration</b>			
Please select the client's secondary drug route by checking appropriate box:			
<b>Ask:</b> What usual route of administration do you use most often for your secondary drug of abuse?			
<input type="checkbox"/>	Oral	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	Injection (IV or intramuscular)	<input type="checkbox"/>	None or Not Applicable
<input type="checkbox"/>		<input type="checkbox"/>	Inhalation
<input type="checkbox"/>		<input type="checkbox"/>	Other
<b>Days of Alcohol Use in the Last 30 Days</b>			
Please enter the frequency of alcohol use in the last 30 days. This field is used when the primary and secondary drugs are not alcohol			
<b>Ask:</b> How many days in the past 30 days have you used alcohol? _____			
<b>*If the participant's primary or secondary drug problem is alcohol, enter 99902</b>			
<b>IV Use</b>			
Please enter the frequency of the IV use			
<b>Ask:</b> How many days have you used needles to inject drugs in the past 30 days? _____			

<b>Employment</b>	
<b>Employment Status</b>	
Please select the client's employment status by checking appropriate box:	
<b>Ask: What is your current employment status?</b>	
<input type="checkbox"/> Employed Full Time (35 hours or more)	<input type="checkbox"/> Employed Part Time (less than 35 hours)
<input type="checkbox"/> Unemployed Looking for Work	<input type="checkbox"/> Unemployed – (Not seeking)
<input type="checkbox"/> Not in the labor force (Not seeking)	
<b>Work Past 30 Days</b>	
Please enter the number of work days the client has had in the past 30 days	
<b>Ask: How many days were you paid for working in the past 30 days?</b>	
<b>Enrolled in School</b>	
Please select the client's enrollment status by checking appropriate box:	
<b>Ask: Are you currently enrolled in school?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client declined to state	<input type="checkbox"/> Client unable to answer
<b>Enrolled in Job Training</b>	
Please select the client's job training status by checking appropriate box:	
<b>Ask: Are you currently enrolled in a job training program?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client declined to state	<input type="checkbox"/> Client unable to answer
<b>Highest School Grade Completed</b>	
Please enter the client's highest school grade completed	
<b>Ask: What is the highest school grade you completed?</b>	
Enter "99900" to indicate that the client declines to state	
Enter "99904" to indicate that the client is unable to answer	

<b>Criminal Justice</b>	
<b>Number of</b> – Please enter the number of times the client has been involved with the specified activity in the last 30 days	
<b>Ask: How many times have you been arrested in the past 30 days?</b>	
<b>Ask: How many days in the past 30 days were you in jail?</b>	

<b>Medical/Physical Health</b>	
<b>Last 30 Days</b>	
Please enter the number of times the client has been involved with the activity in the last 30 days	
<b>Ask: How many times have you visited an emergency room in the past 30 days for physical health problems?</b>	
<b>Ask: How many days have you stayed overnight in a hospital in the last 30 days for physical health problems?</b>	
<b>Ask: How many days in the past 30 days have you experienced physical health problems?</b>	
<b>Pregnant At Admission</b>	
Please check appropriate box:	
<b>Ask: Were you pregnant at any time during treatment?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Not Sure/Don't know
<input type="checkbox"/> Yes	
<b>HIV Tested</b>	
Please select the client's HIV testing status and results by checking appropriate box	
<b>Ask: Have you been tested for HIV/AIDS?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client declined to state	<input type="checkbox"/> Client unable to answer
<b>Ask: Did you receive the results of your HIV/AIDS test?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client declined to state	<input type="checkbox"/> Client unable to answer

<b>Mental Illness</b>	
<b>Mental Illness</b>	
Please select <b>Yes, No or Not Sure/Don't Know</b> if the client has mental illness (check appropriate box):	
<b>Ask:</b> Have you ever been diagnosed with a mental illness?	
<input type="checkbox"/> No	<input type="checkbox"/> Not Sure/Don't know <input type="checkbox"/> Yes
<b>Emergency Room Use/Mental Health</b>	
<b>Ask:</b> How many times in the past 30 days have you received outpatient emergency services for mental health needs?	
<b>Psychiatric Facility Use</b>	
Please enter the number of days in the last 30 days the client has stayed for more than 24 hours in a hospital or psychiatric facility	
<b>Ask:</b> How many days in the past 30 days have you stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs?	
<b>Mental Health Medication</b>	
Please select the client's mental health prescription medication use in the last 30 days by checking appropriate box:	
<b>Ask:</b> In the past 30 days, have you taken prescribed medication for mental health needs?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Client unable to answer

<b>Family/Social</b>	
<b>Social Support</b>	
Please enter the number of days in the last 30 days the client has participated in social support recovery activities	
<b>Ask:</b> How many days have you participated in any social support recovery activities in the past 30 days such as 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, meetings of organization other than those listed above, interactions with family members and/or friend support of recovery?	
<b>Current Living Arrangements</b>	
Please select the client's current living arrangement by checking appropriate box:	
<b>Ask:</b> What are your current living arrangements?	
<input type="checkbox"/> No Homeless	<input type="checkbox"/> Independent Living <input type="checkbox"/> Dependent Living
<b>Living with Someone</b>	
Please enter the number of days in the last 30 days the client has lived with someone who uses alcohol or drugs	
<b>Ask:</b> How many days in the past 30 days have you lived with someone who uses alcohol or other drugs?	
<b>Family Conflict Last 30 Days</b>	
Please enter the number of days in the last 30 days the client had serious conflicts with their family	
<b>Ask:</b> How many days in the past 30 days have you had serious conflicts with members of your family?	
<b>Number of Children</b>	
Please enter the number of children associated with the client	
<b>Ask:</b> How many children do you have aged 17 or younger (birth or adopted) whether they live with you or not?	
<b>Ask:</b> How many children (birth or adopted) do you have aged five years or younger?	
<b>Ask:</b> How many of your children (birth or adopted) are living with someone else because of a child protection court order?	
<b>Ask:</b> If you have children (birth or adopted) living with someone else because of a child protection court order, for how many of these children aged 17 or under have your parental rights been terminated?	