Person's Name (First MI Last): Jean B. Stone	**Record #:**	**Date of Admission:** 7/1/10
Organization/Program Name: Creative Life Choices Inc/Oak Street Residence	**DOB:** 10/1/84	**Gender:** ☐ Male ☒ Female ☐ Transgender

Has the Person Ever Used:	Age of First Use	Date of Last Use	Frequency	Amount	Method
☐ ***Alcohol***	*13*	*October 10,2009*	☒ *No use past 30 days* ☐ *1-3x past 30 days* ☐ *1-2x/week* ☐ *3-6x/week* ☐ *Daily/Multiple times/day*		☒ *Oral* ☐ *Smoked* ☐ *Inhaled* ☐ *Injected* ☐ *Other:*
☐ **Amphetamines/Stimulants**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Barbiturates/Sedatives**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Benzodiazepines**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☒ **Caffeine**	11	This moring	☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☒ Daily/Multiple times/day	4 cups of coffee a day	☒ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Crack/Cocaine**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Hallucinogens**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Heroin/Opiates/Oxycontin**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Inhalants**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☒ **Marijuana**	14	November 2000	☒ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day	"1 don't remember "	☐ Oral ☒ Smoked ☐ Inhaled ☐ Injected ☐ Other:

Person's Name (First MI Last): Jean B. Stone				**Record #:**	
☒ **Nicotine/Tobacco**	16	This morning	☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☒ Daily/Multiple times/day	8 cigarettes a day	☐ Oral ☒ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Gambling**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		
☐ **Food**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		
☐ **Exercise**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		
☐ **Sex**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		
☐ **Internet/Social Media**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		
☐ **Other:**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:

Longest period of abstinence:

Substance Use/Addictive Behavior Service History

☐ **None Reported** - If None Reported, skip to the next question

Substance Use Treatment: (Check all that apply) ☐ Outpatient ☒ Residential ☐ Inpatient/Detox ☐ Court Mandated
☐ Other Treatment:

Type of Service	Dates of Service	Reason	Name of Provider/ Agency:	Completed
Residential Treatment Program	11/2000-2/2001	Alcohol & Marijuana Abuse(trigering self harm and suicidal thoughts)	Sunrise House	☒**Yes** ☐**No**
Support Group	10/2009-present	Sobriety support for alcohol use	AA	☐**Yes** ☒**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**

Toxicology Screen Completed: ☒ **No** ☐ **Yes – If Yes, Results:**

Other Addictive Behaviors: ☒ None reported ☐ Gambling ☐ Tobacco ☐ Food ☐ Exercise ☐ Sex ☐ Other:

American Society of Addiction Medicine (ASAM) Degree of Severity at Admission for the Following Dimensions
☒ NA

Dimension	Intoxication / Withdrawal Potential	Biomedical Conditions/ Complications	Emotional / Behavioral / Cognitive	Readiness to Change	Relapse / Continued Use Potential	Recovery Environment	Family Functioning (Youth Only)
	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe

For Persons considering an Opiate Treatment Program-complete this box ☒ **Not Applicable**

If under age 18 dates of two attempts to quit prior to today
Evidence of tolerance to an Opiod
Multiple and daily self-administration of an Opiod.
Evidence of two or more proofs of narcotic dependence: ☐ urine ☐ needle marks ☐ withdrawal symptoms
☐ evidence from physical exam ☐ written history ☐ lab test

Other Comments Regarding Substance Use (Include SU by other family members/significant others, SU related legal problems, and stage of treatment information): Jean described her father as "an alcoholic" and reported that the paternal side of her family struggled with alcohol and drug abuse. Jean currently denies any use of alcohol or marijuana and stated that she has an AA sponser as well as regular attendance at AA meetings to assist her in sobriety. Her current use of caffine is within normal limits but she may benefit from information regarding the effects of caffine on anxiety levels. Jean stated that she is not currently interested in smoking cessation but would consider it once she has moved out on her own.

Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential: **Anna Renner, LMHC**	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		