Clear Vision Counseling Substance Abuse Programs

Referral Reason

Have you ever been a client at Clear Vision Counseling before? ☐ No ☐ Yes, When?_____

Check One: ☐ DUI (#)_____ ☐ Alcohol/Drug Assessment ☐ Other _____

☐ Probation/Parole_____ ☐ CPS _____
Officer's Name CPS Worker Name

Do you have an attorney? ☐ No ☐ Yes Attorney Name:_____

Name: _____ **SS#**:_____
first name middle initial last name

Home Address:_____
street address city state zip code

Phone #:_____ **Date of Birth:**_____ **Age:**_____ **Race:**_____

(Check Answer)

Gender: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)

Education: ☐ 8th grade or less ☐ partial high school ☐ high school graduate ☐ GED

☐ technical/trade school ☐ partial college ☐ college graduate ☐ graduate school

Religious Preference:_____ **Military** ☐ No ☐ Yes **Branch:**_____

Employer:_____ **How Long** _____ **# of Jobs in last five years:**_____

Emergency contact name & phone number:_____

Assessor Note (Family, work & Education)

_____

_____

In the space below, provide a brief description of incident

_____

_____

Legal History: Number of prior DUI's_____ Number of Public Intoxication Arrest_____

Number of Marijuana arrest_____ Number of other drug arrest_____ Arrest for Selling Drugs_____

List other type of arrests:_____

_____

Assessor Note (legal history)

_____

_____

CLIENT HISTORY FORM

Alcohol History: Age of first use:_____Last time you drank:_____How much?_____
(Check appropriate answer)
Frequency of use: ☐ daily ☐ several times a week ☐ once a week ☐ three or less per month

☐ Stopped Using (How Long Sober?)_____

Amount typically consumed:_____**Types of alcohol used:**_____
Family members who drink: (Check all that apply)
☐ spouse/girlfriend/boyfriend ☐ siblings ☐ parents ☐ adult children ☐ grandparents
Any alcoholic Family members? ☐ Yes ☐ No **Identify relationship**:_____
Are you concerned that you may have an alcohol or drug problem? ☐ Yes ☐ No

Social Group

Do you most often drink with friends or family in social situations? ☐ Yes ☐ No
Do you typically drink more, same as or less than you family or friends? ☐ More ☐ Same ☐ Less
Do you often drink at: ☐ Home ☐ Bars ☐ Friends home ☐ Family gatherings ☐ Other

Drug History: Types of Drugs that you have tried (Check all that apply)

☐ **I HAVE NOT USED ANY ILLICIT DRUGS OR ABUSED PRESCRIPTION MEDICATION**
If you have not used illicit drugs or abused any prescription medication check the box and skip the drug use section

Stimulants: ☐ Cocaine ☐ Crack/Rock Cocaine ☐ Freebase Cocaine ☐ Stimulants or Crank
Age of first use of above listed substances?_____Last time above was used?_____

Hallucinogens: ☐ LSD ☐ Psilocybin (Mushrooms) ☐ Mescaline ☐ Phencyclidine (PCP)
Age of first use of above listed substances?_____Last time above was used?_____

Narcotics: ☐ Opiates ☐ Morphine ☐ Codeine ☐ Heroin ☐ Fentanyl ☐ Dilaudid/other
Age of first use of above listed substances?_____Last time above was used?_____

Cannabis: ☐ Marijuana ☐ Hashish
Age of first use of above listed substances?_____Last time above was used?_____

Depressants/Tranquilizers/Sedatives: ☐ Valium ☐ Xanax ☐ Seconal ☐ Phenobarbital
Age of first use of above listed substances?_____Last time above was used?_____

Inhalants: ☐ Volatile Solvents (glue, gas or paint) ☐ Aerosols (hair sprays and spray paints)
☐ Nitrous Oxide ☐ Amyl Nitrate ☐ Toluene
Age of first use of above listed substances?_____Last time above was used?_____

Have you ever used steroids? ☐ Yes ☐ No
Age of first use of above listed substances?_____Last time above was used?_____

Frequency of use: ☐ Daily ☐ Several times a week ☐ Once a week ☐ monthly or less

Do you think you have a drug problem? ☐ Yes ☐ No

If yes, do you want help for your drug problem? ☐ Yes ☐ No

Assessor Notes (Alcohol & Illicit drug use/abuse)

_____

_____

1. When you drink do often use other drugs at the same time? ☐ YES ☐ NO
2. Do you sometimes drink more than you intend to? ☐ YES ☐ NO
3. Do you have difficulty not drinking/drugging when around others who are using? ☐ YES ☐ NO
4. Do you ever feel guilty about your use of drugs or alcohol? ☐ YES ☐ NO
5. Have you ever thought that you should quit using drugs or alcohol? ☐ YES ☐ NO
6. Do you believe that your use has created other problems for you? ☐ YES ☐ NO
7. Have you tried to control your use by limiting it to certain days of the week or certain times of the day? ☐ YES ☐ NO
8. Have you made promises to yourself or others that you were going to cut down or stop using altogether? ☐ YES ☐ NO
9. Do you get hangovers that linger for more than a few hours? ☐ YES ☐ NO
10. Have you ever missed important obligations because you were using or recovering from the effects of using drugs or alcohol ? ☐ YES ☐ NO
11. Have family/friends ever suggested that you should cut down or quit using? ☐ YES ☐ NO
12. Have you ever gotten into fights or conflicts while intoxicated? ☐ YES ☐ NO
13. Have you ever damaged your own or someone else's property while intoxicated? ☐ YES ☐ NO
14. Have you ever had a situation where you could not recall what happened to you while you were intoxicated? ☐ YES ☐ NO
15. Do you think that you drink/drug to often? ☐ YES ☐ NO
16. Have you been arrested more than once while intoxicated? ☐ YES ☐ NO
17. Have you ever intentionally hurt yourself or attempted suicide? ☐ YES ☐ NO
18. Do you want to stop drinking or using drugs? ☐ YES ☐ NO
19. Have you ever voluntarily attended AA or NA? ☐ YES ☐ NO
20. Have you ever experienced any withdrawal symptoms when you stopped using drugs or alcohol for extended periods of time? ☐ YES ☐ NO

Assessor Notes (MAST)

_____

_____

_____

PRESCRIPTION MEDICATION List currently prescribed medications

Medicine	Dosage	How Often	For how long

Mental Health History

Are you involved with any mental health agency? ☐ Yes ☐ No **Name**:_____

Have you been hospitalized for any mental illness? ☐ Yes ☐ No **Reason:**_____

Assessor Notes (Medications/Mental Health)

_____

_____

Describe current living situation/arrangement:_____

_____

Have you ever filed an EPO or been involved as a victim in a Family Court case? ☐ **Yes** ☐ **No**
Have you been accused of domestic violence or abuse? ☐ **Yes** ☐ **No**

CHECK ALL THAT APPLY

- ☐ I have not made any changes in my use of drugs and/or alcohol.
- ☐ I have reduced the quantity and frequency of my use.
- ☐ I have avoided certain friends and acquaintances.
- ☐ I have stopped going to bars, pubs and other old hangouts where I used to drink and/or drug.
- ☐ I have stopped using drugs and/or alcohol completely. How long sober?_____
- ☐ I am attending AA or NA or other self-help groups. How many meetings per week?_____

❖ PLEASE COMPLETE THE FOLLOWING STATEMENTS

- In order for me to avoid future problems with drinking and/or drugging, I should _____

  _____
- List examples of social activities you do with friends _____

  _____
- I enjoy the following leisure (free) time activities _____

  _____
- My family life is really _____

  _____
- In order to improve my life I am willing to _____

  _____

Adverse Childhood Experience (ACE) Questionnaire
While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt?

☐ YES ☐ NO

2. Did a parent or other adult in the household often push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured?

☐ YES ☐ NO

3. Did an adult or a person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or try to or actually have oral, anal or vaginal sex with you?

☐ YES ☐ NO

4. Did you often feel that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other?

☐ YES ☐ NO

5. Did you often feel that you didn't have enough to eat, had to wear dirty clothes and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☐ YES ☐ NO

6. Were your parents ever separated or divorced?

☐ YES ☐ NO

7. Was your mother or stepmother: often pushed, grabbed, slapped, or had something thrown at her or sometimes or often kicked, bitten, hit with a fist or hit with something hard or ever repeatedly hit over at least a few minutes or threatened with a gun or a knife?

☐ YES ☐ NO

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

☐ YES ☐ NO

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

☐ YES ☐ NO

10. Did a household member go to prison?

☐ YES ☐ NO

Now add up your "Yes" answers: _____ this is your ACE Score

The information that I have provided is true and accurate. I have not attempted to deceive or misrepresent myself. I understand that the information will be used to determine my treatment or education needs.

_____ _____
(signature) (date)

General Program Rules

1. Court mandated clients should provide court paperwork to the assessor. Delays in processing completion paperwork will occur if court information is missing from our records. This is especially true for DUI clients. A DUI completion form for license re-instatement will be delayed without the proper court paperwork in your file.
2. If you have to miss an assigned group session, call the office as soon as possible at 502-995-3350. If no one is available to take your call, leave a message. Speak clearly, state your name, phone number, the group type and the reason for your absence. Staff will only call back if further clarification is needed regarding the absence.
3. Payment is due at time of service. Unless you have paid ahead, you will be denied admission to a group session if you do not have payment. Keep receipts for your records.
4. You are only allowed two (2) absences the entire time you are attending group sessions. This absence policy does not apply to PRI 20-DUI Education clients. 20-Hour clients must attend each session as scheduled and pay in full by the 6th session.
5. Arrive at least five (5) minutes prior to start time of your group session. Group leaders are instructed to lock the door at when group begins and will not allow late admission. On the occasion of arriving late, DO NOT DISTURB A GROUP IN SESSION BT YELLING, KNOCKING OR BANGING LOUDLY ON THE DOOR.
6. In the event of inclement (bad) weather an announcement will be left on the recorder (995-3350) at the main office indicating if groups will be held. In most cases, we do not cancel group sessions.
7. In the rare instance when you arrive for group and the group leader is not present, please wait at least fifteen (15) minutes after the scheduled group start time before leaving.
8. If payment for final group session is by check, completion paperwork may not be released for up to two (2) weeks.
9. You are not allowed to bring food or drink into the group room.
10. Use of any tobacco products including e-cigarettes is prohibited at all locations.
11. You must turn off or silence all cell phones. Cell phone use is not permitted during group. You will be asked to leave if you violate this policy and will not be given credit for the session.
12. You must be courteous and respectful to other group members and the group leader. Disruptive, threatening or other inappropriate behavior will not be tolerated. Individuals violating this policy will be dismissed from Clear Vision Counseling and a notice of such will be sent to the referring agency.
13. Program participants at Clear Vision Counseling must respect the confidentiality of others receiving services. Disclosure of information of a private nature overheard or that others shared during group, individual or other counseling/education service is strictly prohibited. In a therapeutic environment program participants are encouraged to share personal and private pain as a part of the healing process. Therefore participants routinely become privy to such confidential information and must honor this sacred trust by respecting confidentiality. Participants must avoid discussing these matters outside of the treatment environment. Individuals that violate this confidentiality agreement will be subject to dismissal from services at Clear Vision Counseling and a notice of such dismissal will be sent to the referring agency.

Client Signature:_____ Date:_____

Client Name:_____

Please check the appropriate box. If yes, please describe in the space provided

History of Medical Problems

Yes	No	
☐	☐	Problems with eyes, ears, nose or throat?_____
☐	☐	Glaucoma?_____
☐	☐	Dizziness, fainting, headache, fatigue, seizures, head injuries?_____
☐	☐	Chest pains, high blood pressure, heart attack, stroke, or other heart disorders, blood diseases, hardening of the arteries._____
☐	☐	Cough, shortness of breath, asthma, chronic obstructive pulmonary disease or other respiratory disorder?_____
☐	☐	Ulcers or other stomach or bowel symptoms?_____
☐	☐	Diabetes, thyroid, pancreas, liver or jaundice problems?_____
☐	☐	Disorder of muscles, bones, back or joint arthritis?_____
☐	☐	Any allergies (plants, animals, food, etc.)?_____
☐	☐	Disorders of the skin, tumor, or cancer, sever infections?_____
☐	☐	Problems with female or male organs?_____
☐	☐	Venereal (sexually transmitted) diseases?_____
☐	☐	Menopausal?_____
☐	☐	Are you pregnant?_____
☐	☐	Any problems with pregnancy?_____
☐	☐	Infectious diseases (tuberculosis, hepatitis, AIDS, etc.)?_____
☐	☐	Do you drink alcohol or use non-prescription drugs/street drugs (give frequency, amount, and duration of use)?_____
☐	☐	DT's or blackouts?_____
☐	☐	Do you smoke tobacco? How many packs a day?_____
☐	☐	Major health problems, hospitalizations, surgeries, or visits to emergency room not listed above?_____
☐	☐	Have you ever been under a doctor's care? If yes, for what reason?_____
☐	☐	Have members of your family had a history of alcohol or drug abuse, depression, major mental/emotional problems, or other major illnesses? Please list who and what:_____
☐	☐	Are you sleeping well?_____
☐	☐	Do you use alcohol/drugs/medication to help you sleep?_____

Date of last physical exam:_____ Name of family doctor/clinic:_____
Doctor or Clinic address/phone:_____
Date of last dental examination and dentist_____
Do you have any condition that may affect your participation in this program?_____

Nutritional

Yes	No	
☐	☐	Are you required to be on a special diet? If yes, describe:_____
☐	☐	Have you had a change in appetite or weight in the last 6 months (If change, how much?)_____
☐	☐	Do you diet?_____
☐	☐	Do you use diet pills?_____
☐	☐	Have you gone more than a day without eating any food, except when ill?_____

Are you allergic to any medication or ever had a reaction to any medications? If yes, what was the medication and what was the reaction?_____

Client Signature and Date:_____

Summary of Client's Needs

Does the clinician believe this client have a medical condition that will interfere with participation in the program?

☐ Yes ☐ No Is there a need to refer this client for medical consultation?_____

If so, action taken? ☐ Referral to physician ☐ Referral to:_____ ☐ Client refused

Assessor Signature and Date:_____

The Medical History section of this intake package was developed by the Division of Substance Abuse, Department for Mental Health and Mental Retardation Services in consultation with Ed Maxwell, M.D., Clinical Director.

The Basics of HIV Prevention; Key Points

- HIV is spread through contact with the blood, semen, pre-seminal fluid, vaginal fluids, rectal fluids, or breast milk from a person infected with HIV.
- In the United States, HIV is spread mainly by having sex or sharing injection drug equipment, such as needles, with someone who has HIV.
- To reduce your risk of HIV infection, use condoms correctly every time you have vaginal, oral, or anal sex. Don't inject drugs. If you do, use only sterile injection equipment and water and never share your equipment with others.
- Treatment with HIV medicines (called antiretroviral therapy or ART for short) helps people with HIV live longer, healthier lives. Although ART can reduce the risk of HIV transmission, it's still important to use condoms during sex.

How is HIV spread?

HIV is spread through contact with the certain body fluids from a person infected with HIV:

Blood, Semen, Pre-seminal fluids, Rectal fluids, Vaginal fluids

The spread of HIV from person to person is called HIV transmission.

In the United States, HIV is spread mainly by having sex or sharing injection drug equipment, such as needles, with someone who has HIV.

HIV can also pass from an HIV-infected woman to her child during pregnancy, childbirth (also called labor and delivery), or breastfeeding. This spread of HIV is called mother-to-child transmission of HIV.

In the past, some people were infected with HIV after receiving a blood transfusion or organ transplant from an HIV-infected donor. Today, this risk is very low because the supply of donated blood and organs is carefully tested in the United States.

You can't get HIV by shaking hands with, hugging, or closed-mouth kissing a person infected with HIV. And you can't get HIV from contact with objects such as toilet seats, doorknobs, or dishes used by a person infected with HIV.

How can I reduce my risk of getting HIV?

Anybody can get HIV, but you can take steps to protect yourself from HIV infection.

- **Get tested and know your partner's HIV status.** Talk to your partner about HIV testing and get tested before you have sex.
- **Have less risky sex.** Oral sex is much less risky than anal or vaginal sex. Anal sex is the most risky type of sex for the spread of HIV.
- **Use condoms.** Use a condom every time you have vaginal, anal, or oral sex. Read this fact sheet on how to use condoms correctly.
- **Limit your number of sexual partners.** If you have more than one sexual partner, get tested for HIV regularly. Get tested and treated for sexually transmitted infections (STIs), and insist that your partners do, too. Having an STI can increase your risk of becoming infected with HIV.
- **Talk to your health care provider about pre-exposure prophylaxis (PrEP).** PrEP is an HIV prevention method that involves taking an HIV medicine every day. PrEP is intended for people who don't have HIV but who are at high risk of sexually transmitted HIV infection. PrEP should always be combined with other prevention methods, including condom use.
- **Don't inject drugs.** But if you do, use only sterile drug injection equipment and water and never share your equipment with others.

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