SOLUTIONS4LIFE

DUI & Substance Abuse Program

CONFIDENTIAL INTAKE FORM

Personal Information

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____

Date of Birth: _____ Age: _____

Gender: _____

Marital Status: _____

Religious Preference: _____

Race: _____

Hispanic/Hispanic Origin: _____

Home Phone: _____ Cell Phone: _____

When calling, can we leave a detailed message? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

Referral Information

Referral Source (select one):

☐ Probation Officer ☐ Suncoast Safety Council ☐ Other

Other: _____

Please describe the circumstances leading to your referral to our agency:

_____

_____

_____

_____

Medical Care

From whom or where do you receive your medical care?

Clinic Name: _____

Doctor's Name: _____

Phone: _____

Address: _____

CONFIDENTIAL INTAKE FORM

Employment

Employer: _____

Work Phone: _____

Address: _____

Occupation: _____

Length of time with employer: _____

Present Relationships

Do you live with anyone? ☐ Yes ☐ No

Marital/relationship status: _____

How do you get along with your spouse or partner? _____

Do you have children? Please list names and ages:

_____

_____

Does your child or children live with you? ☐ Yes ☐ No

Education

Highest education level (select one):

☐ No Diploma ☐ High School Diploma/GED ☐ Technical School ☐ Some College

☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ PhD

Past Psychological/Psychiatric or Substance Use Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

☐ Yes ☐ No

Type of treatment (select one):

☐ Inpatient ☐ Outpatient ☐ Both

When: _____

From Whom: _____

For What: _____

Results:

_____

_____

_____

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Psychiatric/Emotional Medication History

Have you ever taken medication for psychiatric or emotional problems? ☐ Yes ☐ No

When: _____

From Whom: _____

For What: _____

Results: _____

Substance Use

Do you currently consume alcohol? ☐ Yes ☐ No

Date when you last drank: _____

Average number of drinks per occasion: _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? ☐ Yes ☐ No

Have family members or friends expressed concern about your drinking? ☐ Yes ☐ No

Do you currently use non-prescribed drugs or street drugs? ☐ Yes ☐ No

Do you have a history of problematic use of prescription or non-prescription drugs? ☐ Yes ☐ No

Do you have a family history of alcohol or drug problems? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Treatment Goals

What do you hope to get from counseling/substance abuse treatment? (This section must be completed by you.)

_____

_____

_____

_____

_____

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DUI & Substance Abuse Program

AUTHORIZATION TO RELEASE / OBTAIN CONFIDENTIAL INFORMATION

Client Information

Client Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Authorization

I authorize Solutions4Life to disclose information to and/or obtain information from the persons or organizations identified on this form for the purposes selected. Information may be communicated verbally, electronically, or in writing as permitted by applicable law.

DUI Program Reporting

If you were referred to Solutions4Life by Suncoast Safety Council, probation, or another monitoring/referral agency, authorization to communicate necessary program information is needed for Solutions4Life to report participation, progress, compliance, and completion. You may decline or later revoke this authorization; however, Solutions4Life may then be unable to verify your participation or completion to the referring agency, which may affect whether you receive credit for satisfying your referral or program requirements.

Authorize disclosure to the applicable referring/monitoring agency:

☐ Suncoast Safety Council ☐ Probation Officer

Other Referring / Monitoring Agency

Name / Agency _____ Phone _____

Optional Recipients

Primary Care Physician

Name / Agency _____ Phone _____

Psychiatrist

Name / Agency _____ Phone _____

Therapist / Counselor

Name / Agency _____ Phone _____

Family Member / Significant Other

Name / Agency _____ Phone _____

Other

Name / Agency _____ Phone _____

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AUTHORIZATION TO RELEASE / OBTAIN CONFIDENTIAL INFORMATION

Information Authorized for Disclosure / Exchange

Check all that apply:

☐ Treatment participation / attendance ☐ Assessment / evaluation information

☐ Treatment recommendations ☐ Progress / program compliance

☐ Drug / alcohol testing information ☐ Completion / discharge status

☐ Diagnosis / treatment summary ☐ Other _____

Psychotherapy notes and any records requiring a separate authorization are not included unless specifically authorized as required by law.

Purpose of Disclosure / Exchange

☐ DUI program / referral requirements ☐ Coordination of care

☐ Probation / legal compliance ☐ Treatment planning

☐ At my request ☐ Other _____

Expiration

This authorization expires one (1) year from the date signed unless I specify an earlier date or event below:

_____

Client Rights and Acknowledgment

- I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.
- I may refuse to sign this authorization. If I decline or revoke authorization needed for DUI/referral reporting, Solutions4Life may be unable to report my participation, progress, compliance, or completion to the referring/monitoring agency, which may affect program credit.
- Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA. Substance use disorder records remain subject to any additional protections that apply under federal or state law.
- I am entitled to receive a copy of this signed authorization.

Signatures

By signing below, I confirm that I have read and understand this authorization and voluntarily authorize the disclosures selected above.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian/Authorized Representative Signature (if applicable) Date

_____ _____

Witness Signature Date

If signed by an authorized representative, relationship/authority: _____

Revocation and Confidentiality Notice

To revoke this authorization, submit a written request to Solutions4Life. Revocation does not affect information already disclosed or actions already taken in reliance on this authorization.

Substance use disorder information may receive additional confidentiality protections under 42 CFR Part 2 when applicable. Part 2 records generally may not be used or disclosed in proceedings against a patient unless the requirements of applicable law are satisfied.

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HEALTH RISK ASSESSMENT SCREENING

The purpose of this screening is to identify health concerns that may require medical follow-up or clearance and to provide appropriate health-risk education or referral. Please answer each question as accurately as possible.

Communicable Health Screening

Have you had a tuberculosis (TB) test within the past year? ☐ Yes ☐ No

Have you ever had a positive tuberculosis (TB) test? ☐ Yes ☐ No

Have you ever tested positive for hepatitis? ☐ Yes ☐ No

Have you had sexual contact with a person known to have hepatitis? ☐ Yes ☐ No

Do you currently have any open sores or wounds on your body? ☐ Yes ☐ No

Do you currently have, or have you recently been told you may have, a contagious or communicable illness? ☐ Yes ☐ No

Medical Clearance for In-Person Services: If your responses indicate a potentially active or communicable condition that could affect safe participation in an in-person group or other in-person service, Solutions4Life may require written medical clearance from an appropriate healthcare provider before in-person participation. This requirement is intended to protect the health and safety of clients and staff.

HIV / Sexually Transmitted Infection (STI) Risk Screening

The following questions identify behaviors that may increase exposure to HIV or other sexually transmitted infections. Your responses are used for screening, education, and referral purposes.

Have you ever experienced a blackout while using alcohol or drugs and later been unable to remember what happened? ☐ Yes ☐ No

Have you had sexual contact while intoxicated or high? ☐ Yes ☐ No

Have you had sexual contact without a barrier method, or had a condom or other barrier fail during sexual contact? ☐ Yes ☐ No

If you are a man, have you had sexual contact with another man without a barrier method? ☐ Yes ☐ No

Have you had sexual contact with a partner known to have HIV or another sexually transmitted infection? ☐ Yes ☐ No

Have you had multiple sexual partners since your most recent STI test? ☐ Yes ☐ No

Have you exchanged sexual activity for money or drugs, or had a partner who has done so? ☐ Yes ☐ No

Have you ever experienced sexual activity that occurred without your consent? ☐ Yes ☐ No

Have you had a partner who disclosed that they experienced sexual activity without their consent? ☐ Yes ☐ No

Have you shared needles or other injection equipment for drugs or non-prescribed medication? ☐ Yes ☐ No

Date of most recent HIV/STI test (if known): _____

If your responses suggest possible exposure, or if you are unsure of your current status, consider discussing HIV/STI testing with a healthcare provider or local public health clinic.

_____ _____

Client Signature Date

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DUI & Substance Abuse Program

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Current Medical Care

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Are you receiving medical care for these problems? ☐ Yes ☐ No

Are you currently taking any prescription or over-the-counter medications? ☐ Yes ☐ No

List medications:

_____

_____

Physician / healthcare provider name(s): _____

Medical & Behavioral Health History

Have you been hospitalized within the past 5 years? ☐ Yes ☐ No

If yes, when and why?

_____

_____

Are you currently being treated, or have you previously been treated, for an emotional or mental health concern? ☐ Yes ☐ No

If yes, please list the diagnosis (if known) and current medications:

_____

_____

Substance & Nicotine Use

Do you currently smoke, vape, or use cigarettes, nicotine, or other tobacco products? ☐ Yes ☐ No

If yes, approximately how much each day: _____

Approximately how many alcoholic drinks do you usually consume each week: _____

In the past 6 months, have you used drugs or medications that were not prescribed to you? ☐ Yes ☐ No

If yes, please describe: _____

Pregnancy & Breast Health (if applicable)

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently pregnant? ☐ Yes ☐ No

If yes, estimated due date: _____

Medical Conditions

Please check any conditions that currently apply or are part of your medical history:

☐ Anemia	☐ Bleeding tendency	☐ Crohn's disease	☐ Hepatitis	☐ Seasonal allergies
☐ Anxiety	☐ Breathing problems	☐ Depression	☐ Hearing problems	☐ Sinus problems
☐ Asthma	☐ Bronchitis	☐ Diabetes	☐ Frequent headaches	☐ Stroke
☐ Allergies	☐ Cirrhosis	☐ Emotional concerns	☐ High blood pressure	☐ Sexual dysfunction
☐ Bipolar disorder	☐ Cardiac problems	☐ Eye problems	☐ Lupus	☐ Thyroid disease
☐ Bone/joint pain	☐ Colitis	☐ Fainting	☐ Migraine headaches	

If you checked any condition above, have you received treatment for it? _____

Other medical or emotional concerns not listed above: _____

Do you have any medical or emotional condition that might interfere with your treatment? ☐ Yes ☐ No

_____ _____

Client Signature Date

SOLUTIONS4LIFE

DUI & Substance Abuse Program

FLUID TESTING (SALIVA & URINE) POLICY AND PROCEDURE

Program Expectations

A primary requirement of the program is that clients do not consume alcohol or use drugs or medications that are not prescribed to them while participating in treatment. If you believe you may experience withdrawal symptoms, become ill, or have difficulty abstaining from alcohol or drugs, please notify your counselor promptly so appropriate recommendations can be discussed.

Random Testing

As part of the program, you agree to submit to random alcohol and/or drug testing. Testing may include saliva or urine samples and will generally occur at least once per month. Solutions4Life may require additional testing during treatment when there is a clinical or program-related reason to do so.

Dilute or Positive Results

A laboratory result classified as **dilute** will require a retest. The client is responsible for the cost of the retest. If a second test is also classified as dilute, the result will be treated as a positive result for program purposes.

A positive result, or a result treated as positive because of two dilute samples, will require an additional 30-minute individual counseling session to review and update the treatment plan. Because treatment plans are individualized, any modification will be based on the client's assessment, progress, and clinical needs.

Refusal or Failure to Report for Testing

Refusal to submit to required fluid testing will be treated as a positive result for program purposes and may result in additional treatment requirements or additional weeks being added to the treatment plan. **Failure to report for a requested drug or alcohol test within the time frame provided by Solutions4Life will also be treated as a refusal to test.**

Testing Fees

Drug & Alcohol Urine/Saliva Test	**$35**
Alcohol-Only Test	**$55**
Expanded/confirmatory testing requested following a positive result to evaluate a possible non-drug source or other explanation	**$55**

Client Agreement

By signing below, I acknowledge that I have read and understand the Solutions4Life fluid testing policy and agree to comply with the alcohol and drug testing requirements of the program.

_____ Client Signature _____ Date

_____ Counselor Signature _____ Date

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DUI & Substance Abuse Program

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

Please mark **Yes** or **No** for each item as it applies to you.

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	☐ Yes	☐ No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	☐ Yes	☐ No
3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	☐ Yes	☐ No
4. Can you stop drinking without a struggle after one or two drinks?	☐ Yes	☐ No
5. Do you ever feel guilty about your drinking?	☐ Yes	☐ No
6. Do friends or relatives think you are a normal drinker?	☐ Yes	☐ No
7. Are you able to stop drinking when you want to?	☐ Yes	☐ No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	☐ Yes	☐ No
9. Have you gotten into physical fights when drinking?	☐ Yes	☐ No
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	☐ Yes	☐ No
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	☐ Yes	☐ No
12. Have you ever lost friends because of drinking?	☐ Yes	☐ No

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DUI & Substance Abuse Program

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

Please continue marking **Yes** or **No** for each item.

13. Have you ever gotten into trouble at work or school because of drinking?	☐ Yes	☐ No
14. Have you ever lost a job because of drinking?	☐ Yes	☐ No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	☐ Yes	☐ No
16. Do you drink before noon fairly often?	☐ Yes	☐ No
17. Have you ever been told you have liver trouble? Cirrhosis?	☐ Yes	☐ No
18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	☐ Yes	☐ No
19. Have you ever gone to anyone for help about your drinking?	☐ Yes	☐ No
20. Have you ever been in a hospital because of drinking?	☐ Yes	☐ No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	☐ Yes	☐ No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	☐ Yes	☐ No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? If YES, how many times? _____	☐ Yes	☐ No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times? _____	☐ Yes	☐ No

FOR STAFF USE

MAST Score: _____ Reviewed by: _____

Clinical notes / follow-up:

_____

_____

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DUI & Substance Abuse Program

DRUG ABUSE SCREENING TEST (DAST - 28)

Directions: The following questions concern your involvement with drugs during the **past year (12 months)**. Drug abuse refers to (1) use of prescribed or over-the-counter drugs in excess of directions and (2) non-medical use of drugs. Consider the past year and mark **Yes** or **No** for every question.

1. Have you used drugs other than those required for medical reasons?	☐ Yes	☐ No
2. Have you abused prescription drugs?	☐ Yes	☐ No
3. Do you abuse more than one drug at a time?	☐ Yes	☐ No
4. Can you get through the week without using drugs (other than those required for medical reasons)?	☐ Yes	☐ No
5. Are you always able to stop using drugs when you want to?	☐ Yes	☐ No
6. Do you abuse drugs on a continuous basis?	☐ Yes	☐ No
7. Do you try to limit your drug use to certain situations?	☐ Yes	☐ No
8. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐ Yes	☐ No
9. Do you ever feel bad about your drug abuse?	☐ Yes	☐ No
10. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes	☐ No
11. Do your friends or relatives know or suspect you abuse drugs?	☐ Yes	☐ No
12. Has drug abuse ever created problems between you and your spouse?	☐ Yes	☐ No
13. Has any family member ever sought help for problems related to your drug use?	☐ Yes	☐ No
14. Have you ever lost friends because of your use of drugs?	☐ Yes	☐ No

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DUI & Substance Abuse Program

DRUG ABUSE SCREENING TEST (DAST - 28)

Please continue marking **Yes** or **No** for each question, based on the past year (12 months).

15. Have you ever neglected your family or missed work because of your use of drugs?	☐ Yes	☐ No
16. Have you ever been in trouble at work because of drug abuse?	☐ Yes	☐ No
17. Have you ever lost a job because of drug abuse?	☐ Yes	☐ No
18. Have you gotten into fights when under the influence of drugs?	☐ Yes	☐ No
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	☐ Yes	☐ No
20. Have you ever been arrested for driving while under the influence of drugs?	☐ Yes	☐ No
21. Have you engaged in illegal activities in order to obtain drugs?	☐ Yes	☐ No
22. Have you ever been arrested for possession of illegal drugs?	☐ Yes	☐ No
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	☐ Yes	☐ No
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	☐ Yes	☐ No
25. Have you ever gone to anyone for help for a drug problem?	☐ Yes	☐ No
26. Have you ever been in a hospital for medical problems related to your drug use?	☐ Yes	☐ No
27. Have you ever been involved in a treatment program specifically related to drug use?	☐ Yes	☐ No
28. Have you been treated as an outpatient for problems related to drug abuse?	☐ Yes	☐ No

FOR STAFF USE - SCORING & INTERPRETATION

Scoring: Score 1 point for each **Yes** response, except items **4, 5, and 7**, for which a **No** response receives 1 point. Add the points for a total DAST-28 score.

Total Score	Original DAST-28 Interpretation
0	No drug abuse problem reported.
1–5	Low level of drug abuse.
6–10	Moderate level of drug abuse.
11–15	Substantial level of drug abuse.
16–20	Severe level of drug abuse.
21–28	Very severe level of drug abuse.

DAST Score: _____ Reviewed by: _____

Clinical interpretation / follow-up:

_____

_____