Today's date: ______________

Catholic Family Center

Intake Information Sheet

Last Name: ______________________________ **MI**____ **First Name:** ___________________________

Have you been here before by another name? If yes, please specify: ___________________________________

Date of Birth: ____________ **SSN:** __________________ **E-Mail Address:** ______________________

Address: ____ Zip Code_______ Phone:__________

Preferred Method of Contact: Phone ☐ Text☐ e-mail☐ USPS letter☐ **Religion:** _________________

Race: African American or Black ☐ American Indian ☐ Alaska Native ☐ Asian ☐

Hawaiian or other Pacific Islander ☐ Hispanic or Latino ☐ White ☐

Marital Status: Married☐ Separated☐ Divorced ☐ Single (never married)☐ Widowed☐

Emergency Contact Name:__________________________ **Emergency Contact Phone:**______________

Insurance Provider: Aetna ☐ BlueCross/BlueShield ☐ Family Health Plus/Child Health Plus ☐ Fidelis ☐

Medicare ☐ Medicaid ☐ MVP ☐ United Health Care☐ **Insurance Number:**____________________

What is happening in your life that led you to coming here today?_________________________________

____

Were you referred here by someone? Yes☐ No☐ Name of person/organization:___________________

Do you have a legal requirement that mandates treatment? Yes ☐ No ☐

If yes, what type? Probation ☐ Parole☐ Pre-Trial☐ DWI☐ Family Court☐ Other: _____________

Have you been in Mental Health Treatment before? Yes ☐ No ☐ If yes, where?____________________

Are you currently receiving treatment from another Mental Health program?

If yes, name of organization/agency: ____

Have you been in Chemical Dependency Treatment before? Yes☐ No☐ If yes, where?______________

Are you currently receiving treatment from another Chemical Dependency program? Yes☐ No☐

If yes, name of organization/agency: ____

Have you been in treatment at CFC before? Yes☐ No☐ If yes, when? __________________________

Do you have any family members in treatment at Catholic Family Center? Yes☐ No☐

Are you in need of immediate Medication Assisted Therapy for Chemical Dependency? Yes ☐ No ☐

Have you received any addiction medications from another medical or treatment provider in the past month? Yes ☐ No ☐

If yes, please explain: ____

Please continue to complete the back portion of this form

Please fill in the grid below (please check all that apply):

Substance Used	Last Use Date	Amount	Frequency of use			
			Daily	Weekly	# times/wk	Other
Alcohol ☐			☐	☐		
Marijuana ☐			☐	☐		
Cocaine ☐			☐	☐		
Opioids (heroin) ☐			☐	☐		
Opioids (prescription pain medication) ☐			☐	☐		
Other (specify):						

Are you experiencing withdrawal symptoms currently? Yes ☐ No ☐

If yes, when did you start to experience withdrawal symptoms (agitation, unable to sit still, body aches – rubbing areas of body that hurt, flushed skin, sweating, hair standing up on arms –may look chilled)?

____

Have you had any emergency room visits or hospitalizations for any reason (include medical and mental health reasons) within the past month? Yes ☐ No ☐

Date of hospitalization? ________________ Name of hospital ______________________________

Reason for hospitalization? ______________________________________

Please check all that apply to you:

	Depression		Chest pain		Delusions/hallucinations
	Low energy		Trembling/shaking		Not thinking clearly/confusion
	Low self-esteem		Sweating		Feeling that you are not real
	Poor concentration		Chills/hot flashes		Feeling that things around you are not real
	Hopelessness		Tingling/numbness		Unpleasant thoughts won't go away
	Worthlessness		Fear of dying		Anger/frustration
	Guilt		Fear of going crazy		Defying rules
	Sleep disturbances (more or less)		Nausea		Blaming others
	Appetite disturbances (more or less)		Phobias		Argumentative
	Thoughts of harming yourself		Obsessions/compulsive behaviors		Excessive use of drugs or alcohol
	Thoughts of harming someone else		Racing thoughts		Excessive use of prescription medications
	Isolation/social withdrawal		Can't hold on to an idea		Black outs
	Sadness/loss		Easily agitated		Physical abuse
	Anxiety/panic		Excessive behaviors (gambling/spending)		Sexual abuse
					Spousal Abuse
					Other

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Generalized Anxiety Disorder Scale (GAD-7)

Name: ______________________________ Date: ________________

Over the last 2 weeks, have you felt bothered by any of these things?	**Not at all**	**Several Days**	**More than half the days**	**Nearly Every day**
1. Feeling nervous, anxious, or on edge?	0	1	2	3
2. Not being able to stop or control worrying?	0	1	2	3
3. Worrying too much about different things?	0	1	2	3
4. Trouble relaxing?	0	1	2	3
5. Being so restless that it is hard to sit still?	0	1	2	3
6. Becoming easily annoyed or irritable?	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3

Total ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of the things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name:______________________________ Date:______________

Fagerstrom Test for Nicotine Dependence (FTND)

Do you smoke? (Circle one) Yes No

If yes, please continue

	0	1	2	3
1. How soon after you wake up do you smoke your first cigarette?	After 60 minutes	31-60 minutes	6-30 minutes	Within 5 minutes
2. Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, cinema, etc?	No	Yes		
3. Which cigarette would you hate most to give up?	All others	The first one in the morning		
4. How many cigarettes/day do you smoke?	10 or less	11-20	21-31	31 or more
5. Do you smoke more frequently during the first hours of waking than during the rest of the day	No	Yes		
6. Do you smoke if you are so ill that you are in bed most of the day?	No	Yes		

Scoring the Fagerstrom Test for Nicotine Dependence (FTND)

In scoring the Fagerstrom Test for Nicotine Dependence, the three yes/no items are scored 0 (no) and 1 (yes). The three multiple-choice items are scored from 0 to 3. The items are summed to yield a total score of 0-10.

Classification of dependence:

- 0-2 Very low
- 3-4 Low
- 5 Moderate
- 6-7 High
- 8-10 Very high

SOUTH OAKS GAMBLING SCREEN (SOGS)

1. Indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: "not at all," "less than once a week," or "once a week or more."

Not at all	Less than once a week	Once a week or more	
			a. played cards for money
			b. bet on horses, dogs or other animals (in off-track betting, at the track or with a bookie)
			c. bet on sports (parley cards, with a bookie, or at jai alai)
			d. played dice games (including craps, over and under, or other dice games) for money
			e. went to casino (legal or otherwise)
			f. played the numbers or bet on lotteries
			g. played bingo
			h. played the stock and/or commodities market
			i. played slot machines, poker machines or other gambling machines
			j. bowled, shot pool, played golf or played some other game of skill for money

2. What is the largest amount of money you have ever gambled with any one day?

____ never have gambled

____ more than $100 up to $1000

____ $10 or less

____ more than $1000 up to $10,000

____ more than $10 up to $100

____ more than $10,000

3. Do (did) your parents have a gambling problem?

____ both my father and mother gamble (or gambled) too much

____ my father gambles (or gambled) too much

____ my mother gambles (or gambled) too much

____ neither gambles (or gambled) too much

4. When you gamble, how often do you go back another day to win back money you lost?

___ never

___ some of the time (less than half the time) I lost

___ most of the time I lost

___ every time I lost

5. Have you ever claimed to be winning money gambling but weren't really? In fact, you lost?

___ never (or never gamble)

___ yes, less than half the time I lost

___ yes, most of the time

6. Do you feel you have ever had a problem with gambling?

___ no

___ yes, in the past, but not now

___ yes

	Yes	No
7. Did you ever gamble more than you intended?	___	___
8. Have people criticized your gambling?	___	___
9. Have you ever felt guilty about the way you gamble or what happens when you gamble?	___	___
10. Have you ever felt like you would like to stop gambling but didn't think you could?	___	___
11. Have you ever hidden betting slips, lottery tickets, gambling money, or other signs of gambling from your spouse, children, or other important people in you life?	___	___
12. Have you ever argued with people you like over how you handle money?	___	___
13. (If you answered "yes" to question 12): **Have money arguments ever centered on your gambling?**	___	___
14. Have you ever borrowed from someone and not paid them back as a result of your gambling?	___	___

	Yes	No
15. Have you ever lost time from work (or school) due to gambling?	____	____
16. If you borrowed money to gamble or to pay gambling debts, where did you borrow from? (Check "yes" or "no" for each)	____	____

a. from household money		
b. from your spouse		
c. from other relatives or in-laws		
d. from banks, loan companies or credit unions		
e. from credit cards		
f. from loan sharks (Shylocks)		
g. your cashed in stocks, bonds or other securities		
h. you sold personal or family property		
i. you borrowed on your checking account (passed bad checks)		
j. you have (had) a credit line with a bookie		
k. you have (had) a credit line with a casino		

Scoring Rules for SOGS

Scores are determined by adding up the number of questions that show an "at risk" response, indicated as follows. If you answer the questions above with one of the following answers, mark that in the space next to that question:

Questions 1-3 are not counted

____ Question 4: most of the time I lost, or every time I lost

____ Question 5: yes, less than half the time I lose, or yes, most of the time

____ Question 6: yes, in the past, but not now, or yes

____ Question 7: yes

____ Question 8: yes

____ Question 9: yes

____ Question 10: yes

____ Question 11: yes

Question 12 is not counted

____ Question 13: yes

____ Question 14: yes

____ Question 15: yes

____ Question 16a: yes

____ Question 16b: yes

____ Question 16c: yes

____ Question 16d: yes

____ Question 16e: yes

____ Question 16f: yes

____ Question 16g: yes

____ Question 16h: yes

____ Question 16i: yes

Questions 16j and 16k are not counted

Total = ________ (20 questions are counted)

**3 or 4 = Potential pathological gambler (Problem gambler)

**5 or more = Probable pathological gambler

New York State of Opportunity | Office of Mental Health

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

____________________	____________________	____________________
Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
Signature of Patient or Patient's Legal Representative	Date	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
Signature of Witness	Print Name of Witness	

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Can be Used.** Your electronic health information can only be used by your treatment provider to:
   - Provide you with medical treatment, care coordination, and related services
   - Evaluate and improve the quality of medical care provided to all patients
   - Notify your treatment providers if you have an emergency (e.g., go to an emergency room)

2. **What Types of Information About You Are Included?** If you give consent, ______________________________ can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may include information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: ______________________________'s doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for ______________________________ and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call ______________________ at ______________ or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by ______________________________; to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any services from ______________________________ or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to ____________________. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling ____________________ at ________________. Note: Organizations that access your health information through ______________________________ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: Catholic Charities Family And Community Services

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even** in a medical emergency (except for minor patients).*

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: ____________________; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

Name ______________________________ ENGLISH
Date ______________________

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months…

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)		
1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)		
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		

5. Have you had any health problems? Please check if you have:
   - ___ Had blackouts or other periods of memory loss?
   - ___ Injured your head after drinking or using drugs?
   - ___ Had convulsions, delirium tremens ("DTs")?
   - ___ Had hepatitis or other liver problems?
   - ___ Felt sick, shaky, or depressed when you stopped?
   - ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ___ Been injured after drinking or using?
   - ___ Used needles to shoot drugs?

Please continue ⇒

Name ______________________________ ENGLISH

Date ______________________

Modified Simple Screening Instrument for Substance Abuse (continued)

	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends?		
7. Has your drinking or other drug use caused problems at school or at work?		

	Yes	No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		

The next questions are about your lifetime experiences.

	Yes	No
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you have a drinking or drug problem now?		

Thank you for filling out this questionnaire.