# Edgewater Recovery Center and Blue Sky Recovery Center

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## Date: _____ Completed By: _____

### General Information

Name: _____ DOB: _____ Phone: _____
Address: _____ City/State: _____
SSN: _____ Marital Status: _____
Sex: _____ Pregnant: _____ Race: _____
Do you have Dependent Children? Yes ☐ No ☐ Ages: _____
Who currently has custody: _____
Employer: _____ What was the last grade of school completed: _____
Do you receive disability income (Mental or Physical)? _____
Referral Source: _____ Phone: _____
Currently in Residential Facility? Yes ☐ No ☐ Facility Name: _____
Does client have transportation to treatment: Yes ☐ No ☐
What are those arrangements: _____

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### Medical Coverage

Private Insurance _____ KY Medicaid_____ Other_____
Insurance Provider: _____ Insurance Phone: _____
Policy or Medicaid MCO Number: _____Group Number: _____
Primary Insured Name: _____ Relationship to Primary Insured: _____

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### Judicial Information

Incarcerated, if so what facility: _____Date of Arrest: _____
Court Order: Yes ☐ No ☐ If So, How Long?: _____Active Warrants: _____
Pending Charges_____
Casey's Law: ☐ Sex Offender Registry:☐ Current DUI: ☐
Attorney: _____ Phone: _____ Email: _____
Probation or Parole: _____ Officer Name: _____ Phone: _____
History (or current) violent offenses: Yes ☐ No ☐ Explain: _____
_____
_____

### Medical Information

Drugs of Choice: _____
Last Date of use: _____ Substance(s) Used: _____
How long have you attempted to abstain from use: _____
When you cease use do you experience any of these symptoms:
Headache☐ nausea ☐ tremors ☐ anxiety ☐ elevated blood pressure ☐
agitation ☐ restlessness ☐ mind cloudiness/disorientation ☐ hallucinations ☐
seizures ☐
Have you ever been to Detox? Yes ☐ No ☐ When & Where _____

Mental Health Diagnosis: Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ PTSD ☐
Other: _____
Mental Health Medications: _____
Is Client Stable? Yes ☐ No ☐
Abuse: Physical ☐ Mental ☐ Sexual ☐
Suicidal/Homicidal Thoughts? Yes ☐ No ☐ When? _____
Suicide Attempts Yes ☐ No ☐ Dates: _____

1) Has the client had two or more episodes of inpatient care for mental illness within the past 12 months? _____
2) Has the client had continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months? _____
3) Has the client been treated by a crisis team two or more times within the past 24 months? _____
4) Has the client been committed by the court as a mentally ill individual in the last three years? _____
5) Has the client had a legal guardian that made or makes financial decisions for the recipient? _____
6) Has the client been prescribed psychotropic medications but is not stable on or compliant with medication? _____

Previous Treatment (where): _____ Type: _____
Completion or Discharge; Why? _____
**Are you currently a MAT client:** Yes ☐ No ☐ If so, what type:
Buprenorphine (Suboxone or Subutex) ☐
Naltrexone (Vivitrol) ☐
Methadone ☐
Do you wish to continue this treatment? Yes ☐ No ☐

**Health Conditions**:

| | | | |
|---|---|---|---|
| Bleeding disorder: | Yes ☐ No ☐ | Hep A | Yes ☐ No ☐ |
| Hearing/Vision Issues | Yes ☐ No ☐ | Hep B | Yes ☐ No ☐ |
| Gastro-intestinal | Yes ☐ No ☐ | Hep C | Yes ☐ No ☐ |
| Mobility Issues | Yes ☐ No ☐ | Climb Stairs | Yes ☐ No ☐ |
| Tuberculosis | Yes ☐ No ☐ | Walk 1 Mile (Unassisted) | Yes ☐ No ☐ |
| Open Wounds/MRSA | Yes ☐ No ☐ | Fainting | Yes ☐ No ☐ |
| Diabetes | Yes ☐ No ☐ | Fall Risk | Yes ☐ No ☐ |
| Heart Issues | Yes ☐ No ☐ | | |
| Seizure History | Yes ☐ No ☐ | Date of Last Seizure: _____ | |

Have you received Hep A or Hep B Vaccination? Yes ☐ No ☐ Which One? _____
Specialty Medical Treatments or Devices _____
Allergies: _____ **Bring EPIPEN if needed.**
Can said person walk up to 1 mile unassisted? _____
Other Prescribed Medications _____

# ASAM CRITERIA

**Dimension # 1: Acute Intoxication/Withdraw Potential:** Have you ever had life threatening withdrawal signs or symptoms? (Have you currently or in the past been in detox, hospitalized or had an OD?) (0.5) Yes _____ No_____

If Yes, are you currently having similar withdrawal symptoms? (0.5)Yes _____ No _____
Please note any signs or symptoms you have ever had:
_____

**Dimension # 2: Biomedical Conditions and Complications:** Do you have any current, untreated severe physical problems? (i.e. high blood pressure, chest pains, stomach issues, hepatitis, etc.) (1) Yes_____ No_____
Are you an IV drug user: Yes ___ No___ Have you seen a Dr. in the past year Yes ____ No ____

**Dimension # 3: Emotional/Behavioral Conditions & Complications:** Do you feel that you are in imminent danger of harming yourself or others? (0.5) Yes _____ No_____

Have you been diagnosed with a mental health diagnosis, such as depression, anxiety, Post traumatic stress disorder, schizophrenia, etc.? (0.5) Yes _____ No_____

If Yes, please note any diagnosis: _____

**Dimension # 4: Treatment Acceptance/Resistance:** Do you feel that you are in immediate need of alcohol/drug treatment? (0.5) Yes_____ No_____

Have you been referred or required to have an assessment and/or treatment by the criminal justice system, health or social services, work, or family/significant other? (0.5) Yes ____ No___

If so, who referred you? _____

**Dimension # 5: Relapse/Continued Use Potential:** Are you currently under the influence? (0.5) Yes _____ No_____

Are you likely to continue using alcohol/drugs or relapse? (0.5) Yes _____ No _____

**Dimension # 6: Recovery Environment:** Are there any dangerous/using family, significant others, and/or living/working situations threatening your safety, immediate well-being and/or recovery? (0.5) Yes _____ No _____

Are you homeless? Yes ____ No____ Are there any toxic relationships? Yes _____ No _____

**Total ASAM Score: _____**