Alternative Counseling

I agree to provide a true and accurate report of my medical, legal, employment, school, relationship, residential, social and alcohol/drug use history, whether from written report or presented verbally. I understand this information will be utilized by Alternative Counseling to help determine any treatment or referral needs for me. I understand that falsification or omission of data or information can invalidate the assessment. I understand that if new information contradicting or disputing my information is obtained, I might have to be re-evaluated at my own expense. I also understand that this will result in notification to all involved entities including courts, attorney, probation, Child Protective Services, etc. I agree to absolve Alternative Counseling and its employees of any liability or responsibility that may result from my not revealing or providing accurate information.

Client Signature:_____Date:_____
Printed Full Name: _____
Alias/Any other names used: _____
DOB: _____ Age:_____ Gender:_____
Home Address: _____
City_____State _____ZIP _____
Phone Number: (_____)_____
Emergency contact person: _____
Phone Number: _____

Race/Ethnicity:
☐ Native American ☐ White ☐ Eskimo/Alaskan Native ☐ Hispanic ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Korean ☐ Vietnamese ☐ Japanese ☐ Samoan ☐ Asian Indian ☐ Cambodian ☐ Asian/Pacific Islander ☐
Other:_____

Where were you born? (City, State, Country):_____
Have you ever lived for a significant period of time in any another places besides Washington State, and if so, where?_____

How long have you lived in Washington?_____

How do you identify your sexual orientation?
☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Questioning
☐ Declined to answer ☐ Other:_____

Marital status:
☐ Single ☐ Committed Relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Who do you currently live with?_____

Do you have children? ☐ No ☐ Yes

Name Sex Age

Name Sex Age

Name Sex Age

Name Sex Age

Do your children currently live with you? ☐ No ☐ Yes

Have your parental rights been terminated? ☐ No ☐ Yes

Are you currently employed? ☐ No ☐ Yes

Position: _____ For how long:_____

Year graduated high school, last year attended, or year GED received: _____

College attended:_____

Degree received:_____ Year:_____

Did you serve, or are you serving in the Military? ☐ No ☐ Yes

Which branch _____ Year(s)_____

Please describe in your own words what brought you in for an evaluation:

_____

_____

_____

_____

_____

_____

Are any of the following concerns applicable in regard to this evaluation?

☐ DUI ☐ Reinstate driving privileges ☐ Family pressure ☐ Employer intervention

☐ Physician referral ☐ Legal pressure ☐ Child custody

Do you have an attorney representing you? ☐ No ☐ Yes

Attorney: _____ Phone (____)_____FAX (____)_____

Email:_____

Do you have any prior alcohol or drug-related charges? ☐ No ☐ Yes

If yes, specify when and what kind of charge_____

_____

_____

Are you currently on probation, or under the Department of Corrections supervision? ☐ No ☐ Yes

If yes, which court and the probation/corrections officer's name:

_____

Are you court ordered to receive substance use disorder treatment? ☐ No ☐ Yes

Have you ever experienced employment problems due to alcohol or drug use? ☐ No ☐ Yes

If yes, specify when and what kind of problems:

Have you ever participated in Substance Use Disorder (Chemical Dependency) treatment or Education in the past? ☐ No ☐ Yes

If yes, specify when and what kind of treatment:

_____

_____

Do you have a primary care doctor? ☐ No ☐ Yes

Doctor's name:_____

Do you have any current medical issues? ☐ No ☐ Yes

If yes, specify what they are:

_____

_____

Are you currently taking any prescription medications? ☐ No ☐ Yes

Medication: _____

Reason for medication: _____

Current dosage: _____

Medication: _____

Reason for medication: _____

Current dosage: _____

Medication: _____

Reason for medication: _____

Current dosage:_____

Are you currently taking any nonprescription medications? ☐ No ☐ Yes

Medication: _____

Reason for medication: _____

Current dosage: _____

Medication: _____

Reason for medication: _____
Current dosage: _____
Medication: _____
Reason for medication: _____
Current dosage:_____

Do you have any medical conditions that you feel are negatively impacted by your use of alcohol or other drugs? ☐ No ☐ Yes ☐ Unsure
If yes, or unsure, specify what you think they are:_____
_____
_____
_____
_____

Are you currently experiencing any of the following:

☐ Feeling hopeless ☐ Moodiness ☐ Sleeplessness ☐ Self destructive ☐ Decreased energy
☐ Preoccupation w/death ☐ Feeling Withdrawn ☐ Taking unnecessary risks
☐ Giving away valued possessions

Are there any other significant life events (losses, deaths, hardships, loss of custody of children, etc.)? ☐ No ☐ Yes
If yes, describe:
_____
_____
_____
_____

Have you ever received mental health counseling or psychiatric treatment? ☐ No ☐ Yes

Have you ever been diagnosed with a mental health condition? ☐ No ☐ Yes
If yes what was the diagnosis? _____

Are you currently a client at a mental health center or seeing a private practitioner? ☐ No ☐ Yes

Are you court ordered to receive mental health treatment? ☐ No ☐ Yes

Is there a history of mental illness in your family? ☐ No ☐ Yes
If yes, who, and what is the illness?_____

How would you describe your childhood?_____
_____

Who was primarily responsible for raising you?_____

In the last twelve months-

Have you gambled more than you intended to?	☐ No	☐ Yes
Have you told anyone that you were winning money when you weren't?	☐ No	☐ Yes
Have you ever felt guilty about your gambling or the consequences of it?	☐ No	☐ Yes
Has anyone criticized you about your gambling?	☐ No	☐ Yes
Have you had arguments about the money you spend on gambling?	☐ No	☐ Yes

Please check any of the following substances that you have ever used.

☐ Cigarettes/Cigars ☐ Snuff/Chew ☐ Nicotine Vape
☐ Alcohol
☐ Marijuana ☐ Hash ☐ Cannabis ☐ Pot ☐ Dabs ☐ Cannabis Vape ☐ Cannabis edibles
☐ Methamphetamine ☐ Amphetamines ☐ Speed ☐ Crank ☐ Ice ☐ Crystal
☐ Cocaine ☐ Crack ☐ Rock
☐ Opium ☐ Morphine ☐ Heroin ☐ Codeine ☐ Darvon ☐ Fentanyl
☐ Percocet ☐ Percodan ☐ Oxycodone ☐ OxyContin ☐ Vicodin ☐ Hydrocodone
☐ Demerol ☐ Meperidine ☐ Dilaudid ☐ Hydromorphone ☐ Methadone
☐ Valium ☐ Xanax ☐ Librium ☐ Klonopin ☐ Rohypnol ☐ Benzodiazepine
☐ Ambien ☐ Sedatives ☐ Soma ☐ Muscle Relaxers
☐ GHB ☐ Quaaludes ☐ Ketamine
☐ Tranquilizers ☐ Barbiturates ☐ Barbital ☐ Seconal ☐ Tuinal ☐ Phenobarbital

☐ LSD ☐ Acid ☐ Psilocybin ☐ Mushrooms ☐ Peyote ☐ Mescaline ☐ DMT
☐ MDMA ☐ Ecstasy ☐ XTC ☐ Molly ☐ Methylone ☐ Butylone
☐ Bath Salts ☐ Cathinone ☐ MDPV ☐ Mephedrone
☐ PCP ☐ Angel Dust ☐ Sherm ☐ Wet
☐ Amyl Nitrate ☐ Poppers ☐ Nitrous Oxide ☐ Whippits
☐ Inhalants ☐ Glue ☐ Butane ☐ Gasoline
☐ Salvia ☐ Khat ☐ Mirra ☐ Kratom ☐ K2 ☐ Bufotein
☐ Other_____
☐ Other_____
☐ Other_____

Describe any negative impact the use of drugs or alcohol has had on your life:

Describe any concerns that you or anyone else has about your alcohol/drug use:

Have you ever driven a motor vehicle after consuming alcohol or drugs? ☐ No ☐ Yes

Did it ever result in arrest or charges for DUI or impaired driving? ☐ No ☐ Yes

Would you like to reduce or quit using alcohol or drugs? ☐ No ☐ Yes

Have you ever tried to quit alcohol or drugs in the past? ☐ No ☐ Yes

Are you currently experiencing symptoms of withdrawal from drug or alcohol?
☐ No ☐ Yes ☐ Unsure

If yes or unsure, please describe:

Have you ever experienced withdrawal from drugs or alcohol in the past?
☐ No ☐ Yes ☐ Unsure

If yes or unsure, which ones:

Have you ever used a substance to relieve or avoid withdrawals? ☐ No ☐ Yes

Have you ever been admitted to a Detoxification Facility? ☐ No ☐ Yes

Do you have any other concerns that need to be addressed as part of this evaluation? ☐ No ☐ Yes

If yes, describe:

_____

_____

_____

_____

_____

_____

Client Signature

_____

Date

M.A.S.T.

1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)	☐ No	☐ Yes
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?	☐ No	☐ Yes
3. Does any near relative or close friend ever worry or complain about your drinking?	☐ No	☐ Yes
4. Can you stop drinking without difficulty after one or two drinks?	☐ No	☐ Yes
5. Do you ever feel guilty about your drinking?	☐ No	☐ Yes
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	☐ No	☐ Yes
7. Have you ever gotten into physical fights when drinking?	☐ No	☐ Yes
8. Has drinking ever created problems between you and a near relative or close friend?	☐ No	☐ Yes
9. Has any family member or close friend gone to anyone for help about your drinking?	☐ No	☐ Yes
10. Have you ever lost friends because of your drinking?	☐ No	☐ Yes
11. Have you ever gotten into trouble at work because of drinking?	☐ No	☐ Yes
12. Have you ever lost a job because of drinking?	☐ No	☐ Yes
13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	☐ No	☐ Yes
14. Do you drink before noon fairly often?	☐ No	☐ Yes
15. Have you ever been told you have liver trouble such as cirrhosis?	☐ No	☐ Yes
16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?	☐ No	☐ Yes
17. Have you ever gone to anyone for help about your drinking?	☐ No	☐ Yes
18. Have you ever been hospitalized because of drinking?	☐ No	☐ Yes
19. Has your drinking ever resulted in your being hospitalized?	☐ No	☐ Yes
20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?	☐ No	☐ Yes
21. Have you been arrested more than once for driving under the influence of alcohol?	☐ No	☐ Yes
22. Have you ever been arrested, even for a few hours, because of other behavior while drinking?	☐ No	☐ Yes

DRUG USE QUESTIONNAIRE (DAST-20)

1. Have you used drugs other than those required for medical reasons?	☐ No	☐ Yes
2. Have you abused prescription drugs?	☐ No	☐ Yes
3. Do you abuse more than one drug at a time?	☐ No	☐ Yes
4. Can you get through the week without using drugs?	☐ No	☐ Yes
5. Are you always able to stop using drugs when you want to?	☐ No	☐ Yes
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐ No	☐ Yes
7. Do you ever feel bad or guilty about your drug use?	☐ No	☐ Yes
8. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ No	☐ Yes
9. Has drug abuse created problems between you and your spouse or your parents?	☐ No	☐ Yes
10. Have you lost friends because of your use of drugs?	☐ No	☐ Yes
11. Have you neglected your family because of your use of drugs?	☐ No	☐ Yes
12. Have you been in trouble at work because of drug abuse?	☐ No	☐ Yes
13. Have you lost a job because of drug abuse?	☐ No	☐ Yes
14. Have you gotten into fights when under the influence of drugs?	☐ No	☐ Yes
15. Have you engaged in illegal activities in order to obtain drugs?	☐ No	☐ Yes
16. Have you been arrested for possession of illegal drugs?	☐ No	☐ Yes
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ No	☐ Yes
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	☐ No	☐ Yes
19. Have you gone to anyone for help for a drug problem?	☐ No	☐ Yes
20. Have you been involved in a treatment program specifically related to drug use?	☐ No	☐ Yes

CAGE

Have you ever felt you should cut down on your drinking?	☐ No	☐ Yes
Have people annoyed you by criticizing your drinking?	☐ No	☐ Yes
Have you ever felt bad or guilty about your drinking?	☐ No	☐ Yes
Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover?	☐ No	☐ Yes

_____ _____

Client's signature Date