



FRESNO COUNTY REACH TEAM QUICK SCREEN

This assessment is to be completed by a certified Substance Abuse Specialist

Date: _____

Client Name: (last) _____ (first) _____ Case # _____ SSN: _____ - _____ - _____

Male Female DOB: _____ Race/Ethnicity: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Staff Name: _____ Phone: _____ FAX: _____

Referral Source: _____

Part I – AOD Use Information:

Drug of Choice: _____

Check all substances that client has used in the past or present and add any that are not listed:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Heroin/Opiates | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Methamphetamine / Crank | <input type="checkbox"/> Methadone | <input type="checkbox"/> Amphetamines |
| <input type="checkbox"/> Cannabis | <input type="checkbox"/> LSD | <input type="checkbox"/> Prescription Drugs |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> PCP | <input type="checkbox"/> OTC Drugs |
| <input type="checkbox"/> Crack/Rock | <input type="checkbox"/> Inhalants | <input type="checkbox"/> Other _____ |

Complete the following for each drug that client reports using within the last 6 months:

Drug (from above)	Age of highest/first use	Method of Use	Frequency of Use	Amount Used	Date of last use

Have you ever had life threatening withdrawals or symptoms? yes no

Are you currently having them? yes no

Have you been in treatment before? yes no

Comments: _____

Part II – Medical:

Are you taking any medications? _____

Are you pregnant? yes no Receiving prenatal care? yes no Due Date: _____

Any history of seizures, heart problems or other medical problems? _____



Part III – Emotional/Behavioral:

In the past 30 days have you felt or had difficulty with the following:

Sad, blue, depressed? Anxious thoughts and feelings? Thoughts that interrupted you?

Any current or past suicidal behaviors or ideations? _____*

Any current or past homicidal or violent behaviors or ideations? _____

Are you taking any medications for psychological problems? _____

Have you ever? _____

Any hallucinations that were not related to substances? _____

Any physical abuse? yes no Sexual abuse? yes no Comments: _____

Part IV – Readiness to Change:

Do you feel that treatment or recovery is necessary at this time? yes no

Stage of change/motivation level for treatment of substance abuse: _____

Ready for treatment with reservations Denial Minimization Seeks treatment

(Interviewer's assessment)_____

Part V – Relapse/Continued Use:

Are you likely to continue using? _____

What is the longest period in the last year that you have gone without any substances? _____

How many friends do you have? _____ How many of those friends use AOD? _____

Comments: _____

Part VI - Recovery Environment:

Is anyone in the home using substances? _____

If you were to decide today to quit using who would support your decision? _____

Are you on Probation or Parole? _____

***Note: If client is currently having thoughts of self-harm, walk them to the REACH Clinician or the I-Person at Pathways to Recovery**

Part IV – ASAM ratings Rate the client's level of functioning in the following areas from 1-4:

Intoxication/Withdrawal Potential: _____

Biomedical Conditions and Complications: _____

Emotional/Behavioral Conditions and Complications: _____

Readiness to Change: _____

Relapse/Continued use Potential: _____

Recovery Environment: _____

Referred to: _____

Screening format and questions adapted from Sacramento County Alcohol and Other Drug Screening Form, Stanislaus County Treatment Evaluation and Recommendation Report, and ASAM PPC2-R