Insurance? [ ] Yes [ ] NO- Ins. Company:	Member ID#	Phone # on back of INS card:	Date: / /
CLIENTS NAME:			PHONE #
Have you ever been a Client At CCS? [ ] Yes [ ] No	VITALS: BP: /	Pulse:	Temp: Resp:
Age: DOB:	SS#:	Marital Status:	US Citizen: [ ] Yes [ ] NO
Tennessee Resident: [ ] Yes [ ] NO	Are you a Veteran: [ ] Yes [ ] No	DUI: [ ] Yes [ ] NO	Gender: [ ]Male [ ]Female
Race: [ ] White [ ] Black [ ] Hisp/Lat. [ ] Other	Number of Children:	Ages & Gender of Children:	
Who has Custody?			Your Education Level:
Homeless [ ] Yes [ ] NO			COMMIT TO TX [ ] Yes [ ] NO
Client Mailing Address:			
City:		State:	Zip:
Phone: [ ]	County:	Referral Source Name:	
Relationship to Referral:			
Are you on Social Security: [ ] Yes [ ] No	SSI: [ ] Yes [ ] No	Do you have any Physical Disabilities: [ ] Yes [ ] No	
Employed: [ ]Yes [ ]No	If yes Where?	Job Description:	How Long?
Monthly Income:	Income Source(s):		
Do you have a Valid Driver's License: [ ] Yes [ ] No	Is this court ordered? [ ] Yes [ ] No		On Probation/Parole:[ ] Yes [ ] No
P.O./CM Name:			Notify court or P.O. if discharged early: [ ]Yes [ ]No
P.O./CM Phone #:	Probation Company:		
The number of arrests in the 30 days prior to admission? [ ] in the last two years? [ ]	Current Legal Issues:		
Previous Alcohol or Drug Treatment History (when/where)?			
Reason For Treatment (what happened recently) Presenting Problem:			

Name of Problem Substance	Prescribed Y/N	Date last Used	Dosage	Rating (1st,2nd,etc.)	Duration (How long)	Route	Frequency	Age of 1st Use

IV Drug Use: [ ] Yes [ ] No	Pregnant: [ ]Yes [ ]No Due Date:	Priority Status: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6	
Medical Problems (past and/or present):		Any Detox Symptoms?[ ] Yes [ ] No	Known Allergies:
Medications taking for medical problems:			History of seizures:[ ] Yes [ ] No
Have you ever tested positive for T.B.? [ ] Yes [ ] No		If Yes, When/Where?	
Last Physical Exam:		Primary Care Physician:	Phone:
Psychiatric Treatment (past and/or present): [ ] Yes [ ] No		If Yes, Diagnosis:	
Prescribed medication for psychiatric Problem:			
How long have medications been taken?		How long has medications been stopped?	
Suicidal ideations/attempts (when)?	Did you have a plan?	Current Living Situation:	
How long have you been there?		Living Plans on discharge:	
Is there drinking/drug use going on? [ ]Yes [ ]No		Same [ ] Family [ ]	Halfway House [ ]
Emergency Shelter Needed? [ ] Yes [ ] No		Other [ ] Undecided [ ]	
Transportation needed to treatment? [ ]Yes [ ]No		Housing Needed? [ ]Yes [ ] No	
Address/directions to pick-up location:		Level of care screened for: [ ] DETOX [ ] RTC [ ] IOP [ ] OP	

Payer Source: [ ] BG	[ ] CTC	[ ] ADAT	[ ] SPOT	[ ] ARP	[ ] Federal	[ ] INS	Self-Pay [ ]

Emergency/Alt. Contact	Address/City/State/ Zip	Phone	Relation

Date of Contact:	Type of Contact Made:	Date of Contact:	Type of Contact Made:
re: waiting list	[ ] Phone [ ] Letter [ ] Other	re: waiting list	[ ] Phone [ ] Letter [ ] Other

Agency Referred to:	[ ]Health Dept	[ ]12 Step AA	[ ]Hospital	[ ] Outpatient Counseling	[ ]Other
Details of Referral (Agency Name/Contact Information					
Date Interim Service Began:				Type of Interim Service:	
Screened By:		Actual Admit Date:		Date ASI Scheduled:	
Final Disposition:		Family Member/PO Notified: [ ]Yes [ ] No If so, who was notified?			
Additional Comments: (Include any problems that would interfere with Tx such as court date, Dr. apt., etc)					
Informed client of call in procedures If you fail to call in weekly your bed date will be given to someone else Initials.					Revised:4/29/15

Patient #_____

Mental Health Screening Form-III

Instructions: Read each question and circle the appropriate response. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins with "Have you ever….."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?

YES NO

3. Have you ever been advised to take medication for anxiety, depression, and/or hearing voices or for any other emotional problem?

YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?

YES NO

6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?

YES NO

7. Have you ever attempt to kill yourself?

YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?

YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?

YES NO

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

Revised January 22, 2014

12. Have you ever had a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?

YES NO

13. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

YES NO

14. Have you ever had a period of time when you were so full or energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? For example repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate?

YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?

YES NO

Comments:_____
_____
_____
_____

Total Score of YES responses _____ If you have checked more than three Yes remarks, it is suggested to contact a mental health provider. Would you like to be referred for an Psychiatric Evaluation: (Circle one) Yes No

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

CCS
COMPREHENSIVE COMMUNITY SERVICES

Drug Abuse Screening Test (DAST)

Patient # _____

To take the DAST, answer YES or NO to the following questions.

	YES	NO	
1	○	○	Have you used drugs other than those required for medical reasons?
2	○	○	Have you abused prescription drugs?
3	○	○	Do you abuse more than one drug at a time?
4	○	○	Do you use other drugs, meaning, do you use drugs other than those required for medical reasons?
5	○	○	Is it difficult for you to stop using drugs when you want to?
6	○	○	Do you abuse drugs on a continuous basis?
7	○	○	Do you try to limit your drug use to certain situations?
8	○	○	Have you had "blackouts" or "flashbacks" as a result of drug use?
9	○	○	Do you ever feel bad about your drug abuse?
10	○	○	Does your spouse (or parents) ever complain about your involvement with drugs?
11	○	○	Do your friends or relatives know or suspect you abuse drugs?
12	○	○	Has drug abuse ever created problems between you and your spouse?
13	○	○	Has any family member ever sought help for problems related to drug use?
14	○	○	Have you ever lost friends because of your use of drugs?
15	○	○	Have you ever neglected your family or missed work because of your use of drugs?
16	○	○	Have you ever been in trouble at work because of drug abuse?
17	○	○	Have you ever lost a job because of drug abuse?
18	○	○	Have you gotten into fights when under the influence of drugs?

Revised January 22, 2014

Drug Abuse Screening Test (DAST)

Patient # _____

	YES	NO	
19	○	○	Have you ever been arrested because of unusual behavior while under the influence of drugs?
20	○	○	Have you ever been arrested for driving while under the influence of drugs?
21	○	○	Have you engaged in illegal activities in order to obtain drugs?
22	○	○	Have you been arrested for possession of dangerous drugs?
23	○	○	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?
24	○	○	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?
25	○	○	Have you ever gone to anyone for help for a drug problem?
26	○	○	Have you ever been in a hospital for medical problems related to drug use?
27	○	○	Have you ever been involved in a treatment program specifically related to drug care?
28	○	○	Have you been treated as an out-patient for problems related to drug use?

Your DAST score is equal to the number of questions you answered YES.
A score of five or less points indicates a Normal Score.
A score of six or more points indicates a Drug Problem.

Comments:

_____

_____

_____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised January 22, 2014

CCS
COMPREHENSIVE COMMUNITY SERVICES

Short Michigan Alcoholism Screening Test (SMAST 13)

Patient # _____

Please circle the appropriate answer.

1. Do you feel you are a normal drinker?	Yes	No
2. Do your spouse or parents worry or complain about your drinking?	Yes	No
3. Do you ever feel bad about your drinking?	Yes	No
4. Do friends or relatives think you are a normal drinker?	Yes	No
5. Are you always able to stop drinking when you want to?	Yes	No
6. Have you ever attended a meeting of Alcoholics Anonymous?	Yes	No
7. Has drinking ever created problems between you and your spouse?	Yes	No
8. Have you ever gotten into trouble at work because of drinking?	Yes	No
9. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?	Yes	No
10. Have you ever gone to anyone for help about your drinking?	Yes	No
11. Have you ever been in the hospital because of drinking?	Yes	No
12. Have you ever been arrested even for a few hours because of drinking?	Yes	No
13. Have you ever been arrested for drunk driving or driving after drinking?	Yes	No

A "No" answer to question 1,4, and 5, and each "Yes" response to the other questions earn one point. Two points indicate a possible problem. Three points indicate a probable problem.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised January 22, 2014

AUTHORIZATION TO EXCHANGE INFORMATION
FOR ALCOHOL AND DRUG TREATMENT PROGRAM

Sections 1-4 must be completed for this release to be valid

6145 TEMPLE STAR ROAD
KINGSPORT TENNESSEE 37660
423-349-4070 Fax: 423-349-6597

_____/_____Client received a copy of this completed release

_____/_____Client declined a copy of this completed release

_____ I'm refusing to sign consent to release information to any previous/current medical or mental health care professional.

Section 1:

I, _____SS#_____DOB:_____,

Authorize the following organization and/or person(s) to exchange information with Comprehensive Community Services, 6145 Temple star Road, Kingsport Tennessee, 37660

_____
Name of Organization/Person(s)-Required Relationship/Title

_____
Address of Organization (including City, State, Zip Code)-REQUIRED

_____ _____
Telephone Number Fax Number

Section 2:
For what purpose is this information being requested (Required): Admission, Coordination of Care, After Care and Follow Up Treatment

Section 3:
INFORMATION TO BE RELEASED: (This section is REQUIRED. Only specified information will be released. Requests for "any/or All records" will not be honored) Circle one.

[Y N] Admission Summary	[Y N] Preadmission Assessment	[Y N] Medical Records
[Y N] Treatment Plans	[Y N] This Completed Release Form	[Y N] Disciplinary Reports
[Y N] Weekly Case Reviews	[Y N] Social History	[Y N] Aftercare Plan
[Y N] Pre-Admission	[Y N] Verbal Progress Reports	[Y N] Discharge Summary
[Y N] A.S.I	[Y N] Medication History	[Y N] Other_____
[ ] Verify Admission	[ ] ADAT, SPOT, BG, ARP, INS, SELF	[Y N] Yes on all

THE ABOVE INFORMATION IS NECESSARY FOR THE FOLLOWING PURPOSES (CHECK EACH APPLICABLE CATEGORY):

[Y N] Follow-Up Treatment/Aftercare	[Y N] Family/Significant Other Involvement	[Y N] Further Evaluation
[Y N] Referral Source Feedback	[Y N] Coordination of Care with Physician	[Y N] Other:_____
[Y N] Legal Involvement/Follow-Up	[Y N] Diagnosis and Treatment	[Y N] Yes on all

Section 4: I understand that my alcohol and/or drug treatment records are protected under Federal regulations governing Confidentiality and Drug Abuse Client records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPPA Privacy Law. The federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R.; Part 2, noted above however, will continue to protect the confidentiality of information that identifies me as a Client in an alcohol or other drug program from re-disclosure. I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken in reliance on it. This consent will expire automatically after 365-days from the date which it is signed. This release is only valid for this admission, no prior or future admissions. I hereby release Comprehensive Community Services, the administrator, personnel, staff, and the organization stated above from all legal responsibilities or liability that may arise from the release of such records. I also acknowledge the understanding that this release does not interchange for the release of information from any other treatment programs. I also understand that generally, Comprehensive Community Services, may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. This authorization to obtain and release information is fully understood and is voluntary on my part.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Date Revoked:_____

By Whom: _____

Staff: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information without the express written consent of the individual to whom it pertains, except in emergency conditions specified by those regulations. A general release or generic release for medical or other information is NOT sufficient for this purpose.