

ADAPT SCREENING FORM

Client Name: _____

Date: _____

| | | Please check Yes or No | |
|--|--|--|----|
| During the past 6 months: | | Yes | No |
| 1 | Did you often use larger amounts of alcohol or drugs or use them for a long time than you had planned or intended? | | |
| 2 | Did you try to cut down on alcohol or drugs and were unable to do it? | | |
| 3 | Did you spend a lot of time getting alcohol or drugs, using them, or recovering from their use? | | |
| 4 | Did you often get so high or sick from alcohol or drug that it a. Kept you from doing work, going to school, or caring for children? b. caused an accident or became a danger to yourself or others? | | |
| 5 | Did you often spend less time at work, school, or with friends so that you could drink or use drugs? | | |
| 6 | Did your use of alcohol or drugs often cause – a. Emotional or psychological problems? b. Problems with family, friends, work, or police? c. physical health or medical problems? | | |
| 7 | Did you increase the amount of alcohol or a drug you were taking so that you could get the same effects as before? | | |
| 8 | Did you ever keep drinking or taking a drug to avoid withdrawal or keep from getting sick | | |
| 9 | Did you get sick or have withdrawal when you quit or missed drinking or taking a drug. | | |
| 10 | Which drugs or alcohol caused you the MOST serious problems? | # of days used in last 30 days | |
| | Primary Substance | | |
| | Secondary Substance | | |
| | Tertiary Substance | | |
| Total Score* | | | |
| <p><small>*Score: 1 point for each "Yes" response. Questions 4 & 6 are worth 1 point each if the respondent answers "Yes" to any portion. The total score can range from 0-9; score values of 3 or greater may indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis. A formal assessment should be performed to comprehensively evaluate the nature of the problem. Response to question 10 indicate which drug (or drugs) the respondent feels is primarily responsible for his/her drug-related problems. A score of 1 or 2 may indicate a substance abuse problem. Referral to an intervention service or a more in depth evaluation may be indicated.</small></p> | | | |
| 11 | How often did you inject drugs with a needle? | <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always | |
| 12 | How serious do you think your drug problems are? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Extremely | |
| 13 | How many times before now have you ever been in an alcohol/drug treatment program | | |
| 14 | Do you think that you need treatment for your alcohol/drug use now? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | How important to you is it that you get into some type of treatment program | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Extremely | |
| 15 | How many times have you received psychiatric treatment or counseling services for reasons other than alcohol or drugs? | | |
| 16 | Do you currently have a medical condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | If "yes" what? | | |

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| | | | |
|-----------|---|-------------------------------------|--|
| 17 | What medications have you been prescribed or have you been taking in the past 6 months for substance abuse problems? | | |
| | | | |
| | | | |
| 18 | Have you used needles to inject drugs | | |
| | a. Within the past two years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | b. At any time within the past 20 years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19 | Have you shared injecting equipment | | |
| | a. Within the past two years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | b. At any time within the past 20 years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20 | Have you ever had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barriers with person(s) whose HIV status is unknown: | | |
| | a. More than 10 times within the past two years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | b. At any time within the past 20 years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21 | Have you had unprotected sex with someone known to inject drugs | | |
| | a. Within the past two years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | b. At any time within the past 20 years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22 | Have you ever had unprotected sex (vaginal/oral/anal penetration) without condoms or latex barriers with person(s) whose sexual history is unknown: | | |
| | a. Within the past month? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | b. Within the past 6 months? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23 | Have you had a persistent cough (longer than three months) for which you have not seen a physician | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24 | Have you been tested (screened for TB) within the past year? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25 | Are you currently feeling suicidal? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If "yes," do you have a plan? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26 | Are you currently being treated by a mental health clinician? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If "yes", clinicians name: | | |
| | | If "yes," when was your last visit? | |
| 27 | Have you smoked at least 100 cigarettes in your entire life? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28 | Do you smoke: | | <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Never smoked |
| 29 | How long has it been since you quit | | |

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Client Statement

I have answered all questions on this form to the best of my ability.

Client Signature

Date

Staff Printed

Date

Staff Signature

QCC/ DATE

Referral recommendation after Screening

| | |
|--------------------------|--|
| Referral: | |
| Basis for Recommendation | Does the client's score warrant a formal assessment and a referral is made for a formal assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is follow-up necessary | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Comments: | |