



Welcome to Associated Behavioral Health. Please fill out the following screening packet as completely and accurately as possible. Note that all information that you give is confidential and will be disclosed only to individuals or agencies to which you give written consent. Failure to report information accurately may result in the need for a new assessment.

PERSONAL HISTORY

How were you referred to us today? (Please circle) Attorney Probation / Court Friend Internet

Dex Seattle Yellow Pages Dex Eastside Yellow Pages Other Yellow Pages Other

Today's Date Office Location: Bellevue North Seattle West Seattle

Name First Middle Last

Address Street City State

Date of Birth Age Social Security #:

Cell Phone ( ) Phone ( ) Email:

Name of person or organization to whom you would like this report sent:

Have you ever been in the military? Branch and years

Marital/Relationship Status? Children? With whom do you live? Any drug/alcohol use in home?

Length of Education? Occupation and Employer? Length of Employment?

LEGAL HISTORY (If Applicable)

Current legal action (s) pending: Description of arresting incident including how much you had to drink or used:

Breathalyzer test results (if taken) Were you cited with refusal of the breathalyzer test? Yes No

Previous arrests: Charge(s) and year:

Next court date: Jurisdiction/Court Location: Case #

Are you petitioning for a deferred prosecution?

PHYSICAL / MENTAL HEALTH HISTORY

How would you rate your current physical health? Good Fair Poor

Have you ever had any serious illnesses, injuries or medical concerns?

Are you currently taking any medications? Yes No If yes, please describe:

Do you have any family history of physical or mental health problems?

Have you ever been diagnosed or suspected you had a mental health condition (such as depression, anxiety or panic attacks)?  Yes  No

Explain: \_\_\_\_\_

Have you recently experienced suicidal thoughts?  Yes  No In the past?  Yes  No

Have there been in changes in your sleeping patterns? \_\_\_\_\_ Any changes in your eating habits? \_\_\_\_\_

Would you say your self-esteem is: \_\_\_\_\_ high \_\_\_\_\_ moderate \_\_\_\_\_ low

### SUBSTANCE USE HISTORY

At what age did you first try alcohol? \_\_\_\_\_. When was the last time you had alcohol? \_\_\_\_\_ At what age did you drink the most and

How often and how much did you drink at a time? \_\_\_\_\_

How often have you consumed alcohol recently? \_\_\_\_\_ How much do you drink at a time? \_\_\_\_\_

How long have you gone without drinking or using since your use began? \_\_\_\_\_

How many times have you driven after drinking alcohol? \_\_\_\_\_

Mark any mood altering substances you have ever used in your life:

Marijuana  Cocaine  Amphetamines  Hallucinogens  Ecstasy  Heroin  Other \_\_\_\_\_

Mark any mood altering substances you have ever used in the past six month:

Marijuana  Cocaine  Amphetamines  Hallucinogens  Ecstasy  Heroin  Other \_\_\_\_\_

Please describe use: (including first use, peak use pattern and date of last use) \_\_\_\_\_

Have you ever received education or treatment for alcoholism or drug addiction?  Yes  No If yes explain: \_\_\_\_\_

Have you received a previous assessment for alcohol or drug use?  Yes  No

Have you ever attended a meeting of Alcoholics Anonymous or Narcotics Anonymous?  Yes  No

Do you think you have a problem with alcohol or other drugs?  Yes  No

Do you have a family history of alcohol and/ or drug abuse?  Yes  No If yes who \_\_\_\_\_

Have you ever abused prescription medication?  Yes  No

*Washington Administrative Code 440-22-565 requires that you furnish us with a copy of your Five (5) Year Complete Driving Record Abstract, which includes a history of all segments of your driving record, including Department of Licensing administrative action. This is in order to complete your DUI/PC Alcohol/Drug Evaluation. We request that you go to the nearest Washington State Driver's License Examining Office and get a copy of your Five (5) year Complete Driving Abstract. Your DUI/PC Alcohol/Drug Evaluation report will not be mailed to the Department of Licensing (All releases need to be completed) until we have received your Five (5) Year Complete Driving Record Abstract. The Department of Licensing will charge you \$4.50 for your abstract, payable at the Examining Office. The location of the nearest Washington State Driver's License Examining Office can be found in the phone book under Government Pages, Washington State.*

*Please return a copy of your Five (5) Year Complete Driving Record Abstract to us within five (5) days of your DUI/PC Alcohol/Drug Evaluation appointment.*

## Counselor Disclosure Statement

Counselors practicing for a fee must be registered with the Department of Licensing or certified by the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. The following information is required to be provided prior to commencing treatment.

### FEES

Associated Behavioral Health treatment fees are outlined and agreed to in your Financial Agreement.

### REGISTRATION

The purpose of the law regulating counselors is to provide protection for the public health and safety, and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

### PLEASE ASK YOUR COUNSELOR IF YOU HAVE ANY ADDITIONAL QUESTIONS OR CONCERNS ABOUT THEIR QUALIFICATIONS

## Confidentiality

*The confidentiality of patient records maintained by Associated Behavioral Health is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a client unless:*

1. The patient consents in writing; OR
2. The disclosure is allowed by a court order; OR
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation; OR
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_