FACES Professional Services LLC

I_____ authorize _____ at the

above address to:

___ Release of any records regarding results in alcohol & drug assessments, urine drug screens, treatment diagnosis and recommendations and information to sent to the following people listed below. I understand these individuals may communicate through fax/email/phone with the above facility and (therapists, specialists, family members, probation officers, state workers or legal entities).

I give permission to release my information to:

1) Name, Address: _____

_____

Email Address: _____

2) Name, Address: _____

_____

Email Address:_____

For the purpose of:

___ A&D Assessment ____ Other: _____

___ Court Referral _____

___ Probation Referral _____

___ DCS Referral

Signed :_____ Date:_____

Here are your 4 step instructions to begin:

1. Copy off the paperwork I have emailed you to complete- It will take you 1 hour. (Be very honest in all answers).
Once completed Email or Fax paperwork to me to 423-717-5600.

2. Look for a Paypal email with your invoice. (Check spam folder if needed).

3. Pay the invoice ASAP so I can enroll into the last assessment, SASSI-4 online.

4. After enrolled, you will be emailed a link to click and complete SASSI-4 online assessment. It is very easy and takes 15 minutes.

5. Once your 4 steps are complete above, I can begin writing the final report. It takes 3 days-3 weeks, depending on our agreement on your due date.

6. After I am 98% finished with final report, we need to complete your phone interview.

7. You will receive the final report no later than 2 days after our phone interview.

You may text me any questions throughout this process. I am always available.

Thank you,

Deneen

Release of Records:

I am requesting a service provided and agree the service will be provided. I have been invoiced by D. Deneen Bunch through paypal and will be paying for this service provided through paypal. I understand documentation may be provided to prove the service was provided. I understand there are no refunds for this service provided.

Name:_____

Date:_____

Email:_____

Phone:_____

FACES Professional Services LLC

Personal Information: **(use N/A for not applicable)**

Name: _____

Gender: _____

Age: _____ Date of Birth: _____

Race: _____

Address: _____

Phone#: _____

Social Security #: _____

Employment (Full time or Part Time): _____

Marital Status: _____

Number in Household: _____

Highest education completed: _____

Number of total arrests: _____

What were reasons for and dates of all Arrests in your history? _____

_____

Number of DUI/DWI Arrests: _____

Blood Alcohol Content (0. ##): _____

Prior Alcohol and Drug Treatment: _____

How did you locate our agency?_____

(Examples- Google, website, psychology today.com, web search)

The information above will be used for the Final Assessment Report and to enroll you into SASSI-4 online assessment.

Signature: _____ Date: _____

COUNSELING & THERAPY
INTAKE ASSESSMENT SCREENING

GENERAL INFORMATION

Date: _____

Name (self) _____ Date of Birth: _____

Marital Status (check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed ☐Significant Relationship

Education: What is the last grade completed (degree)? _____

Occupation: _____ How Long?: _____

Who referred you here or how did you hear about these services? _____

Is there a particular problem that brought you here to seek therapy? _____

Can you identify areas that you'd like to work on in therapy? _____

DRUG USAGE HISTORY

Route of Administration: (1) Oral (2) Smoking (3) Inhalation (4) Injection (5) Other
Severity: (0) No Problem (1) Primary (2) Secondary (3) Tertiary

Drug	Amt/Freq	Last Use	Length of Use	Age of 1st Use	Route	Severity

Do you use tobacco products? ☐Yes ☐No If yes, what, how much and how long? _____

Do you use caffeine products? ☐Yes ☐No If yes, what, how much and how long? (Include caffeinated beverages, diet pills, etc.) _____

Withdrawal Symptoms? ☐Yes ☐No List Symptoms: _____

How often do you use alcohol (circle one)? ☐Yearly ☐Monthly ☐Weekly ☐Daily

MEDICAL INFORMATION

Who is your personal or family physician? _____ Phone #: _____

Clinic: _____ Address: _____

Pregnant: ☐Yes ☐No Hepatitis: ☐Yes ☐No If yes, What type? _____

TB Test: ☐Yes ☐No Date: _____

Allergies: _____

Do you have any current concerns about your physical health? Please specify: _____

_____

_____

Have you had any significant medical problems in the past? Please specify: _____

_____

_____

Have you ever been hospitalized for psychological problems? ☐Yes ☐No

If yes, when and where? _____

Previous or current therapy/counseling. Please list any therapy/counseling that you or other members of your family/household have received. What led you to seek therapy/counseling at that time or times? How would you describe the results of that therapy/counseling? _____

_____

_____

Are you taking any medications for anxiety, depression or nervous tension? If so, what and how much? Who prescribed the medication? _____

_____

_____

Please list any medications you are currently taking, or have taken during the past year: _____

_____

_____

Have you had any previous Mental Health, Alcohol or Drugs and/or Psychiatric Treatment? ☐ Yes ☐ No

If yes, Where? _____ When? _____

Reason: _____

Current/Past Suicidal Ideation: ☐Yes ☐No Plan: ☐Yes ☐No

Current/Past Homicidal Ideation: ☐Yes ☐No Plan: ☐Yes ☐No

Explain: _____

FAMILY/RELATIONSHIP BACKGROUND

Father's Name: _____ Age: _____

If deceased, indicate age at death and year of heath: _____

Occupation: _____

Briefly describe his alcohol/drug use: _____

Mother's Name: _____ Age: _____

If deceased, indicate age at death and year of heath: _____

Occupation: _____

Briefly describe her alcohol/drug use: _____

If you were not brought up by your parents, who raised you? Between what years? _____

_____

In your family life as a child, list any critical events and your age when they occurred (e.g. deaths, divorce, hospitalization, loss of job, a difficult move, etc.) _____

_____

List the names, ages and occupations of children in your family of origin in order of birth including yourself (brothers and sisters): _____

_____

_____

MARRIAGE/LONG TERM PARTNERSHIP (CURRENT)

What is your partner's age? _____ How long have you been a couple? _____

What is your partner's occupation? _____

What is your partner's pattern of alcohol/drug use? _____

Indicate your level of satisfaction with the relationship: 1= Very Dissatisfied.....5=Very Satisfied

1----------2----------3----------4----------5

Do you have any children? ☐Yes ☐No If yes, how many? _____

Please give their name, ages and sexes: _____

_____

Do any of your children present special problems? ☐Yes ☐No Please list: _____

_____

LEGAL HISTORY

Have you been arrested in the last (2) years? ☐Yes ☐No If yes, how many times? _____

Are you presently incarcerated? ☐Yes ☐No If yes, what is your release date? _____

Upcoming court dates? ☐Yes ☐No If yes, please list when, where and why: _____

_____

Substance Abuse/Chemical Dependency Assessment

Client name: _____ Case #: _____

General symptoms of chemical dependency (check all that apply) :

___ preoccupation
___ loss of control
___ prescription abuse
___ use to reward self
___ daily use
___ A.M. drinking
___ pre-drinking
___ unable to stop
___guilt/remorse
___ hiding supply
___ sneaking use
___use to reduce stress
___ seizures
___ blackouts
___ binging

Notes/triggers: _____

Physical- withdrawal symptoms of chemical dependency:

___ tremors ___ delirium (DTs) ___ seizures ___ high blood pressure
___ hepatitis ___ nosebleeds ___ ulcers ___ gastritis

Other symptoms: _____

Behavior- personality changes associated with use:

___ verbally abusive
___ physical abuse
___ excessive anger
___ more/less social
___ effects on morality or spirituality
___ un-kept promises
___ social isolation
___ labile mood
___ depression
___ more relaxed
___ family concerned
___ work concerned
___ insomnia
___ sexual performance
___embarrassed by behavior during use

Notes: _____

Financial and legal history:

___ wages garnished
___ repossessions
___ bankruptcy
___ suspended license
___ legal problems
___ collection agency

List date of arrest if known:

DWI/DUI _____ Possession _____ Drug sales _____
Burglary _____ Other _____
Domestic violence _____ History of probation:

_____

Problems in job, school or other role functions:

___ attendance
___ disciplined
___ erratic behavior
___ promises to improve
___ tardiness
___ argumentative
___ using at work/school
___ deteriorating performance
___ Monday or Friday absences
___ accidents/safety violations

Treatment history: (indicate dates of treatment)

Detox _____ Outpatient _____ Aftercare _____
Inpatient _____ Other _____ longest abstinence _____

Substance abuse/alcohol/chemical dependence history: *(for client aged twelve and over, please complete for each substance used including past use or substances not being used. Include over the counter medications, prescriptions, controlled substances, nicotine patches and alcohol)*

___ Client reports past history of use, but is now abstinent: _____

Substance used	Amount/frequency	Age began	Length of use	Last used

Do you use tobacco products? ___ yes ___ no If yes, how much and how long?: _____

_____

Do you use caffeine products? This includes: soft drinks, coffee, tea, diet pills, etc.

___ yes ___ no What and how long: _____

_____

Withdrawal symptoms? ___ yes ___ no List symptoms: _____

_____

How often do you use alcohol? ___ yearly ___ monthly ___ weekly ___ daily

Other addictions:

___ eating ___ spending ___ gambling ___ sexual ___ codependency
___ Other _____

To be completed by agency staff:

Chemical dependency assessment summary

Chemical dependency apparent: ___ yes ___ no
Chemical abuse apparent: ___ yes ___ no
Refer for evaluation of level of care ___ yes ___ no

Clinician signature credentials date

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

_____

_____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

CAGE Alcohol Abuse Screening Tool

The CAGE questionnaire, the name of which is an acronym of its four questions, is a widely used screening test for problem drinking and potential alcohol problems (alcoholism).

Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

C	Have you ever felt the need to cut down on your drinking?	Yes	No
A	Have people annoyed you by criticizing your drinking?	Yes	No
G	Have you ever felt guilty about drinking?	Yes	No
E	Have you ever felt you needed a drink first thing in the morning (Eye-Opener) to steady your nerves or to get rid of a hang over?	Yes	No

Fast alcohol screening test (FAST)

FAST is an alcohol harm assessment tool. It consists of a subset of questions from the full alcohol use disorders identification test (AUDIT). FAST was developed for use in emergency departments, but can be used in a variety of health and social care settings.

Questions	Scoring system					
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

AUDIT Screening Tool

	Questions	0	1	2	3	4	Score Totals	Sub Scores
1	How often do you have a drink containing alcohol?	NEVER	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week		
2	How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more		
3	How often do you have 5 or more drinks in one occasion?	NEVER	Less than monthly	Monthly	Weekly	Daily or almost daily		
4	How often during the last year have you found that you were not able to stop drinking once you started?	NEVER	Less than monthly	Monthly	Weekly	Daily or almost daily		
5	How often in the last year have you failed to do what was normally expected of you because of drinking?	NEVER	Less than monthly	Monthly	Weekly	Daily or almost daily		
6	How often during the last year have you needed a first drink in the morning to get yourself going ager a heavy drinking session?	NEVER	Less than monthly	Monthly	Weekly	Daily or almost daily		
7	How often during the last year have you had a feeling of guilt or remorse after drinking?	NEVER	Less than monthly	Monthly	Weekly	Daily or almost daily		
8	How often during the last year have you been unable to remember what happened the night before because of your drinking?	NEVER	Less than monthly	Monthly	Weekly	Daily or almost daily		
9	Have you or someone else been injured because of your drinking?	NO		Yes, but not in last year		Yes, during the last year		
10	Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	NO		Yes, but not in last year		Yes, during the last year		
						Total		

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

Date: _____

Patient Name: _____ DOB: _____

Brief Psychiatric Questionnaire

Medical History: Check any current or previous health problems.

____ Anxiety or Panic Attacks
____ Alcohol or Drug Problems
____ Emotional, Physical or Sexual Abuse
____ Forgetfulness Resulting in Accidents
____ Frequent Pain such as Headache or Backache
____ Heart Problems or High Blood Pressure
____ Serious Illness or Operation
____ Stroke or Prolonged Fainting Spells
____ Several Unexplained Physical Problems
____ Problems Not Listed Above: _____

____ Appetite or Weight Changes
____ Asthma or Lung Problems
____ Family Psychiatric Problems
____ Hallucinations
____ Head Injury or Seizures
____ Loss of Energy or Motivation
____ Suicidal Thoughts or Attempts
____ Thyroid/Endocrine Problems
____ Violent Behavior

Habits: Describe if answer is "Yes".

____ Smoke Cigarettes _____
____ Drink Caffeine _____
____ Use Alcohol or Recreational Drugs _____
____ Have you ever felt you should cut down on your use of alcohol or recreational drugs?
____ Have people annoyed you by criticizing your use of alcohol or recreational drugs?
____ Have you ever felt guilty about your use of alcohol or recreational drugs?
____ Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to relieve a hangover?

Prescribed Medications and Drug Allergies:

Please list your prescribed medications, including dosage.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any medication? _____ If yes, please list medication: _____

Background Information:

The highest level of school completed during your formal education was _____.
During adulthood, I have worked as _____.

Stressful Life Events: Please "X" if happened to you in the past, or "XX" if during the past 12 months.

__ Death of Spouse
__ Jail Term
__ Personal Injury/Illness
__ Retirement
__ Child Leaving Home
__ Problems with Family Members
__ Gain of a New Family Member
__ Marital Separation
__ Death of friend/family member
__ Marriage
__ Sexual Difficulties
__ Work Dissatisfaction
__ Change in Social/Recreational Activities
__ Divorce
__ Fired from Job
__ Financial/Legal Problems
__ Changing Residence
__ Spouse Starts/Ends Work