TREATMENT ASSIGNMENT PROTOCOL ASSESSMENT (TAP) - CLIENT INFO

CLIENT PROFILE

Current First Name: _____ Current Last Name: _____

Birth First Name: _____ Birth Last Name: _____

Gender: ☐ Male ☐ Transgender Identifies as Male
☐ Female ☐ Transgender Identifies as Female ☐ Transgender Unknown

DOB: _____ SSN: _____ County _____

Intake ID: _____ UCN: _____

Ethnicity: ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Specific Hispanic ☐ Not of Hispanic Origin
☐ Hispanic – specific origin unknown ☐ Unknown

Race: ☐ Alaska Native ☐ American Indian ☐ Black or African American ☐ White ☐ Asian ☐ Other Single Race
☐ Two or More Races ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic/Latino ☐ Unknown

Veteran Status: ☐ Yes ☐ No ☐ Unknown

Address Type: ☐ Client Billing ☐ Client Home ☐ Client Homeless ☐ Client Mailing ☐ Client Previous
☐ Client Unknown ☐ Client Work

Address Line 1: _____

Address Line 2: _____

City: _____ State _____ Zip _____

***Please note, a Client Group Enrollment (CGE) must be completed when entering profile data into PA WITS.**

Initial Contact Date: _____ Initial Contact: ☐ Phone ☐ Referral ☐ Walk-In

Intake Date: _____ Pregnant: ☐ Yes ☐ No ☐ Unknown

(If Yes, enter Due Date ____/____/____)

Source of Referral:

☐ SCA
☐ Court/Criminal Justice – DUI/DWI
☐ Court/Criminal Justice – Diversionary Program
☐ Court/Criminal Justice –Drug Court/Treatment Court
☐ Employer/EAP
☐ Hospital/Physician
☐ Drug and Alcohol Abuse Care Provider
☐ Court/Criminal Justice – Juvenile
☐ Court/Criminal Justice –State Probation/Parole
☐ Other Non-Voluntary
☐ Clergy/Religious
☐ Other Community Agency
☐ Unknown
☐ Court/Criminal Justice – Other
☐ Court/Criminal Justice – Prison
☐ Court/Criminal Justice – Other Legal Entity
☐ Court/Criminal Justice –State/Federal Court
☐ School/SAP
☐ Court/Criminal Justice – Unknown
☐ PDMP
☐ Court/Criminal Justice – County Probation/Parole
☐ Court/Criminal Justice – Federal Probation/Parole
☐ Other Voluntary
☐ Family/Friend
☐ Self

Injection Drug User: ☐ Yes ☐ No

Scheduled Assessment Date: _____ Actual Assessment Date: _____

Did client complete scheduled assessment? ☐ Yes ☐ No Scheduled Admission Date: _____

Special Initiatives/Populations (check all that apply): ☐ None ☐ Buprenorphine ☐ Methadone
☐ Student Assistance Program ☐ Veteran ☐ Vivitrol ☐ Women w/Children

Interview Date: _____

Type of TAP: ☐ Intake ☐ Follow-up

Contact Code: ☐ In Person ☐ Telephone ☐ Referral How Long at Current Address: _____ Yrs _____ Mos

of Residence: _____ Is the Residence Owned by You or Family? ☐ Yes ☐ No

Primary Payment Source: ☐ Self-Pay ☐ Blue Cross/Blue Shield ☐ Medicare ☐ Medicaid
☐ Other Government Payments ☐ SCA ☐ Workers' Compensation ☐ Other Health Insurance Companies
☐ No Charge (Free, Charity, Special Research or Teaching) ☐ Other ☐ Unknown

Controlled Environment in Last 30 Days? ☐ No ☐ Jail ☐ Alcohol/Drug TX ☐ Medical TX ☐ Psychiatric TX ☐ Other

Interviewer: _____

How Many Days In Controlled Environment _____

Days Attended AA/NA/Similar Meetings in Last 30 Days _____

Months Since Discharged from Last Admission: _____ Is This a TAP for Concerned Person: ☐ Yes ☐ No

Religious Preference: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Islamic ☐ Other ☐ None

TREATMENT ASSIGNMENT PROTOCOL (TAP) ASSESSMENT - WITHDRAWAL

1. What is the longest # of days in a row that you have gone without using alcohol and/or drugs:

   a. In the last 30 days? _____ b. In the last 6 months? _____

2. Is the client reporting or exhibiting any of the following symptoms:

☐ Abdominal cramps/diarrhea	☐ Anxiety/ Depression	☐ Back spasms
☐ Excessive sweating	☐ Excessive Yawning	☐ Hallucination
☐ Increased pulse rate	☐ Insomnia, Sleep Disturbance	☐ Leg Cramps
☐ Nausea, vomiting	☐ Psychomotor Agitation	☐ Runny Nose
☐ Seizures	☐ Tremors	☐ Watery eyes

3. How many times in your life have you been treated for: a. Alcohol abuse? _____ b. Drug abuse? _____

4. How many of these were for: a. Alcohol detox only? _____ b. Drug detox only? _____

5. How many days in the last 30 have you been treated for alcohol and/or drugs as an:
   a. In-patient _____ b. Out-patient? _____

6. How many times in the last 30 days have you used:
   a. Alcohol? ☐ 1-2 times per week ☐ 1-3 times per month ☐ 2-3 times daily ☐ 3-6 times per week ☐ Daily ☐ More than 3 times daily ☐ No use in past month ☐ Unknown
   b. Drugs? ☐ 1-2 times per week ☐ 1-3 times per month ☐ 2-3 times daily ☐ 3-6 times per week ☐ Daily ☐ More than 3 times daily ☐ No use in past month ☐ Unknown

7. How many days in the last 30 have you experienced:

   a. Alcohol problems? _____ b. Drug problems? _____

8. How many times have you had: a. Alcohol DTs? _____ b. A drug overdose? _____

9. Do you sometimes use prescription, over the counter medication, alcohol, or an illicit drug to relieve withdrawal symptoms? ☐ Yes ☐ No

10. Have you noticed the need to increase the amount you use to achieve the same effect or high, or sometimes feel less effect or high, after using your usual amount? ☐ Yes ☐ No

11. Would you say that you often use more than you initially intended to over a longer period of time? ☐ Yes ☐ No

12. Have you ever had blackouts while drinking or using; drank or used enough that you could not remember what you said or did the next day? ☐ Yes ☐ No

13. Would you say that you spend a great deal of time obtaining the substance(s) you use, using them, and/or recovering from their effects? ☐ Yes ☐ No

14. IV drug use in the past? ☐ Yes ☐ No

15. What kind of tobacco do you currently use? ☐ None ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Snuff ☐ Other (specify) _____ ☐ NA ☐ Unknown

16. If cigarettes, indicate daily amount: ☐ ½ to 1 pack ☐ 1 to 2 packs ☐ Less than ½ pack ☐ Greater than 2 packs ☐ Unknown

17. Would there be adequate support at home for you if you needed help while detoxing? ☐ Yes ☐ No

18. Do you have significant problems with other possible addictions such as sex, eating disorders, or gambling? ☐ Yes ☐ No

Interviewer Rating:

19. How would you rate the client's need for detox treatment? ☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

_____

MEDICAL

1. How many times in your life have you been hospitalized for medical treatment? _____

2. How long ago was your last hospitalization for a physical problem? Yrs _____ Mo _____

3. Do you have a history of, or current diagnosis of any of the following: *(Select all that apply)*

☐ Abscess	☐ Arthritis	☐ Cardiac
☐ Cirrhosis or liver problems	☐ Diabetes	☐ Emphysema
☐ Fractures	☐ Gastrointestinal bleeding	☐ Hearing Problems
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ Lung/breathing problems	☐ Pancreatitis	☐ Seizures
☐ Sexually transmitted disease	☐ Vision	

4. Do you have chronic medical problems which continue to interfere with your life? ☐ Yes ☐ No

5. Are you taking any prescribed medication on a regular basis for a physical problem? ☐ Yes ☐ No

   If yes, please list: _____

6. How many days in the last 30 have you experienced medical problems? _____

7. How troubled have you been in the last 30 days by these medical problems?

   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

8. How many times in the last 30 days have you visited an ER? _____

9. Have you ever been diagnosed with TB? ☐ Yes ☐ No

10. Are you currently using birth control? ☐ Yes ☐ No

11. What is your weight? _____ lbs.

12. Have you noticed a recent weight loss? ☐ Yes ☐ No

13. How many times in the last 6 months have you been hospitalized due to a non-Tx drug and/or alcohol related problem? _____

Interview Rating:

14. How would you rate the client's need for medical treatment?

   ☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

_____

_____

CO-OCCURRING

1. How many times have you been treated for any psychological or emotional problems in a hospital or in-patient setting? _____

Have you had a significant period, that was not a direct result of alcohol/drug use, in which you have:

(*The questions require a Yes/No response for both columns*.)	Past 30 Day	Lifetime
2. Experienced serious depression, sadness, hopelessness, lack of interest?	☐ Yes ☐ No	☐ Yes ☐ No
3. Experienced serious anxiety, tension, inability to relax, unreasonable worry?	☐ Yes ☐ No	☐ Yes ☐ No
4. Experienced hallucinations or saw/heard things that did not exist?	☐ Yes ☐ No	☐ Yes ☐ No
5. Experienced trouble understanding, concentrating, remembering?	☐ Yes ☐ No	☐ Yes ☐ No
6. Experienced trouble controlling violent behavior including rage or violence?	☐ Yes ☐ No	☐ Yes ☐ No
7. Experienced serious thoughts of suicide?	☐ Yes ☐ No	☐ Yes ☐ No
8. Attempted suicide?	☐ Yes ☐ No	☐ Yes ☐ No
9. Been prescribed meds for psychological or emotional problems?	☐ Yes ☐ No	☐ Yes ☐ No

If #9 is yes, please specify medications: _____

_____

10. How many days in the last 30 have you experienced psychological or emotional problems? _____

11. How troubled have you been in the last 30 days by these emotional problems?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

12. Psychiatric problem in addition to alcohol/drug problem? ☐ Yes ☐ No

Interview Rating:

At the time of the interview was the client:

13. Obviously withdrawn/depressed? ☐ Yes ☐ No

14. Obviously hostile? ☐ Yes ☐ No

15. Obviously anxious/nervous? ☐ Yes ☐ No

16. Having trouble with reality testing, thought disorders, paranoid thinking? ☐ Yes ☐ No

17. Having trouble comprehending, concentrating, remembering? ☐ Yes ☐ No

18. Having suicidal thoughts? ☐ Yes ☐ No

19. How would you rate the client's need for treatment for emotional problems?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

_____

_____

Motivation

1. Is the client motivated to change his/her alcohol/drug use? ☐ Yes ☐ No

2. Are there any medical conditions which interfere with the client's treatment needs? ☐ Yes ☐ No

   If yes, please specify _____

   _____

3. How important now to the client is treatment for these medical problems?

   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

4. Are there any psychological conditions which interfere with the client's treatment needs? ☐ Yes ☐ No

5. How important now to the client is treatment for these psychological problems?

   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Interview Rating:

6. How would you rate the client's readiness to change?

   ☐ Action ☐ Contemplation ☐ Determination ☐ Maintenance ☐ Pre-contemplation ☐ Relapsed

Notes: _____

_____

_____

Alcohol/Drug Usage

1. Which substance(s) is/are considered the client's Primary, Secondary, Tertiary problems? If None, check here: ☐

Substance Rating - 1 = Primary 2 = Secondary 3 = Tertiary
Age – Enter age in years. Enter "96" if Not Applicable. If age is Unknown, enter "97".
Severity – 1 = Severe Problem 2 = Moderate Problem 3 = Mild Problem 4 = Not a problem 5 = N/A
Frequency – 1 = Daily 2 = 1-3x month 3 = 1-2x week 4 = 3-6x week 5 = N/A 6 = Not in past month 7 = Unknown
Method – 1 = Oral 2 = Smoking 3 = Inhalation 4 = Injection 5 = Snorted 6 = Other 7 = N/A 8 = Unknown

1. Rating	Substance	2. Prescribed?	3. Age/Use	4. Severity	5. Freq.	6. Method
	Alcohol	☐ Yes ☐ No ☐ N/A				
	Cocaine - Crack	☐ Yes ☐ No ☐ N/A				
	Marijuana/Hashish	☐ Yes ☐ No ☐ N/A				
	Heroin	☐ Yes ☐ No ☐ N/A				
	Methadone	☐ Yes ☐ No ☐ N/A				
	Other Opiates and Synthetics	☐ Yes ☐ No ☐ N/A				
	PCP	☐ Yes ☐ No ☐ N/A				
	Hallucinogens	☐ Yes ☐ No ☐ N/A				
	Methamphetamine/Speed	☐ Yes ☐ No ☐ N/A				
	Other Amphetamines	☐ Yes ☐ No ☐ N/A				
	Other Stimulants	☐ Yes ☐ No ☐ N/A				
	Benzodiazepines	☐ Yes ☐ No ☐ N/A				
	Other Tranquilizers	☐ Yes ☐ No ☐ N/A				
	Barbiturates	☐ Yes ☐ No ☐ N/A				
	Other Sedatives or Hypnotics	☐ Yes ☐ No ☐ N/A				
	Inhalants	☐ Yes ☐ No ☐ N/A				
	Over the Counter Medications	☐ Yes ☐ No ☐ N/A				
	Other Drugs	☐ Yes ☐ No ☐ N/A				
	Unknown	☐ Yes ☐ No ☐ N/A				
	None		96		5	7

7. Have you ever tried to reduce or control your use of this substance?

a. Primary ☐ Yes ☐ No b. Secondary ☐ Yes ☐ No c. Tertiary ☐ Yes ☐ No

8. Has anyone ever asked you to stop using these substances?

a. Primary ☐ Yes ☐ No b. Secondary ☐ Yes ☐ No c. Tertiary ☐ Yes ☐ No

9. What was the date of last use? a. Primary _____ b. Secondary _____ c. Tertiary _____

Other Addictions: _____

10. Is Methadone Maintenance Planned? ☐ Yes ☐ No

11. Have you ever attended a self-help/support group (AA/NA, R/R, church, etc.)? ☐ Yes ☐ No

12. Last substance admission environment in the last 10 years:

- ☐ N/A
- ☐ 0.5 – Early Intervention
- ☐ 1 – Outpatient Service
- ☐ 1-WM – Ambulatory Withdrawal Management without Extended On-Site Monitoring
- ☐ 2-WM – Ambulatory Withdrawal Management with Extended On-Site Monitoring
- ☐ 2.1 – Intensive Outpatient
- ☐ 2.5 – Partial Hospitalization
- ☐ 3.1 – Clinically Managed Low-Intensity Residential
- ☐ 3.3 – Clinically Managed Population Specific High-Intensity Residential
- ☐ 3.5 – Clinically Managed Medium-Intensity Residential (Adolescent)
- ☐ 3.5 – Clinically Managed High-Intensity Residential (Adolescent)
- ☐ 3.5 – Clinically Managed High-Intensity Residential (Adult)
- ☐ 3.5 – Clinically Managed Highest-Intensity Residential (Adult)
- ☐ 3.7 – Medically Monitored Intensive Inpatient
- ☐ 3.7 – Medically Monitored High-Intensity Inpatient (Adolescent)
- ☐ 3.7-WM – Medically Monitored Inpatient Withdrawal Management
- ☐ 4 – Medically Managed Intensive Inpatient
- ☐ 4-WM – Medically Managed Intensive Inpatient Withdrawal Management

13. Number of prior substance admissions: _____

Interview Rating:

14. How would you rate the client's potential for continued use?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

_____

_____

EMPLOYMENT

1. Education: ☐ Unknown ☐ None
   Highest Grade Completed: ☐ For grades 1-11 enter the number _____
   ☐ High School Diploma ☐ GED ☐ Some College ☐ Associates Degree ☐ Bachelor's Degree ☐ Graduate Degree

2. Training or technical education? Yrs. _____ Mo. _____

3. Do you have a profession, trade, or skill? ☐ Yes ☐ No If yes, please specify: _____

4. Do you have a valid driver's license? ☐ Yes ☐ No

5. Do you have an automobile available for use? ☐ Yes ☐ No

6. Longest full-time job? Yrs _____ Mo _____

7. Usual or last occupation?
   ☐ Crafts/Operatives ☐ Farm Owners/Laborers ☐ Laborers - Not Farm ☐ None
   ☐ Professional/Managerial ☐ Sales ☐ Service/Household

8. Does someone contribute to your support in any way? ☐ Yes ☐ No

9. Does this constitute the majority of your support? ☐ Yes ☐ No

10. Employment Status: ☐ Full Time (Salary Unknown)
   ☐ Full-time - Annual Salary:
   ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000–$39,999 ☐ $40,000 - $49,999 ☐ $50,000+
   ☐ Part-time ☐ Unemployed
   ☐ Not in Labor Force: ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled
   ☐ Resident of Institution ☐ Other ☐ Unknown
   ☐ Unknown

11. Employer: _____

12. How many days in the last 30 were you paid for work? (Include "under the table") _____

How much money did you receive from the following resources in the last 30 days:

13. Employment (gross)?	$ _____	16. Pension, SS, benefits?	$ _____
14. Unemployment comp?	$ _____	17. Mate, family, friends?	$ _____
15. Welfare?	$ _____	18. Illegal?	$ _____

Current Gross/Taxable Individual monthly income $ _____

19. What is your primary source of income? ☐ Wages/Salary ☐ Public Assistance ☐ Retirement/pension
   ☐ Disability ☐ Other ☐ None ☐ Unknown

19a. Other Income Sources: ☐ Disability ☐ None ☐ Other ☐ Public Assistance ☐ Retirement/pension
   ☐ Unknown ☐ Wages/Salary

20. How many months have you been employed during the last 6 months? _____

21. How many days in the last 30 have you experienced employment problems? _____

22. How many days of work and/or school have you missed in the last 6 months due to substance abuse related problems? _____

23. Do you have current health insurance? ☐ Private Insurance ☐ Blue Cross/Blue Shield ☐ Medicare ☐ Medicaid
   ☐ HMO ☐ Health Choices ☐ SCA ☐ Other ☐ None ☐ Unknown

24. If yes, does it cover substance abuse treatment? ☐ Yes ☐ No

Interview Rating:

25. How would you rate the client's need for employment services?
   ☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

FAMILY/SOCIAL RELATIONSHIPS

1. What is your current relationship status?
   ☐ Unknown ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

2. Are you satisfied with this situation? ☐ Yes ☐ No ☐ Indifferent

If no, please specify: _____

3. What has been your usual living arrangement?
   ☐ Homeless ☐ Dependent Living ☐ Independent Living ☐ Unknown

4. How long have you lived in these arrangements? Yrs _____ Mo _____

5. Are you satisfied with these arrangements? ☐ Yes ☐ No ☐ Indifferent

6. Do you live with anyone who:
   a. Has a current alcohol problem? ☐ Yes ☐ No
   b. Uses non-prescribed drugs? ☐ Yes ☐ No

7. With whom do you spend most of your free time? ☐ Alone ☐ Family ☐ Friends

8. Are you satisfied spending your free time this way? ☐ Yes ☐ No ☐ Indifferent

9. How many close friends do you have? _____

10. Select the people with whom you have had a close, long lasting relationship:

    ☐ Brother/Sister ☐ Children ☐ Father ☐ Friends ☐ Mother

11. Have you had significant periods in the last 30 days or in your lifetime in which you have experienced serious problems getting along with your:

(*The questions require a Yes/No response for both columns*.)	**Past 30 Days**	**Lifetime**
Mother?	☐ Yes ☐ No	☐ Yes ☐ No
Father?	☐ Yes ☐ No	☐ Yes ☐ No
Brother/sister?	☐ Yes ☐ No	☐ Yes ☐ No
Sexual partner/spouse?	☐ Yes ☐ No	☐ Yes ☐ No
Children?	☐ Yes ☐ No	☐ Yes ☐ No
Other significant family?	☐ Yes ☐ No	☐ Yes ☐ No
Close friends?	☐ Yes ☐ No	☐ Yes ☐ No
Neighbors?	☐ Yes ☐ No	☐ Yes ☐ No
Co-workers?	☐ Yes ☐ No	☐ Yes ☐ No

12. Have any of these people abused you? If so, how and when?

(*The questions require a Yes/No response for all columns*.)

Person	Past 30 Days			Lifetime		
	Emotionally	Physically	Sexually	Emotionally	Physically	Sexually
Mother	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Father	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Brother/sister	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Sexual Partner/spouse	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Children	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Other Significant Family	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Close friend	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Neighbor	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Co-worker	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

13. How many children do you have age 17 or less (birth, adopted, or stepchildren) whether they live with you or not? _____

14. How many of these children spent the last 6 months living with you? _____

15. Are any of your children living with someone else because of a child protection order? ☐ Yes ☐ No

16. Does your substance use cause problems at home with your partner, kids, or home obligations? ☐ Yes ☐ No

17. Do you have a DSS case worker? ☐ Yes ☐ No

18. How troubled have you been in the last 30 days by:

    a. Family problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

    b. Social problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

19. Have you given up or reduced your involvement in important social or recreational activities that did NOT include drinking or using? ☐ Yes ☐ No

20. Is there a family history of substance abuse or dependency? ☐ Yes ☐ No

Interview Rating:

22. How would you rate the client's need for family or social counseling?

    ☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

_____

_____

LEGAL

1. Was this admission prompted by the criminal justice system? ☐ Yes ☐ No

2. Are you on parole or probation? ☐ Yes ☐ No

How many times have you been arrested and/or charged and/or convicted for the following: (*Leave gray areas blank)*

	Arrested	Charged	Convicted
3. Shoplifting/vandalism?			
4. Parole/probation violation?			
5. Drug charges?			
6. Forgery?			
7. Weapons offense?			
8. Burglary, larceny, B & E?			
9. Robbery?			
10. Assault?			
11. Arson?			
12. Rape?			
13. Homicide/manslaughter?			
14. Prostitution?			
15. Contempt of court?			
16. OWI in the last 12 months?			
17. Non-drug or alcohol-related crime while under the influence in the last 12 months?			
18. Non-drug or alcohol-related crime while not under the influence in the last 12 months?			
19. Drug or alcohol-related crime in the last 12 months?			
20. Other?			

21. How many times have you been arrested in the past 12 months? _____

22. How many times have you been arrested in the past 30 days? _____

23. How many months were you incarcerated in your life? Yrs _____ Mos _____ Days _____

24. How long was your last incarceration? Yrs _____ Mos _____ Days _____

25. What was it for? _____

26. Are you presently awaiting charges, trial, or sentence? ☐ Yes ☐ No

27. If yes, what for? _____

28. How many days in the last 30 were you detained or incarcerated? _____

29. How many days in the last 30 have you engaged in illegal activities for profit? _____

30. How serious do you feel your current legal problems are?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Interview Rating:

31. How would you rate the client's need for legal services?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes: _____

_____

_____

SUMMARY

Interviewer Confidence Rating:

1. In your opinion, is the information in this assessment significantly distorted due to client's misrepresentation?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

2. In your opinion, is the information in this assessment significantly distorted due to client's ability to understand?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Comments _____

_____

_____

_____

_____

Assessment Duration

Interview: Start Date _____ End Date _____ Total Interview Time _____

MISCELLANEOUS NOTES

Gambling Notes:

Summary: _____

_____

_____

_____

1. Have you lied to cover up the extent of your gambling? ☐ Yes ☐ No

2. Have you bet increasing amounts of money to achieve the level of desired excitement? ☐ Yes ☐ No

TB Screening:

Summary: _____

_____

_____

_____

1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB-incidence areas (Asia, Africa, South America, Central America)? ☐ Yes ☐ No

2. Are you a recent immigrant (within the past 5 years) from a high TB-risk foreign country (includes countries in Asia, Africa, South America, and Central America)? ☐ Yes ☐ No

3. Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? (*If residents of any of these facilities were tested within the past three months, they don't need to have their risk for TB reassessed.) ☐ Yes ☐ No

4. Have you had any close contact with someone diagnosed with TB? ☐ Yes ☐ No

5. Have you been homeless within the past year? ☐ Yes ☐ No

6. Have you ever been an injection drug user? ☐ Yes ☐ No

7. Do you or anyone in your household, currently have the following symptoms, such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?
☐ Yes ☐ No