[Insert organisation name/logo]

# CLIENT ASSESSMENT FORM

**🖌Note\***

This template has been adapted from the Adult Alcohol and Drug (AOD) Screening and Assessment Tool, Step 2: Comprehensive assessment for adults with AOD problems from the [Department of Health, Victoria](http://www.health.vic.gov.au/aod/sectorreform.htm).

The [Step 2: Comprehensive assessment for adults with AOD problems](http://docs.health.vic.gov.au/docs/doc/C1FD9A6163F330F7CA257B11006DBF4B/$FILE/Step%202%20-%20Comprehensive%20Assessment%20for%20adults%20with%20AOD%20problems.pdf) document was last accessed on 4 November 2013.

This template is only a guide of a general assessment form and provides 7 sections with a thorough review of past and present client factors. It is understood that each organisation implement different assessment processes and tools, it is recommended that organisations adapt this template to better suit individual organisational requirements. For example, each section of the document can be used separately before or after the client intake however it is the organisation responsibility to adapt and implement the template to suit the clients and organisational needs.

In addition it should be noted that many organisations now integrate client assessment into electronic client management systems.

\*Please delete note before finalising this policy.

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## Section 1. Substance Use

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.1 Substance use history**  [Detail name of specific substances used] | **Route of use [oral, inject, etc.]** | **Age at first use** | **When last used** | **No. days used in the last month** | **Average amount used daily** | **Frequency/ duration used / pattern** | **Effect sought** | **Dependency (see below)** |
| **Tobacco products** |  |  |  |  |  |  |  |  |
| **Alcoholic beverages** |  |  |  |  |  |  |  |  |
| **Cannabis** [marijuana, pot, grass, hash, etc.] |  |  |  |  |  |  |  |  |
| **Amphetamine type stimulants**  [speed, meth, ice, ecstasy] |  |  |  |  |  |  |  |  |
| **Inhalants**  (Nitrous, glue, petrol, paint thinner, etc.) |  |  |  |  |  |  |  |  |
| **Sedatives or Sleeping pills**  [benzodiazepines, xanax,  valium, rohypnol, etc.]  **Prescribed: □Yes □ No** |  |  |  |  |  |  |  |  |
| **Hallucinogens**  (LSD, acid, mushrooms, PCP, Special K, etc.) |  |  |  |  |  |  |  |  |
| **Opioids**  [Heroin, codeine, methadone, oxycodone, morphine, etc.]  **Prescribed: □Yes □ No** |  |  |  |  |  |  |  |  |
| **Emerging Psychoactive Substances** (kronic, bath salts, etc) |  |  |  |  |  |  |  |  |
| **Other**  [cocaine, GHB, etc] |  |  |  |  |  |  |  |  |

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| **1.2 Current drug use state** [signs of intoxication, withdrawal, BAC] |
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| **1.3 AOD use history and behaviours** | |
| **Tick as many boxes as relevant to**  **indicate when experienced** | **Notes** |
| **1.3.1 Periods of abstinence**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.2 Treatment / interventions**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.3 Hospitalisations/ED presentations related to AOD use**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.4 Overdoses**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.5 Withdrawal and related complications (seizures, delirium, hallucinations, etc.)**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.6 Risky injecting practices (shares equipment, etc.)**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.7 Drives while intoxicated (or under the influence of**  **other drugs)**  □Current (within the last four weeks) □Past □Never |  |
| **1.3.8 Have you or someone else (e.g. children, family significant others, friends etc.) been hurt (mentally or physically) because of your drinking or use of drugs other than alcohol?**  □Current (within the last four weeks) □Past □Never |  |

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| **1.4 Notes/actions/patterns of use:** |
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## Section 2. Medical History

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| **2.1 Problem/condition/experience** [tick appropriate] | | | |
| **□ Allergies** | **□ Cardiac or respiratory**  **problems**  (e.g. asthma, emphysema, high blood pressure, heart attack/ angina) | **□ Gastrointestinal/**  **hepatic problems**  (e.g. liver disease, pancreatitis, gastric ulcer, reflux) | **□ Skeletal injuries or**  **problems**  (e.g. back injury, limb fracture or injury] |
| **□ Endocrine**  **problems**  (e.g. diabetes) | **□ Neurological problems**  (e.g. fits, seizures, epilepsy, migraines) | **□ Head injuries** | **□ Dental problems** |
| **□ Chronic pain**  **condition** | **□ Pregnancy** | **□ Other:** | |

**2.2 Would the client like to be tested for blood borne viruses? □Yes □No**

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| **2.3 History of conditions, investigations and treatments where appropriate:** |
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| **2.4 Client and clinician perspective of the role of AOD in medical issues** |
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| **2.5 Current prescribed medications** (including methadone, psychotropic medication, over-the-counter-drugs, and complementary medicines) | | | | |
| **Medication** | **Reason for prescription** | **Prescribed dose and duration of treatment** | **Taken as prescribed (if no, reason?)** | **Prescriber/pharmacy and pick-up arrangements** |
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| **2.6 Notes and actions:** |
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## Section 3. Mental Health

**🖌Note\***

Organisations are encouraged to identify and implement a mental health screener tool to suit their individual organisations requirements. The below section is just a guide, and not a replacement for your current Mental Health screener tool for example K10 (Kessler Psychological Distress Scale. For more information about Mental Health screener tool please refer to the NADA document [“A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings”](http://www.nada.org.au/media/17954/nada_review_of_tools_and_measures_final_apr09.pdf)

\*Please delete note before finalising this policy

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| --- | --- | --- | --- |
| **3.1 Current diagnosed conditions** [tick appropriate] | | | |
| **□ Depression** | **□ Anxiety** | **□ Psychosis** | **□ PTSD** |
| **□ Bipolar disorder** | **□ Other:**  (Please specify) | | |

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| **3.2 History, treatments and outcomes (current diagnosis, community treatment order, past diagnosis, history of trauma, hospitalisations):** |
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| **3.3 Mental state** | |
| **Appearance/ Behaviour**  Grooming, hygiene, eye contact, motor activity, abnormal movements |  |
| **Speech**  Rate, volume (loud, quiet, whispered), quantity (poverty of speech, monotonous, mutism), fluency (stuttering, slurring, normal) |  |
| **Mood/Affect**  Client (Self) rated mood on a scale of 1-10. Staff observed affect; Anxious, elevated, blunted, labile (uncontrollably/excessively sad, happy, angry), incongruent, range and intensity |  |
| **Thoughts: Form**  Amount and speed of thought, poverty of ideas. Flight of ideas, perseveration, loosening of associations, continuity of ideas, disturbances in language (incoherence) |  |
| **Thoughts: Content**  Delusions, suicidal thought, obsession and phobias |  |
| **Perceptions**  Hallucinations (auditory, visual taste, touch, smell), depersonalisation, derealisation, illusions, distortion of senses, misinterpretation of true sensation |  |
| **Cognition**  Level of consciousness & alertness, memory (recent and past), orientation, concentration |  |
| **Insight/Judgement**  Client’s knowledge of problem and need for treatment. Reasoned, poor or impaired judgement |  |

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| **3.4 Notes** (role of AOD use in mental health issues, actions, etc.) |
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## Section 4. Suicide Prevention, Self-Harm and risk to others

**🖌Note\***

The following Suicide Risk Screener is part of the Suicide Assessment Kit (SAK)\* from the National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia. Refer to the Suicide Risk Screener Instructions in the Client Clinical Management Policy for more information in how to complete the screener.

If your organisation is using a different tool, please insert the tool/screener below and delete the SAK template attached below. Please note that all the information and templates in the NADA Policy Toolkit is just a guide, and not a replacement for your current self-harm and suicide risk screener.

For more information on Suicide and Self-harm Prevention refer to section to the Client Clinical Management Policy on the NADA Policy Toolkit.

\*Deady, M., Ross, J. & Darke, S. (2011). Suicide Assessment Kit (SAK). Sydney: National Drug and Alcohol Research Centre.

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| **Screen completed by** |  | |
| **Date** |  | **Time: .am/pm** |

**I need to ask you a few questions on how you have been feeling, is that ok?**

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| **1. In the past 4 weeks did you feel so sad that nothing could cheer you up?**  □ All of the time □ Some of the time □ Most of the time    □ A little of the time □ None of the time |
| **2. In the past 4 weeks, how often did you feel no hope for the future?**  □ All of the time □ Some of the time □ Most of the time    □ A little of the time □ None of the time |
| **3. In the past 4 weeks, how often did you feel intense shame or guilt?**    □ All of the time □ Some of the time □ Most of the time    □ A little of the time □ None of the time |
| **4. In the past 4 weeks, how often did you feel worthless?**  □ All of the time □ Some of the time □ Most of the time    □ A little of the time □ None of the time |
| **5. Have you ever tried to kill yourself?**   |  |  | | --- | --- | | **Yes\*** | **No** |   **If Yes,**   1. How many times have you tried to kill yourself? □ Once □ Twice □3 + 2. How long ago was the last attempt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Please mark □ In the last 2 months □ 2-6 months ago □ 6-12 months ago  □ 1-2 years ago □ More than 2 years ago   1. Have things changed since? |
| **6. Have you gone through any upsetting events recently?**  **(tick all that apply**)   |  |  | | --- | --- | | **Yes\*** | **No** |   □ Family breakdown □ Relationship problem □ Impending legal prosecution  □ Trauma □ Chronic pain/illness □ Loss of loved one  □ Child custody issues □ Conflict relating to sexual identity  □ Other (specify below) |
| |  |  | | --- | --- | | **Yes\*** | **No** |   **7. Have things been so bad lately that you have thought about killing yourself?**  **If No, skip to question number 10.**  **If Yes, please complete below**  a. How often do you have thoughts of suicide? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  b. How long have you been having these thoughts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  c. How intense are these thoughts when they are most severe?  □ Very intense □ Intense □ Somewhat intense □ Not at all intense  d. How intense are these thoughts in the last week?  □ Very intense □ Intense □ Somewhat intense □ Not at all intense |
| |  |  | | --- | --- | | **Yes\*** | **No** | | **Yes\*** | **No** | | **Yes\*** | **No** |   **8. Do you have a current plan for how you would attempt suicide?**  **If Yes, please complete below**  a. What method would you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Access to means?)  b. Where would this occur?\_\_\_\_\_\_\_\_\_(Have all necessary preparations been made?)  c. How likely are you to act on this plan in the near future?  □ Very likely □ Likely □ Unlikely □ Very unlikely |
| **9. What has stopped you acting on these suicidal thoughts?** |
| |  |  | | --- | --- | | **Yes\*** | **No** |   **10. Do you have any friends/family members you can confide in if you have a serious problem?**   1. Who is/are this/these person/people? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. How often are you in contact with this/these person/people? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   □ Daily □ A few days a week □ Weekly □ Monthly □ Less than once a month |
| **11. What has helped you through difficult times in the past?** |

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| **Client presentation/statements (tick all that apply)**  □ Agitated □ Disorientated/confused □ Delusional/ hallucinating  □ Intoxicated □ Self-harm □ Other: \_\_\_\_\_\_\_\_\_  **NOTE**: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically HIGH |

**Yes\*** = Indicates high risk answer

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| **Workers rated risk level** | **□ Low** | **□ Moderate** | **□ High** |

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| **Level of risk** | **Suggested response** |
| **Low**   * No plans or intent * No prior attempt/s * Few risk factors * Identifiable ‘protective’ factors | * Monitor and review risk frequently * Identify potential supports/contacts and provide contact details * Consult with a colleague or supervisor for guidance and support * Refer client to safety plan and keep safe strategies should they start to feel suicidal. |
| **Moderate**   * Suicidal thoughts of limited frequency, intensity and duration * No plans or intent * Some risk factors present * Some ‘protective’ factors | * Request permission to organise a specialist mental health service assessment as soon as possible * Refer client to safety plan and keep safe strategies as above * Consult with a colleague or supervisor for guidance and support * Remove means where possible * Review daily |
| **High\*:**   * Frequent, intense, enduring suicidal thoughts * Clear intent, specific/well thought out plans * Prior attempt/s * Many risk factors * Few/no ‘protective’ factors   \*or highly changeable | * If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone * Remove means where possible * Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available * Consult with a colleague or supervisor for guidance and support |

## Section 5. Psychosocial

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| **5.1 Resources and Supports** |
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| **5.2 Genogram / Ecomap** |
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| **5.3 Family, Children and Social relationships** (child care responsibilities and impact of substance use on these, child protection involvement, child’s perception of a caregiver’s substance use and their perception of impacts) |
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| **5.4 Housing** |
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| **5.5 Finances, employment and training** |
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| **5.6 Current legal status** [tick appropriate] |
| **□** No criminal justice involvement **□** Parole **□** Bail/charged  **□** Community correction order **□**Court order **□** Bond  **□** Combined custody and treatment order  **□** Compulsory treatment (Severe Substance dependence Act 2011)  **□** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Charges pending, offences and legal history** |
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## Section 6. Assessment summary

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| **Assessment outcome:** |
| **□Priority □Waiting list □ [Insert group program name/s] □ Referral to another agency**  **□Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **6.1 Client allergies** |
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| **6.2 Goals and reasons for presentation** (including client demographics e.g. gender, age & presenting issues) |
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| **6.3 Substances used and dependence** | |
| **Main substance used** | **Other substances used** |
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| **Dependence** | |
| **□ Mild dependence □ Moderate dependence □ Severe dependence** | |

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| **6.4 Medical** | | | | | | | |
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| **6.5 Mental health** | | | | | | | |
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| **6.6 Suicide prevention, self-harm and risk to others** | | | | | | | |
| Suicide screener attached | | | | □ Yes □No | | | |
| Suicide risk Formulation template attached | | | | □ Yes □No | | | |
| If no, please explain the reasons | | | | | | | |
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| Suicide prevention | | | | Self-harm | | Risk to other | |
| □ Low  □ Moderate  □ High\*  \*High risk levels require immediate action, for more information refer to the Client Clinical Management of the NADA Policy Toolkit. | | | | □ Low  □ Moderate  □ High\* | | □ Low  □ Moderate  □ High\* | |
| Comments | | | | | | | |
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| **6.7 Psychosocial** | | | | | | | |
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| **6.8 Brief Case formulation** | | | | | | | |
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| **6.9 Treatment type(s) required** | | | | | | | |
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| **6.10 [Insert organisation name] actions** | | | | | | | |
| **Date** | | **Action** | | | | | |
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| **6.11 Referrals** | | | | | | | |
| **Date** | **Agency name** | | | | **Contact details** | | **Referral form completed** |
|  |  | | | |  | | □ Yes □No |
|  |  | | | |  | | □ Yes □No |
|  |  | | | |  | | □ Yes □No |
| **6.12 Your agency’s detailed care/treatment plan complete:** | | | | | | | |
| **□ No** | | | **[insert date]** | | | | |
| **□ Yes** | | | **[Insert date]** | | | | |
| **Review date** | | | **[insert review date]** | | | | |

## Section 7. Client Assessment Checklist

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| **Section details** | **Complete** |
| **Section 1. Substance Use** | **□Yes □No** |
| **Section 2. Medical History** | **□Yes □No** |
| **Section 3. Mental Health** | **□Yes □No** |
| **Section 4. Suicide Prevention, Self-Harm and risk to others** | **□Yes □No** |
| **Section 5. Psychosocial** | **□Yes □No** |
| **Section 6: Assessment summary** | **□Yes □No** |
| **Section 7: Client assessment checklist** | **□Yes □No** |