CO-OCCURRING DISORDERS ASSESSMENT

CLEAR FORM

I. Current Substance Use

A. Alcohol Screening Questions

1 Drink = 12 Ounces of Beer

1. How often do you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 3 times a week	☐ 4+ times a week
1a. How many 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+
1b. How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

Alcohol Screening Score:_____Was a Brief Intervention Provided? ☐ Yes ☐ No

B. Drug Screening Questions

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? ☐ Yes ☐ No

2. Drug Type(s) Used (Indicate with an "*" which substances are most preferred.)	Ever Used? Yes	Ever Used? No	Recently Used? (Past 6 Months) Yes	Recently Used? (Past 6 Months) No	Route of Administration or other comments (IV use, smoking, snorting, etc.)
Amphetamines (Meth, crank, ice, etc.)	☐	☐	☐	☐	
Cocaine or crack	☐	☐	☐	☐	
Hallucinogens	☐	☐	☐	☐	
Inhalants	☐	☐	☐	☐	
Marijuana	☐	☐	☐	☐	
Nicotine (Cigarettes, cigars, smokeless tobacco)	☐	☐	☐	☐	
Opiates (Heroin, codeine, etc.)	☐	☐	☐	☐	
Over the Counter Meds (Cough syrup, diet aids, etc.)	☐	☐	☐	☐	
Sedatives (Pain meds, etc.)	☐	☐	☐	☐	
Other (specify): _____	☐	☐	☐	☐	

C. Additional Comments (i.e. frequency, duration of use, etc.):

II. Family History of Alcohol and/or Drug Use

Please describe any history of family alcohol and/or drug use (i.e. mother, father, etc.)

III. Past and Current Substance Use Treatment/Self-Help

1. Have you received help in the past for substance use issues (e.g. Self-Help or Professional)? ☐ Yes ☐ No

   If yes, please list the dates you were enrolled: From_____To_____From_____To _____
   Was it beneficial? If so, how?

   _____

2. Are you currently enrolled in a substance use program? ☐ Yes ☐ No
   If yes, what was your date of enrollment?_____Please specify the type of program it is:_____

   Were you referred to mental health services by this program? ☐ Yes ☐ No
   Referred by:_____ Contact Number: _____
   ☐ Records were requested on (date): _____

3. Additional comments:

Client Name: _____

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IV. Benefits of Substance Use

How true is the following about substance use for you:	Very True	Somewhat True	Not True	Comments
It is important in socializing with friends	☐	☐	☐	
It helps me meet and get to know people	☐	☐	☐	
It lowers my anxiety when I'm with people	☐	☐	☐	
It makes me feel less depressed or empty	☐	☐	☐	
It makes me feel less anxious	☐	☐	☐	
It helps me forget my problems	☐	☐	☐	
It helps me sleep better	☐	☐	☐	
It gives me something to look forward to	☐	☐	☐	
It is an important source of pleasure to me	☐	☐	☐	
It helps reduce my boredom	☐	☐	☐	
It is one of the only things that makes me feel okay	☐	☐	☐	
It is chiefly a habit or helps to avoid withdrawal	☐	☐	☐	
It enhances sexual experiences	☐	☐	☐	
It helps me lose weight	☐	☐	☐	

V. Costs of Substance Use

Is it possible that your substance use has played a role in or contributed to any of the following:	Yes	No
Problems keeping or getting housing (i.e. eviction, homeless)?	☐	☐
Problems at school or work?	☐	☐
Legal problems (i.e. DUI, possession, public intoxication, dealing)?	☐	☐
Money problems (i.e. lack of money)?	☐	☐
Developing or not attending to health problems (i.e. physical exams, dental exams, treatment)?	☐	☐
Feeling sick before or after using?	☐	☐
Ignoring my mental health treatment?	☐	☐
Increasing my mental health symptoms?	☐	☐
Not taking my medications as prescribed?	☐	☐
Being rejected or judged by others?	☐	☐
Conflicts with or losing friends and/or family?	☐	☐
Getting into dangerous situations (i.e. that involve weapons, unprotected sex, trading sex for drugs, sharing needles)?	☐	☐
Feeling a sense of anger/guilt/shame or feeling like a failure?	☐	☐

VI. Readiness for Change/Treatment Plan Identification

1. In looking over the benefits and costs of your alcohol/drug use, how do the costs compare to the benefits?

_____

2. Which benefits seem most important to you?_____

3. If we could identify or develop healthier ways for you to achieve those benefits (identified in #2), do you think it might be easier for you to cut down on your alcohol/drug use? ☐ Yes ☐ No
4. Which of the costs do you think cause the most overall problems for you? _____

_____

5. Are you willing or wanting to address any of these costs? If so, how?

_____

6. Which of these costs do you think affects your Mental Health symptoms the most and might be important to try to reduce?

_____

7. On a scale of 0-5, how ready are you to start working on finding new ways of achieving the benefits? _____
   On a scale of 0-5, how ready are you to start working on reducing the costs? _____

Assessor's Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

Client Name: _____

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*Adapted from Los Angeles County Department of Mental Health MH Form 633

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