Reset Form

Client Name		Client ID	

Effective Date		Author	

1) Which of the following drugs or alcohol have you used in the last 12 months?
(Read list and select all that apply)

☐ Alcohol
☐ Opiates/opioids (e.g., heroin, prescription narcotics)
☐ Stimulants (e.g., cocaine, amphetamines)
☐ Cannabis (e.g., marijuana, Tetrahydrocannabinol [THC])
☐ Benzodiazepines (e.g., sedatives, tranquilizers)
☐ Other drug(s)
☐ None
☐ Skip this question

2) Which of the following are your drug(s) of choice that you may want help with?
(Read list and select all that apply)

☐ Alcohol
☐ Opiates/opioids (e.g., heroin, prescription narcotics)
☐ Stimulants (e.g., cocaine, amphetamines)
☐ Cannabis (e.g., marijuana, Tetrahydrocannabinol [THC])
☐ Benzodiazepines (e.g., sedatives, tranquilizers)
☐ Other drug(s)
☐ None

Is this individual a candidate for substance use services?
☐ Yes ☐ No

Please indicate substance for which potential client may need treatment.

☐ Alcohol
☐ Opiates/opioids (e.g., heroin, prescription narcotics)
☐ Stimulants (e.g., cocaine, amphetamines)
☐ Cannabis (e.g., marijuana, Tetrahydrocannabinol [THC])
☐ Benzodiazepines (e.g., sedatives, tranquilizers)
☐ Other drug(s)

3) **Are you currently experiencing SEVERE WITHDRAWAL symptoms?**
(e.g., tremors/shaking, recent seizures, hallucinations, vomiting, diarrhea, racing heartbeat or other significant physical symptoms)
☐ Yes ☐ No

ALERT: HIGH POTENTIAL FOR CLINICALLY RISKY WITHDRAWAL. CONSIDER NEED FOR IMMEDIATE INTERVENTION.
(e.g., provide immediate medical consult or referral to emergency room/911 or onsite withdrawal management if appropriate/available)

☐ Check this box, sign, and date at the end of the document if you are ending this assessment early for immediate intervention.

-OR-

(if immediate intervention is not needed, proceed to next question)

4) If you stopped using now would you expect to get sick an experience milder withdrawal symptoms like *mild tremors, excessive sweating, nausea and/or vomiting, stomach cramps, or muscle aches?* Or are you currently experiencing these milder symptoms?
☐ Yes ☐ No

5) In your life, have you ever OVERDOSED (e.g., loss of consciousness) or experienced SERIOUS WITHDRAWAL OR LIFE THREATENING DURING WITHDRAWAL?
(e.g., irregular heart rate/arrythmia, seizures, hallucinations with DTs/delirium tremens, need for IV therapy or inpatient medication management)

6) Have you used any drugs or alcohol within the last 3 days?
☐ Yes ☐ No

6a) Have you used any drugs of alcohol within the last 4 hours?
☐ Yes ☐ No

7) Do you currently have any serious MEDICAL issues that you are aware of?
☐ Yes ☐ No

7a) Do these medical problems make it difficult to do your normal daily activities?
☐ Not at all ☐ Sometimes ☐ Quite a bit ☐ All the time

7b) Do you think these medical issues can improve if you do something more or different than what you are doing?
☐ Yes ☐ No

☐ Check this box to indicate that emergency services were engaged for medical issues.

8) In the past 30 days, have you experienced any *periods of sadness, hopelessness, loss of interest in activities, hallucinations, or significant anxiety* that are NOT resulting from withdrawal or drug use?
☐ Yes ☐ No ☐ Unknown

8a) Do these emotional problems make it difficult to do your normal daily activities?
☐ Yes ☐ No

8b) In the past 30 days, have you thought about wanting to kill yourself or wanting to die?
☐ Yes ☐ No

8c) Are you currently having thoughts about wanting to kill yourself or wanting to die?
☐ Yes ☐ No

ALERT: CONSIDER POTENTIAL IMMINENT DANGER TO SELF. Follow your local county/program policies to assess for immediate intervention
(e.g., provide immediate consult, STOP screen and call 911 if imminent need is identified, provide information to call 911/suicide hotline/go to an emergency room)

☐ Check this box, sign, and date at the end of the document if you are ending this assessment early for immediate intervention.

-OR-
(if immediate intervention is not needed, proceed to next question)

9) Has doctor ever given you medications for emotional or mental health issues?
☐ Yes ☐ No ☐ Unknown

10) Which statement best describes your current thinking about your drug and alcohol use?

☐ My use is not a problem; I don't want treatment	☐ I am not sure I have a problem; I am not sure I would go to treatment	☐ I may or may not have a problem; I am willing to go to treatment	☐ I am committed to my recovery; I want treatment and/or supportive services

11) Without help, do you think you would continue using?
☐ Definitely yes ☐ Probably yes ☐ Might or might ☐ Probably not ☐ Definitely not

12) Are you currently experiencing homelessness *(e.g., couch surfing, living outdoors or in a car, no permanent housing)*?
☐ Yes ☐ No

13) Do you have a place to stay that is free of alcohol and other drugs?
☐ Yes ☐ No

14) Do you currently have someone who you would consider as a social support, or someone you can rely on for support when needed?
☐ Yes ☐ No

15)Are you or do you think you could pregnant?
☐ Yes ☐ Don't Know ☐ No (or Not Applicable)

16) Of the drugs we have talked about, have you injected any in the last year?
☐ Yes ☐ No

☐ Check this box to indicate that emergency services

Interview complete – please sign and date at the end of the document

☐ Check here if you stopped the BQuIP early, but **NOT FOR IMMEDIATE INTERVENTION.** (No recommendation will be generated)

Record clinical notes here:

Signature		**Date**	
Printed Name & Credentials			