

HOME Choice Substance Abuse Screening Tool

Complete prior to identifying needed HOME Choice Demonstration Services with the Consumer's Social Worker present for verification of information.

Yes	No	Unknown	Substance Abuse History / Identified Risk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>1. Does the individual have a diagnosis of a substance abuse disorder? If Yes, please list Axis I and II diagnosis in the space provided below: Axis I: _____ Axis II: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>2. Does the individual have a history of treatment for substance abuse? If Yes, how many episodes have occurred in the last 2 years? _____ Number of In-patient: _____ Out-patient: _____ Detox: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>3. Has the individual received case management services from a substance abuse provider in the past? If Please provide the name of the agency: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>4. Has the individual been a danger to him/herself or to others in the last 90 days? <i>Attempted suicide; made suicidal gesture; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situation; attempts to or has sexually assaulted another individuals.</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>5. Has the individual experienced unsuccessful attempts to stop or control substance use? Tried to cut back, limit use or stop.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>6. Has the individual experienced consequences as a result of alcohol or other drug use? <i>Loss of jobs, relationships, housing, etc. Arrests or injuries?</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>7. Has the individual consumed more alcohol or other drugs or for a longer period of time than intended than intended? <i>Just stop for one or two and stay until closing?</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>8. Does the individual need to use more of a substance to achieve the desired affect?</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>9. Has the individual given up or reduced attendance at important events because of use? <i>School, work, home, or other events.</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>10. Does the individual spend a great deal of time obtaining, using or recovering from substance use? <i>Drive long distances, visit multiple doctors, miss work or other events due to 'hangovers' the 'shakes' etc.</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>11. Does the individual continue to use despite experiencing consequences caused by or made worse by substance use?</p>

ANY CHECKED "YES" BOXES SHOULD RESULT IN A REFERRAL TO SUBSTANCE ABUSE ASSESSMENT SERVICES.