



FIRST STEP COUNSELING

Name _____ Date _____
 Address _____ City, State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Email _____ Date of Birth _____
 Age _____ Sex _____ Race _____ Marital Status _____ SSN # _____ - _____ - _____
 Employer _____ Phone _____
 Last Grade Attended _____ College/Other _____
 Do you have a valid Drivers' License? Yes _____ No _____ # _____ - _____ - _____
 Who referred you to our program? _____
 Emergency contact _____ Phone _____

FOR OFFICE USE ONLY

Drug/Alcohol Evaluation _____ Individual Counseling _____
 Level II Education _____ Level II Therapy _____ Relapse Prevention _____

Antabuse _____ Court Ordered _____
 Random UA's _____ Court Ordered _____ Color _____
 Random EtG's _____ Court Ordered _____ Color _____
 Random BA's _____ Court Ordered _____ Color _____

Date of offense _____ Charges _____
 Case Number _____ District _____ Next Court Date _____
 BAC _____ Number of Prior Offenses _____

Attorney's Name _____
 Address _____
 Phone _____ Fax _____
 Email _____



Interstate Compact Unit
 940 N Broadway
 Denver, CO 80203
 P 303.763.2408 F 303.861.1548
DOC_interstatetreatment.state.co.us

**OUT-OF-STATE OFFENDER
 CLIENT QUESTIONNAIRE**

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, **will result in a denial to attend the treatment program** and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

- | | | |
|--|--------------------------|--------------------------|
| 1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or DMV? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No |
| 2) Do you have any pending cases, Probation/Parole supervision, or warrants in any other state? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No |

If yes to 1 or 2, please answer the following questions:

- 3) In what state was the crime committed? _____
- 4) Who are you to report the treatment to? _____
 (Example: Court, Judge, Probation Parole, etc.)
- | | | |
|---|--------------------------|--------------------------|
| 5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No |
| 6) For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring you driving privileges as the result of an alcohol or drug related driving Offense in another state, but are not under court order to do so? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No |

Your Name: _____ Date of Birth: _____
 Social Security Number: _____ Place of Birth: _____
 Signature: _____ Today's Date: _____

If you answered "Yes" to 1 or 2 above, please provide the following:

Name, address and phone number of your Probation officer, parole officer, judge Or diversion officer. _____

A copy of your probation, parole, court or diversion order, including treatment requirements must be included.

Form C





FIRST STEP COUNSELING

Client Payment and Attendance Agreement

I agree to attend _____ Education hours and/or _____ Therapy hours.

I agree to pay First Step Counseling the sum of \$_____. I understand there is a fee of \$50 for intake, \$25 for an education book and \$25 for a therapy book, payable prior to attending the first class. First Step Counseling accepts cash, Venmo and Zelle. We do not accept credit or debit cards.

LEVEL II EDUCATION PROGRAM:

I elect the following payment schedule for 12 classes (24 hours) of Level II Education:

- _____ A. \$411 for the entire class (\$336 class, \$50 enrollment, \$25 book)
Payable \$28 per class, with \$75 paid at intake.
- _____ B. \$377.40 - 10% discount (off classes only) if paid in full at intake or before first class.

LEVEL II THERAPY PROGRAM:

I elect the following payment schedule for Track A, B, C, or D Level II Therapy:

- _____ A. Regular price payable at \$28 per class and \$25 book
- . Track A: 21 classes (42 hours) is \$663
 - . Track B: 26 classes (52 hours) is \$803
 - . Track C: 34 classes (68 hours) is \$1027
 - . Track D: 43 classes (86 hours) is \$1279
- _____ B. A 10% discount (off classes only) for payment in full by the first class.
- . Track A: 21 classes (42 hours) is \$604.20, a savings of \$58.80
 - . Track B: 26 classes (52 hours) is \$730.20, a savings of \$72.80
 - . Track C: 34 classes (68 hours) is \$931.80, a savings of \$95.20
 - . Track D: 43 classes (86 hours) is \$1158.60, a savings of \$120.40
- _____ C. A 15% discount (off classes only) for payment in full for both education and therapy including enrollment fee and books by the first class.
- . Track A: \$935.40, a savings of \$138.60
 - . Track B: \$1054.40, a savings of \$159.60
 - . Track C: \$1244.80, a savings of \$193.20
 - . Track D: \$1459.00, a savings of \$231.00



FIRST STEP COUNSELING

I understand that I may attend only one class per week and I will be assigned a class. I also understand that I am not allowed to attend more than one therapy class a week unless clinically justified. I am aware of class times and it is my responsibility to be on time. I understand that if I come to class more than five minutes late, I will not be allowed to attend class. Continual tardiness will be grounds for termination from the program.

I realize it is my responsibility to attend class on a regular basis. I understand I will only be allowed three absences during the period of my program. I will be only excused from class if there is an emergency/weather related problem or if my absence is previously arranged and approved. I further understand that if I have three consecutive unexcused absences I will be terminated from the program and the court will be notified of this action.

I will not show up for class after consuming alcohol or any other drugs. If I do so, I will be denied attendance to class. If I drive to class under the influence, I will be asked to find a ride home. If I choose to drive, I understand that the police will be notified immediately.

I understand I must keep my balance current and I will be allowed only one payment in arrears. Any arrearage must be paid along with my current payment at my next scheduled class. I also understand that there will be an additional charge of \$20.00 for any checks written by me that are returned to the program for insufficient funds. All treatment fees must be paid in full prior to my completion of the program. I understand that all fees are due and payable prior to the start time of each session. I further understand that I will be given only one opportunity to make up a session for which I have paid but did not attend. If I miss a makeup session for any reason, I will be terminated as non-cooperative and the court will be notified.

Notwithstanding any other provision of this Agreement, I understand that there will be no refunds of prepaid fees. If I fail to complete either the Education Program or the Therapy Program, or I am terminated from the program as set forth in this agreement, I will not receive a refund of amounts paid or prepaid to First Step Counseling, Inc.

I agree to the above terms of this contract and fully understand the contents of this form. I understand that my failure to comply with the terms of this contract will result in my termination from the program and I will be referred back to the court for whatever immediate action is deemed necessary.

Client Signature

Date

Staff Signature

Date



FIRST STEP COUNSELING

DISCLOSURE STATEMENT

First Step Counseling is a substance use disorder treatment program licensed by the Office of Behavioral Health, Colorado Department of Human Services. Treatment license #: 1267-00. The counseling staff employed at First Step Counseling and their qualifications are as follows:

_____ Patrice Bender-Lloyd, MA, CAC III. Pati earned her Bachelor of Science degree in Drug/Alcohol Counseling from Metropolitan State College and earned her MA in Counseling from University of Northern Colorado and is credentialed in Colorado as a Certified Addiction Counselor, Level III. She has been employed in the field of addiction since 1989.

The practice of registered, certified or licensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions and complaints regarding addiction counselors may be addressed to:

Board of Addiction Counselor Examiners
1560 Broadway, Ste. 1350, Denver, CO 80202
303-894-7800

The Division of Behavioral Health has the general responsibility for regulating practices of licensed substance use disorder treatment programs in the State of Colorado. Questions and complaints may be directed to:

Colorado Department of Human Services, Office of Behavioral Health
3824 W. Princeton Circle, Denver, CO 80236 (303) 866-7400

The regulatory requirements applicable to mental health professionals are as follows:

- Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed or certified by the State and is not required to satisfy any standardized educational or testing requirements.
- Certified Addiction Counselor I (CAC I) must be a high school graduate or the equivalent, complete required training hours and 1000 hours of clinically supervised work experience.
- Certified Addiction Counselor II (CAC II) must meet the CAC I requirements, complete additional training hours above the CAC I, and 2000 hours of clinically supervised work experience.
- Certified Addiction Counselor III (CAC III) must have a Bachelor's degree in the behavioral health sciences or field; complete additional training above the CAC II, and 2000 hours of clinically supervised work experience.



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- Licensed Addiction Counselor must have a clinical Master's degree, meet the CAC III requirements, and pass a national examination in addiction treatment.
- Licensed Social Worker must hold a master's degree in social work.
- Psychologist Candidate, Marriage and Family Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision.
- Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

CLIENT RIGHTS

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Board that registers, certifies or licenses the registrant, certificate holder or licensee.

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in Section 12-43-218 of the Colorado Revised Statutes as well as other exceptions in Colorado and federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception to confidentiality arises during therapy, if feasible, you will be informed accordingly.

I understand that my alcohol and/or drug treatment records are protected under the Federal Confidentiality Regulation, 42 C. F. R., Part 2, governing Confidentiality of Alcohol and Drug Abuse Patient Records. Confidential information cannot be disclosed without my written permission unless otherwise provided for by the regulations. Exceptions to confidentiality may also be found in the Notice of Privacy Rights you were provided.

I have read the preceding information, it has been provided to me verbally, and I understand my rights as a client or as the client's responsible party.

Client Signature

Date

Staff Signature

Date



FIRST STEP COUNSELING

CONSENT TO TREAT

We welcome you to First Step Counseling and look forward to helping you. In order to do so, we ask that you read and sign the following statement.

We were established to help residents of this community with alcohol/drug problems, family problems, marriage problems, relationship problems, and individual problems. In order to adequately offer our services, we must charge fees.

I acknowledge that First Step Counseling has the right to determine after an initial assessment, if I am appropriate for admission to education or counseling. I further acknowledge that the care and treatment in this area is not an exact science. No guarantees have been made to me as a result of education or counseling at First Step Counseling.

I consent to the treatment and evaluation as the professional staff may decide. I certify that I have read and fully understand the contents of this form.

Client Signature

Date

Staff Signature

Date

CONSENT FOR FOLLOW-UP

I hereby grant permission to the research staff at First Step Counseling to contact me after my discharge from the program in order to obtain information for research purposes only. All information obtained will be strictly confidential.

Client Signature

Date

Staff Signature

Date



FIRST STEP COUNSELING

NOTICE OF FEDERAL REQUIREMENTS REGARDING CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

- 1) The patient consents in writing;
- 2) The disclosure is allowed by a court order; or
- 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 C.F.R. Part 2 Federal Regulations.)

Client Signature

Date

Staff Signature

Date



FIRST STEP COUNSELING

AGREEMENT TO MAINTAIN CONFIDENTIALITY

I acknowledge that the success of any treatment program depends on the ability of the clients and staff personnel to respect the confidentiality and the rights of others.

Therefore, I agree not to disclose the names or identities of other clients in the program. I further agree not to disclose the nature of any communication made by any client while participating in the program to any persons outside the program whatsoever.

I have read and understand the Federal Requirements Regarding Confidentiality of Alcohol and Drug Abuse Patient Records.

Client Signature

Date

Staff Signature

Date



FIRST STEP COUNSELING

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby give my permission to First Step Counseling, in order to comply with treatment, probation, courts, attorneys and community agencies, to exchange oral and written diagnostic, referral and treatment information about myself to the following:

_____ and/or assigns.

Agency/Institution/Company _____ and Individual _____

Address _____ City _____ State _____ Zip Code _____

Phone # _____ Fax# _____ Email address _____

Specific information to be released:

- | | |
|-----------------------------|------------------------------------|
| _____ Enrollment/Referral | _____ Attendance |
| _____ Clinical Progress | _____ Compliance |
| _____ Evaluation/Assessment | _____ Attitude |
| _____ Recommendations | _____ Diagnostic |
| _____ Termination Data | _____ Urinalysis Testing/Results |
| _____ Payment/Fees | _____ Breathalyzer Testing/Results |
| _____ Other (Specify) _____ | |

This authorization may be revoked by myself, in writing, at any time and expires two years from today's date (Month ____ Date ____ Year ____)

Date Signature of Client

Date Signature of Staff

STATEMENT OF REVOCATION

I hereby revoke the above authorization of disclosure.

Date Signature of Client

Date Signature of Staff

Notice to recipient: This information has been disclosed to you from client records whose confidentiality is protected by Federal Laws. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.



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DRIVING COMPLIANCE

It has come to my attention that some clients have been driving to class without a license. Please remember that driving under suspension or revocation is against the law. Please make arrangements to get here so that you won't have to drive.

As a reminder, please do not come to class under the influence. This includes clients who come into the office to take Antabuse or submit a UA.. If an odor of alcohol is detected, we will not administer the drug to you, nor will we allow you to drive your car from here. You will have to make alternate arrangements for a ride. Failure to adhere to this requirement will result in notification to the proper authorities. We appreciate your attention to this policy.

INTERLOCK ENHANCEMENT COUNSELING

Was your BAC .15 or higher? Yes No

Did you refuse to do a BAC? Yes No

Do you have prior offenses? (lifetime, nationwide) Yes No

Are you required to have an interlock device installed in your car? Yes No

We do not provide Interlock Enhancement Counseling, but we will refer you to an agency that does.

Client Signature

Date

Staff Signature

Date



FIRST STEP COUNSELING

MEDICAL HISTORY

Name _____ Age _____ Date of Birth _____
Family Physician _____ Phone _____ Permission to contact? _____
Last physical _____
Your general state of health: excellent _____ good _____ fair _____ poor _____
Any severe medical problems? yes _____ no _____ Explain: _____

Are you pregnant? yes _____ no _____ Are you receiving pre-natal care? yes _____ no _____

Have you ever received mental health treatment? yes _____ no _____
When and where? _____

Have you ever received substance abuse treatment? yes _____ no _____
When and where? _____

Do you have or have you ever had problems with any of the following?

Heart? yes _____ no _____ How severe? _____
Allergies? yes _____ no _____ What are you allergic to? _____
Ulcers? yes _____ no _____ Bleeding? yes _____ no _____ How severe? _____
Liver? yes _____ no _____ Type of problem? _____
Diabetes? yes _____ no _____ Do you use insulin? yes _____ no _____ How severe? _____
Seizures? yes _____ no _____ Related to what? _____
Tremors? yes _____ no _____ Related to what? _____
Hangovers? yes _____ no _____ DTs? yes _____ no _____

Do you have any drug or alcohol related medical problems? yes _____ no _____
Explain _____

Have you ever been hospitalized due to drugs or alcohol? yes _____ no _____
When and where? _____

Are you currently taking any medications now? yes _____ no _____
List _____

Have you ever taken Antabuse? yes _____ no _____
When and where? _____ For how long? _____

Do you have an advance directive? yes _____ no _____ If so, provide a copy if you are willing to do so.



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DRUG USE INVENTORY

Have you ever used:	Yes/No	Age of first use	Date of last use	Current use/ how much
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____
Anti-depressants	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____
Heroin	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Opiates	_____	_____	_____	_____
P.C.P.	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____

Of the above list of drugs, which one or ones do you think are a problem for you? _____
Explain: _____

Have you experienced unprotected sexual contacts? yes ___ no ___

Have you or your sexual partner injected drugs, shared needles/syringes or other paraphernalia?
yes ___ no ___

Have you had more than one sexual partner? yes ___ no ___

Have you engaged in unsafe sexual practices while under the influence of alcohol or other drugs?
yes ___ no ___

Have you ever been physically or sexually abused? yes ___ no ___

Have you ever been incarcerated? yes ___ no ___

Explain _____



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SOCIAL HISTORY

Full Name _____ Nickname _____

With whom living?

- _____ Parents
- _____ Friend/Roommate
- _____ Spouse/Significant other
- _____ Relative
- _____ Alone

Years of schooling?

- _____ 8 Years or less
- _____ 8-11 Years
- _____ High School
- _____ GED
- _____ College
- _____ Voc/Tech School

Marital Status (# of times):

of children and their ages

Does child live with you?

Single: _____	_____	_____
Married: _____	_____	_____
Divorced: _____	_____	_____
Widowed: _____	_____	_____

Family Data:

You: Birth order in your family: _____ Place of Birth: _____

Parents:	Mother	Father	Brothers/Sisters and their ages
Living/Deceased	_____	_____	_____
Married: (# of times)	_____	_____	_____
Divorced: (# of times)	_____	_____	_____

Work:

Are you working now? yes _____ no _____ Monthly income _____

How long have you held this job? _____ Do you like your job? yes _____ no _____

What do you like or dislike about your job? _____

How many jobs have you had in the last three years? _____

What type of job do you prefer? _____

Have you had any specialized training other than school? _____



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What is your idea of a successful person? _____

What are your personal goals? _____

What are your hobbies or interests? _____

Do you prefer?

Being a leader _____ Being a follower _____ Being in a group _____ Being a loner _____

Describe the most stressful situation that you have experienced in the last year: _____

What do you do to deal with stress? _____

What do you do to relax? _____

What do you do when you are bored? _____

When you were a child/adolescent, what did you do in your spare time? (after school, weekends) _____

Who in your family gives you support when you have a problem? _____

How does that person help? _____

What is your most pleasant childhood memory? _____

What is your most unpleasant childhood memory? _____

What do you think you want to learn here? _____

List three words to describe yourself: 1. _____
2. _____
3. _____



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C.A.S.T.

Please check the answer below that best describes your feelings, behavior and experience related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all questions by checking either "yes" or "no".

Sex: Male ___ Female ___ Age _____

YES	NO	QUESTIONS
_____	_____	1. Have you ever thought that one of your parents had a drinking problem?
_____	_____	2. Have you ever lost sleep because of a parent's drinking?
_____	_____	3. Did you ever encourage one of your parents to quit drinking?
_____	_____	4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
_____	_____	5. Did you ever argue or fight with a parent when he or she was drinking?
_____	_____	6. Did you ever threaten to run away from home because of a parent's drinking?
_____	_____	7. Has a parent ever yelled at or hit you or other family members when drinking?
_____	_____	8. Have you ever heard your parents fight when one of them is drunk?
_____	_____	9. Did you ever protect another family member from a parent who was drinking?
_____	_____	10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
_____	_____	11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
_____	_____	12. Did you ever wish that a parent would stop drinking?
_____	_____	13. Did you ever feel responsible for or guilty about a parent's drinking?
_____	_____	14. Did you ever fear that your parents would get divorced due to alcohol misuse?
_____	_____	15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking?
_____	_____	16. Did you ever feel caught in the middle of an argument or a fight between a problem drinking parent and your other parent?
_____	_____	17. Did you ever feel that you made a parent drink?
_____	_____	18. Have you ever felt that a problem drinking parent did not love you?
_____	_____	19. Did you ever resent a parent's drinking?
_____	_____	20. Have you ever worried about a parent's health because of his or her alcohol use?
_____	_____	21. Have you ever been blamed for a parent's drinking?
_____	_____	22. Did you ever think your father was an alcoholic?
_____	_____	23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
_____	_____	24. Did a parent ever make promises to you that he or she did not keep because of drinking?
_____	_____	25. Did you ever think your mother was an alcoholic?
_____	_____	26. Did you ever wish you could talk to someone who could understand and help the alcohol-related problems in your family?
_____	_____	27. Did you ever fight with your brothers and sisters about a parent's drinking?
_____	_____	28. Did you stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
_____	_____	29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
_____	_____	30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

- (0) Never (Skip to Questions 9-10)
- (1) Monthly or less
- (2) 2 to 4 times a month
- (3) 2 to 3 times a week
- (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- (0) 1 or 2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7, 8, or 9
- (4) 10 or more

3. How often do you have six or more drinks on one occasion?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

For clinician use only:

At risk for HIV

If so is at :

Medium risk

High risk

Score:

INFECTIOUS DISEASE BEHAVIORAL SCREEN

Name: _____ Date: _____

I understand that my responses to this Screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV I STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

I have read and understand the above. Signature: _____

Please mark the one most accurate response to each question.

1. Have you had 2 or more sexual partners in the past 10 years?
 Yes No
2. Have you had anal sex (penis in anus) with any of your sexual partners during the past 10 years?
 Yes No
3. How often have you used a condom when having anal sex in the past 10 years?
 Never Sometimes Always Have not had anal sex
4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?
 Yes No
5. At any time in the past 10 years, have you ever given money or drugs to anyone to have sex with you?
 Yes No
6. Have you ever had sex with someone so that they would give you money or drugs?
 Yes No
7. Have you ever injected street drugs, steroids, or vitamins with a needle?
 Yes No
8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?
 Yes No Don't know
9. Have any of your sexual partners in the past 10 years been men who have had sex with other men?
 Yes No Don't know
10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?
 Yes No Don't know

- Close** contact with active TB
- Medical condition that increases risk of **TB** disease (e.g., HIV, other immune disorders, diabetes, silicosis,[black lung] or coal miners disease}, bleeding/clotting disorders, specific malignancies, kidney failure, etc.)
- Abnormal chest x-ray showing fibrotic lesions
- Resident or employee of a high risk group setting (e.g., correctional facilities, nursing homes, mental institutions, homeless shelters, residential treatment, etc.)
- Health care worker or volunteer who serves high-risk clients
- Foreign-born person who has arrived within the last five years from countries that have a high **TB** incidence or prevalence (e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia)
- Person from a medically underserved, low-income population
- Member of a high-risk racial, ethnic, or other minority population with an increased prevalence of TB (e.g" Asian and Pacific Islanders, Hispanics, African-Americans, Native Americans, migrant farm workers, homeless persons)
- History of inadequately treated TB

10. Have you had a cough for more than three weeks?

- Yes No

11. Have you coughed up blood/colored mucous?

- Yes No

12. Do you have swollen, non-tender lymph nodes?

- Yes No

13. Have you had a prolonged loss of appetite or unexplained weight loss of ten pounds or more?

- Yes No

14. Have you had recurrent fevers or heavy night sweats for more than three weeks?

- Yes No

Response Guide:

If you answered "yes" to any question # 1-7, please see your counselor for a referral to be screened for hepatitis B and C.

If you answered "yes" to question # 8, please see your counselor for a referral for infectious disease screening and testing.

If you answered "yes" to any of the categories in question # 9, please see your counselor for a referral to be screened for tuberculosis.

If you answered "yes" to any question # 10-14, please see your counselor immediately for a referral for tuberculosis screening and treatment.

Your counselor is referring you to the following program/agency for follow-up:

Program/Agency: _____

Address: _____

Contact: _____ **Phone:** _____

For clinician use only:
 At risk for TB
(Based on positive response to
any question 9-14).

INFECTIOUS DISEASE MEDICAL SCREEN

Name _____ Date _____

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state Law authorizes the disclosure.

I have read and understand the above. Signature: _____

Please mark the one most accurate response to each question.

1. Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)?
 Yes No

2. Have you ever been or are you now on long-term hemodialysis (blood cleansing)?
 Yes No

3. Are you a recipient of clotting factor made prior to 1987?
 Yes No

4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C-infected blood?
 Yes No

5. Were you born to a mother who had hepatitis?
 Yes No

6. Have you ever had symptoms of liver disease or abnormal liver function/enzyme tests?
 Yes No

7. Have any of your sexual partners been infected with hepatitis B or C?
 Yes No

8. Have you been the recipient of tattooing or body piercing in unsanitary conditions (e.g. unsterile needles)?
 Yes No

9. Mark all of the following that currently apply to you or that applied to you in the past.

INFECTIOUS DISEASE BEHAVIORAL SCREEN SCORING

Client/Patient Name/ID: _____ Date: _____

Transfer responses from the Infectious Disease Behavioral Screen onto this form and total the corresponding numeric values.

1. Yes (5) No (0)
2. Yes (10) No (0)
3. Never (20) Sometimes (15) Always (10) No anal sex (0)
4. Yes (15) No (0)
5. Yes (10) No (0)
6. Yes (20) No (0)
7. Yes (30) No (0)
8. Yes (30) No (0) Don't know (15)
9. Yes (30) No (0) Don't know (15)
10. Yes (30) No (0) Don't know (15)

My score: _____

Scoring Guide:

0 to 29 indicates low risk for acquiring/transmitting HIV. You do not need to be evaluated further, unless it is believed to be necessary based on other information you have provided.

30 to 119 indicates medium risk for acquiring/transmitting HIV and hepatitis. You should receive further evaluation and appropriate referrals should be provided.

120 or higher indicates high risk for acquiring/transmitting HIV and hepatitis. You should contact the Colorado Department of Public Health and Environment, 303-692-2759, or your local county health department for further evaluation and follow-up.

Note: Answering "yes" to question 7 indicates past or present injection drug use and testing for HIV and hepatitis B and C is strongly encouraged as behaviors associated with injection drug use place you at an increased risk for acquiring and/or transmitting these infections.

INFECTIOUS DISEASE BEHAVIORAL SCREEN SCORING

<p><i>Score is over 120</i></p>	<p style="text-align: center;">HIGH RISK</p> <p>A score over 120 indicates you are at high risk for acquiring/transmitting HIV and/or Hepatitis. See your counselor right away for referral to your local county health department or the Colorado Department of Public Health and Environment for further evaluation and follow-up.</p>
<p><i>Score is 30-119</i></p>	<p style="text-align: center;">MEDIUM RISK</p> <p>A score of 30-119 indicates that you are at medium risk for acquiring/transmitting HIV and/or Hepatitis. See your counselor for more information about ways that you can reduce your risk and other programs that can help you.</p>
<p><i>Score is 0-29</i></p>	<p style="text-align: center;">LOW RISK</p> <p>A score of 0-29 indicates that you are at low risk for acquiring HIV and/or Hepatitis. Low risk doesn't necessarily mean no risk. See your counselor if you have questions or concerns about behaviors that may place a person at risk.</p>

Your counselor is referring you to the following agency/program for follow-up:

Program/Agency: _____

Address: _____

Contact: _____ **Phone:** _____

Appointment: _____

Personal Drinking Questionnaire (SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic.	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5
12. My drinking is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic.	1	2	3	4	5
18. I am working hard to change my drinking.	1	2	3	4	5
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1	2	3	4	5