Reset Form Here

Barth & Associates
Barth Clinic * Barth Family Programs * Barth Consulting, INC
PATIENT INFORMATION FORM

Date_____

NAME: Last _____First_____ Middle Initial _____ SS# _____

ADDRESS_____CITY_____ST_____ZIP_____

MAILING ADDRESS _____CITY _____ST _____ZIP _____

HOME PHONE ( )_____-_____ WORK PHONE ( )_____-_____

CELL PHONE/PAGER( )_____-_____

DATE OF BIRTH_____ AGE_____ SEX_____

Reason for Referral (Check one of the following): Attorney Court Order EAP Employment Family Other

Please explain: _____

RACE **(check)** Black White Hispanic Mexican Native American Asian Other:

Driver's License No.: _____State_____

Employment Status: Full Time___ Steady, but less that 30 hours per week_____
Temporary ___ In School_____ Unemployed/not in school____

Employer:_____

Physicians name: _____ **Hospital: _____**

List any medications you are allergic to: _____

Medical Insurance Benefits: **Yes / No** Group or Policy Number: _____

Name of Medical Insurance Company_____

Living Status: Single / Married / Divorced or Separated / Partner / Mate / Significant Other - Name: _____

Employer: _____

Medical Insurance Benefits: **Yes / No** Group or Policy No._____

Name of Medical Insurance Company_____

EMERGENCY CONTACT PERSON: Name_____ Phone #_____

Relationship_____Address_____

Have you ever been to any Barth Family Programs before: **Yes / No** When:_____

DO NOT WRITE BELOW THIS LINE

Intake Counselor _____
Date of Appt: _____
TIME: _____
Pre-Paid: _____

Confidential Self-Evaluation

Barth Clinic of Central Washington

P.O. Box 1207
Yakima, WA 98907
Toll free (877) 457-5657

www.barthclinic.com

PLEASE PRINT

Date of Evaluation: _____ Patient ID Number: _____

Name: _____ Email:_____
First Middle Last

Home Phone: _____

Address: _____ Work Phone: _____

Cell Phone: _____

_____ Date of Birth: _____
City State Zip Code Month • Day • Year

Drivers License # _____ State: _____ Age:_____

Social Security Number:_____-_____-_____ Height_____ Weight _____

☐ Male ☐ Female ☐ Transgender ☐ Neutral ☐ Prefer Not to Answer ☐ Other:_____

Ever been a patient here before? ☐ Yes ☐ No If Yes, When? _____

How did you learn about us?
(Check the one that influenced your decision the most)

Attorney/Court/Probation	School	Yellow Pages
Chemical Dependency Agency/Detox	Mental Health Counselor	Family Member
Physician or Hospital	Native American Tribe	Friend
Insurance Company/Managed Care	Other	Former Patient/Alumni
Employer/EAP/Union		Re-Admit/Relapse

If you checked a box in the above columns please write the name_____

Why are you seeking an evaluation at this time?

_____

Please explain your version of the events leading to your referral for an evaluation.

_____

_____

_____

Check the one that is closest to your race/ethnicity:

☐ White/European American
☐ Black/African American
☐ Native American •
☐ Eskimo/Alaskan Native•
☐ Aleut •
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Korean
☐ Vietnamese
☐ Japanese
☐ Samoan
☐ Asian India
☐ Guamanian
☐ Cambodian
☐ Laotian
☐ Thai
☐ Other Asian/Pacific Islander
☐ Other race
☐ Refused to answer

• If Native American/Eskimo/Alaska Native/Aleut, please provide tribal information:
Tribe or corporation _____
Tribal recognition ☐ Federal ☐ Non-Federal ☐ Canadian
Eligible for enrollment? ☐ Yes ☐ No
Enrollment Number _____
Blood degree ☐ Less than ¼ ☐ ¼ or more

Check the one that is closest to your Spanish/Hispanic origin:

☐ Not Spanish/Hispanic ☐ Mexican ☐ Other Spanish/Hispanic ☐ Puerto Rican ☐ Cuban ☐ Refused to answer

♦ FAMILY

Marital Status

	Since	Number of Times
☐ Single (Never Married)		
☐ Married	_____	_____
☐ Separated	_____	_____
☐ Divorced	_____	_____
☐ Widowed	_____	_____
☐ Significant other	_____	_____
☐ Partner	_____	_____

Who are you currently living with?_____

Does the person you are now living with:
Drink or use Drugs? ☐ Yes ☐ No
Drink or use Drugs to Excess? ☐ Yes ☐ No
Drink or use Drugs in the Residence? ☐ Yes ☐ No

Is there domestic violence where you live? ☐ Yes ☐ No

Is there any kind of physical, verbal or sexual abuse where you live? ☐ Yes ☐ No

Are you at risk of being abused? ☐ Yes ☐ No

Do you feel that you are living in a safe place? ☐ Yes ☐ No

Typical Daily Activities _____

Describe your childhood religious or spiritual upbringing, traditions experiences_____

Describe the religious or spiritual practices and beliefs you have now_____

Number of Brothers _____
Number of Sisters _____

Your Birth Order? _____ 1st, 2nd, etc.

Children:

Gender	Age	Name
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Birth place _____

Place raised _____ Who raised you? _____

When did you leave Home & Why _____

♦ EDUCATION

Years of Education (Pick One) 1st Grade or write in if more _____

Degree: ☐ None ☐ GED ☐ HS Diploma ☐ Trade School ☐ Associate ☐ BA/BS ☐ Masters ☐ Doctorate

Did alcohol/drug use impact your educational goals? ☐ Yes ☐ No

How do you rate your English reading/writing skills? ☐ Good ☐ Fair ☐ Poor

Have you ever been diagnosed as having a learning disability or placed in a special education class? ☐ Yes ☐ No

♦VETERAN STATUS

	Yes	No	
Military Service?	☐	☐	Branch _____ From _____ To _____ Highest Rank_____
Honorable Discharge?	☐	☐	Drink/Use In Service ☐ Yes ☐ No Demotions ☐ Yes ☐ No
Combat Service?	☐	☐	Combat Location _____
PTSD Diagnosed?	☐	☐	If YES, where and when diagnosed_____
Prior PTSD treatment?	☐	☐	If Yes, where and when treated _____

♦EMPLOYMENT

☐ Employed Full-Time
☐ Employed Part-Time
☐ Self-Employed
☐ Military
☐ Student
☐ Homemaker
☐ Retired
☐ Disabled
☐ Public Assistance
☐ Unemployed (Seeking Work)
☐ Unemployed (Not Seeking Work)

Employer _____Location _____
Length in Current Employment _____
Position & Type of Work _____
Number of Employers In Past Five Years _____ Longest Time With One Employer _____
If Unemployed, What is Your Source of Income _____
Do you Enjoy Your Job? ☐ Yes ☐ No

Have you experienced any of the following employment problems due to substance use?

☐ Late for work ☐ Less productive at work ☐ Missed work ☐ Quit a job
☐ Used at work ☐ Fired ☐ Loss of license/certification ☐ None

Is your job currently in danger? ☐ Yes ☐ No

♦FINANCIAL

Financial Status ☐ Good ☐ Fair ☐ Poor

☐ Insurance
☐ Private Pay
☐ Medicare
☐ CHAMPUS
☐ Title XIX
☐ Agency Funded
☐ Other

Insurance Company Name _____
Phone _____
Group Number _____
Subscriber Number _____
Subscriber Name _____

Do you have significant financial stress at this time? ☐ Yes ☐ No
Do you have a history of gambling problems? ☐ Yes ☐ No
If yes, please explain:_____

♦LEGAL

Current Legal Problem _____ Date of Offense _____ BAC or Breath Test_____

Court _____ Judge _____Case #_____

Next Court Date _____Case Status_____

Attorney Name _____ Phone # _____

Address _____

Probation Officer _____Phone#_____

Do you have your Driving Record available today? ☐ Yes ☐ No ☐ Requested ☐ Not Applicable

Do you have your Criminal Record available today? ☐ Yes ☐ No ☐ Requested ☐ Not Applicable

Do you have your Police Report available today? ☐ Yes ☐ No ☐ Requested ☐ Not Applicable

Do you have current involvement with the Department of Corrections (DOC)? ☐ Yes ☐ No

Any Current or Former Gang Affiliation? ☐ Yes ☐ No If yes, please explain:_____

Are you under civil or criminal ordered mental health or substance use disorder treatment? ☐ Yes ☐ No

Is there a court order exempting your participation in reporting requirements? ☐ Yes ☐ No
(If so, court ordered documentation must be provided.)
Outstanding Warrants? ☐ Yes ☐ No What & When _____

Past Arrests or Convictions

Charge	Date	Court	Final Outcome	BAC
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

♦ MEDICAL & MENTAL HEALTH **(Write "None" for any questions that do not apply)**

How is your overall health now? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current eating pattern; how many meals and snacks per day? _____

What physical or mental problems do you now have?_____

Are you currently under a doctor's care? ☐ Yes ☐ No If Yes Why?_____

What is the name and address of your primary care physician?_____

When was your last physical exam? _____

What prescription medications are you now taking? (name and dose) _____

What over-the-counter products (aspirin, cough medicine, etc.) are you now using?_____

Do you take any prescribed medications (Xanax, Trazadone, Celexa, Paxil, Wellbutrin, Hydrocodone etc.) and then drink alcohol?
☐ Yes ☐ No

Have you ever been seen by a mental health worker? _____ If so, why? _____

Is there any history of harm to self or others? ☐ Yes ☐ No
If yes, are you currently at risk? Please explain:_____

Suicidal/Homicidal Ideation? ☐ Yes ☐ No
If yes, are you currently at risk? Please explain:_____

Do you have a history of self harm? (example: cutting, burning, hitting, etc?) ☐ Yes ☐ No
If yes, are you currently at risk? Please explain:_____

Have you ever experienced an overdose: Accidental? ☐ Yes ☐ No Purposeful? ☐ Yes ☐ No
If yes, please explain:_____

- If yes, was Narcan administered?_____

Have you or anyone in your family ever experienced any of the following problems?
(Check NONE for questions that do not apply)

You	Family	None		You	Family	None	
☐	☐	☐	Alcoholism	☐	☐	☐	Loss of Appetite
☐	☐	☐	Anemia	☐	☐	☐	Mental Illness
☐	☐	☐	Asthma	☐	☐	☐	Morning nausea, vomiting
☐	☐	☐	Cirrhosis	☐	☐	☐	Night Sweats
☐	☐	☐	Depression	☐	☐	☐	Numbness in Fingers or Toes
☐	☐	☐	Diabetes	☐	☐	☐	Pancreatitis
☐	☐	☐	Drug Addiction	☐	☐	☐	Anxiety or Nervousness
☐	☐	☐	Delirium Tremens	☐	☐	☐	Recurrent diarrhea
☐	☐	☐	Fainting	☐	☐	☐	Seizures
☐	☐	☐	Fatty Liver	☐	☐	☐	Shaking
☐	☐	☐	Gastro esophageal Reflux	☐	☐	☐	Significant weight loss or gain
☐	☐	☐	Head Injury	☐	☐	☐	Sleep problems
☐	☐	☐	Headache or Migraine	☐	☐	☐	Suicide attempts or plans
☐	☐	☐	Heart Problems	☐	☐	☐	TB
☐	☐	☐	Heartburn or gastritis	☐	☐	☐	Ulcers
☐	☐	☐	Hepatitis	☐	☐	☐	Physical, sexual or emotional abuse
☐	☐	☐	High Blood Pressure	☐	☐	☐	Obsessive, compulsive behaviors
☐	☐	☐	ADD/ADHD	☐	☐	☐	Other:
☐	☐	☐	Eating Disorder				

How many times in the past five years have you been hospitalized? _____ When? _____
Reason?_____

How many times in the past five years have you used Emergency Room Services?_____ When?_____
Reason? _____

How many days in the past five years have you used sick leave (all employers)? _____ When? _____
Reason? _____

Have You Ever:	Yes	No	Alcohol or Drug related:	Please explain:
Had any fractures or dislocations to your bones or joints?	☐	☐	☐	_____
Been injured in a traffic accident?	☐	☐	☐	_____
Injured your head?	☐	☐	☐	_____
Been injured in an assault or fight (not sports injuries)?	☐	☐	☐	_____
Been injured while drinking?	☐	☐	☐	_____

♦ALCOHOL & DRUG USE HISTORY

At what time in your life did you drink the most? From age _____ to age _____
At what time in your life did you use other drugs the most? From age _____ to age _____
Have you ever used drugs Intravenously? ☐ Yes ☐ No
If yes, What age did you begin?_____How long did you continue?_____
In the past 12 months, have you:

Yes No
☐ ☐ Needed noticeably increased amounts of alcohol or other drugs to achieve intoxication or desired effect?
☐ ☐ Experienced withdrawal symptoms, such as: sweats, shakes, insomnia, nausea or vomiting, hallucination or illusions, anxiety or seizures?
☐ ☐ Taken alcohol or other drugs in larger amounts or over a longer period than you intended?
☐ ☐ Had a persistent desire or unsuccessful efforts to cut down or control substance use?
☐ ☐ Spent a great deal of time obtaining or using alcohol or other drugs or recovering from the effects?
☐ ☐ Given up important social, work or recreational activities because of substance use?
☐ ☐ Continued to use alcohol or other drugs despite knowledge of a persistent physical or psychological problem that is caused Or made worse by such use?

Please complete the table below. List all substances (including alcohol).

List All Drugs Used	Age Of First Use	Age When Regular Use Began	Average Number Of Times Used Each Week **(current)**	Average Amount Used Each time	Usual Way Used (Oral, Smoked, Snorted, IM or IV)	Date Of Last Use
Beer						
Wine						
Liquor						
Nicotine						
Marijuana						
Cocaine						
Caffeine						
Amphetamines						
Benzodiazepines						
Opiate's						
Barbiturates						
Inhalants						
Hallucinogens						
Methadone						
Other Drugs						

Were any of the above drugs you used prescribed by a doctor or dentist in the past 12 months? ☐ Yes ☐ No
Kind:_____
Amount:_____
Frequency:_____

♦ALCOHOL & DRUG USE HISTORY

Has anyone in your family had any problems with alcohol or other drugs? (Children, parents, brothers and sisters, grandparents, uncles and aunts, cousins) ☐ Yes ☐ No

Who? _____Was it treated?_____

Have you ever received education or treatment for alcoholism or drug addiction? ☐ Yes ☐ No

Where and when? _____

Have you ever attended a meeting of Alcoholics Anonymous, Narcotics Anonymous or any other support groups? ☐ Yes ☐ No

What, when? _____

What is the longest period of time you have gone without any alcohol or drug use?_____

When? _____ Why? _____ How?_____

When returning to use how long did you drink/use drugs? _____

How many attempts to stop or control use of alcohol or drugs have you experienced?_____

When did you return to drinking or using other drugs?_____

What led to your return to use of alcohol or drugs? _____

What motivates you to stop or discontinue Alcohol/Drug use at this time?_____

Do you think you have a problem with alcohol or other drugs? ☐ Yes ☐ No Why or Why Not?_____

_____

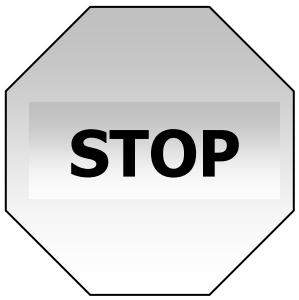
How important to you is it that you change your alcohol/drug use? _____

How confident are you that you will change your current drinking/drug use? _____

If you could do so easily, would you like to reduce or stop your alcohol/drug use? _____

Are you worried about getting in more trouble from drinking or drug use in the future? ☐ Yes ☐ No

Have you ever stopped drinking, then started smoking marijuana or taking another drug, including prescription medications?
☐ Yes ☐ No



Please continue on to next questionnaire. Thank you!

♦COUNSELOR SUMMARY

For Counselor Use only

Patient Presentation (check all that apply)

Attitudinal Posture:
Defensive ☐ Hostile ☐ Arrogant ☐ Passive ☐ Defiant ☐ Open ☐

How Dressed: _____
Hygiene: _____

Orientation to Time, Place and Person: ☐ Yes ☐ No

Patient's Statement of the Incident: _____

_____

_____

_____

Analysis of Breath test report:_____

Analysis of Complete Driving Abstract and/or Defendant Criminal History:
_____

_____

Analysis of Police: _____

Urine Drug Test results/analysis:_____

Substance Use Disorder: Mild ☐ Moderate ☐ Severe ☐

Any major barriers to treatment and/or recovery indicated at this time:
1.

2.

3.

Strengths/Assets:
1.

2.

3.

Major life situations to be aware of in treatment planning:
1.

2.

3.

Name: _____ Date: _____

BARTH CLINIC
JELLINEK QUESTIONNAIRE

NAME _____

DATE _____

Directions: Answer the following questions by filling in the correct answers in the blank at the right of the question or by circling "yes" or "no" at the right of the question.

A. **Age of first drink.** _____
B. **Age the first time you became drunk**. _____

(1)(a) **Do you drink more or less than you used to in order to obtain the same high?**
___More ___Less ___Same

(b) **Do you often take a drink to help relax**? Yes No

(c) **Do you sometimes forget things after drinking**? Yes No

(2)(b) 4. **Do you ever drink to relieve a hangover**? Yes No

5. **Have you had an accidental injury after or during drinking**?
(If yes, please explain) Yes No
_____
_____

6. **Have you ever felt guilt or embarrassed about your drinking**?
(Please explain) Yes No
_____
_____

7. **I occasionally drink heavily after a disappointment, a quarrel, or when the boss, wife, husband, or friends give me a hard time.** Yes No

8. **I have awakened on the "morning after" and discovered that I could not remember part of the evening before, even though my friends told me that I did not pass out.** Yes No

(3) 9. **When drinking with other people, I sometimes have a few extra drinks when others will not know it, or take a quick one while mixing or serving drinks. (Please explain)** Yes No
_____

(5) 10. **There are certain occasions when I feel uncomfortable if alcohol is not available.**
Yes No (if Yes, Please explain)
_____

(5) 11. **I noticed that lately I am in more of a hurry to get the first drink than I used to be**. Yes No

(3) 12. **I often find that I wish to continue drinking after my friends say they have had enough**. Yes No

13. **I usually have a reason for the occasions when I drink heavily**. Yes No
(If yes, give reason)_____

14. **I have tried switching brands or following different plans for controlling my drinking, such as not to drink before a certain hour, only at home, or only with friends, or just drink beer.** Yes No

(4) 15. **I have failed to keep the promises I made to myself about controlling or cutting down on my drinking.** (Even once) Yes No

(4)(3) 16. **I have thought of, or tried to control my drinking by making a change in jobs or moving to a new location.** Yes No

17. **When I drink I try to avoid... who**? _____

(2)(a) 18. **I sometimes have the shakes in the morning and find that it helps to have a drink to get going.** Yes No

(3) 19. **I have lost control of my drinking on occasion intending only to have a couple and I have ended up drunk. (Even once)** Yes No

(5) 20. **Did you ever worry if there would be enough alcohol at a party and have a few drinks before going in order to make sure you would have enough?**
Yes No

21. **Have you ever refused to talk about your drinking behavior?** Yes No
(Please explain. Does it irritate you when people say you have a problem ?)
_____

22. **Did you ever try to justify to yourself, or find an excuse for your heavy drinking**?
(For example, that alcohol was "medicine for your nerves, that your efficiency required alcohol, etc.?") Yes No

23. **Have you ever been aggressive, belligerent, or malicious, or done anything dangerous to yourself or others**? Yes No

24. **I have spent money, that I shouldn't while drinking (i.e. buying drinks, buying unnecessary things, giving big tips, making long distance calls, etc**.)
Yes No

(6) 25. **I have avoided doing things because they would interfere with being able to drink.** Yes No
(Please explain)_____
_____

(5) 26. **I have protected my supply of alcohol, that is, making sure that I would always have some handy that my family and friends would not find**. Yes No

(3) 27. **I sometimes stay drunk for several days at a time (over the weekend, camping trips, conventions, etc**.) Yes No

28. **I sometimes feel very depressed or pity myself and wonder whether life is worth living**. Yes No

(2)(a) 29. **Sometimes after periods of drinking, I see or hear things that aren't there, or become terribly frightened**. Yes No

(2)(b) 30. **I have occasionally used some non-beverage alcohol such as Nyquil cough medicine, vanilla extract, shaving lotion, canned heat, rubbing alcohol, etc., when no other drink was available**. Yes No

(1)(b) 31. **I have noticed I am now getting drunker on less alcohol**. Yes No

(2)(a) 32. **I sometimes have uncomfortable tremors, shakes, or jitters after drinking**.
Yes No

(2)(a) 33. **I have had DTs, seizures, hallucinations, etc., after a drinking bout**.
Yes No

34. **Have you had long periods of persistent remorse caused by your conduct while drinking, that is, not being able to shake off the idea that you've made a fool of yourself while drinking or that you have been unjust to your family or friends or had caused them great trouble, etc**? Yes No
(Please explain) _____
_____

(6) 35. **Have you ever walked out on your friends when drinking**? Yes No
(Please explain)_____

(6) 36. **Have you ever walked out on a job, or quit one while you were drinking, or had a hangover?** Yes No
(Please explain)_____
_____

37. **Have you ever thought about suicide**? (Even once. Please explain) Yes No
_____

Have you ever attempted suicide? Yes No

38. **Have you ever had problems remembering things or felt that your thinking was becoming disorganized?** Yes No
(Please explain)_____
_____

39. **Have you ever sought psychiatric help because of pressure by friends or relatives**? Yes No
(Please explain) _____
_____

(5) 40. **Have you ever had ideas or thoughts about drinking which you couldn't seem to get rid of even though you wanted to be rid of them**? Yes No

41. **Have you ever felt strong religious needs such as prayer, seeking your pastor's advice, began reading the Bible or religious literature, or felt the need for forgiveness since you started drinking?** Yes No

(4) 42. **Did you ever adopt a "what's the use?" attitude, that is, see no sense in trying to control your drinking, making a living, etc**.? Yes No

43. **Have you ever attended Alcoholics Anonymous**? Yes No
Approximately how many meetings? _____
When? _____ **Did it seem to help you**? Yes No

44. **Why are you here**?_____
_____
_____

45. **How do you feel about being here**?_____
_____
_____

46. **Do you think you might have a problem with alcohol**? Yes No
(Please explain)_____

47. **In what year do you feel that you were first an alcoholic, that is, could no longer control your drinking?_____ (Write in the year" or the word "never".)**

_____ _____
(Patient) **(Date)**

_____ _____
(Counselor) **(Date)**

BARTH CLINIC

Michigan Alcohol Screening Test (MAST)

1. Do you feel you are a normal drinker? ("normal"- drink as much or less than most other people)
   Yes ___ No___
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
   Yes ___ No___
3. Does any near relative or close friend ever worry or complain about your drinking?
   Yes ___ No___
4. Can you stop drinking without difficulty after one or two drinks?
   Yes ___ No___
5. Do you ever feel guilty about your drinking?
   Yes ___ No___
6. Have you ever attended a meeting of Alcoholics Anonymous?
   Yes ___ No___
7. Have you ever gotten into physical fights when drinking?
   Yes ___ No___
8. Has drinking ever created problems between you and a near relative or close friend?
   Yes ___ No___
9. Has any family member or close friend gone to anyone for help about your drinking?
   Yes ___ No___
10. Have you ever lost friends because of your drinking?
    Yes ___ No___
11. Have you ever gotten into trouble at work because of drinking?
    Yes ___ No___
12. Have you ever lost a job because of drinking?
    Yes ___ No___
13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
    Yes ___ No___
14. Do you drink before noon fairly often?
    Yes ___ No___
15. Have you ever been told you have live trouble such as cirrhosis?
    Yes ___ No___
16. After heavy drinking have you ever had delirium tremens (D.T.'s), sever shaking, visual or auditory (hearing) hallucinations?
    Yes ___ No___
17. Have you ever gone to anyone for help about your drinking?
    Yes ___ No___
18. Have you ever been hospitalized because of drinking?
    Yes ___ No___
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
    Yes ___ No___
20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was part of the problem?
    Yes ___ No___
21. Have you been arrested more than once for driving under the influence of alcohol? Yes ___ No___
22. Have you ever been arrested, even for a few hours because of other behaviors while drinking? (If yes, how many times _____) Yes ___ No___

_____ _____

Patient Signature Date

_____ _____ _____

Counselor Signature Date Score

X357 Revised 08/10/21

Substance Abuse Screening Instrument (04/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	___	___
2. Have you abused prescription drugs?	___	___
3. Do you abuse more than one drug at a time?	___	___
4. Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5. Are you always able to stop using drugs when you want to?	___	___
6. Do you abuse drugs on a continuous basis?	___	___
7. Do you try to limit your drug use to certain situations?	___	___
8. Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9. Do you ever feel bad about your drug abuse?	___	___
10. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11. Do your friends or relatives know or suspect you abuse drugs?	___	___
12. Has drug abuse ever created problems between you and your spouse?	___	___
13. Has any family member ever sought help for problems related to your drug use?	___	___
14. Have you ever lost friends because of your use of drugs?	___	___
15. Have you ever neglected your family or missed work because of your use of drugs?	___	___
16. Have you ever been in trouble at work because of drug abuse?	___	___
17. Have you ever lost a job because of drug abuse?	___	___
18. Have you gotten into fights when under the influence of drugs?	___	___
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20. Have you ever been arrested for driving while under the influence of drugs?	___	___
21. Have you engaged in illegal activities in order to obtain drug?	___	___
22. Have you ever been arrested for possession of illegal drugs?	___	___
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25. Have you ever gone to anyone for help for a drug problem?	___	___
26. Have you ever been in a hospital for medical problems related to your drug use?	___	___
27. Have you ever been involved in a treatment program specifically related to drug use?	___	___
28. Have you been treated as an outpatient for problems related to drug abuse?	___	___

Patient Name:_____ **Date**:_____

Counselor:_____ **Date**:_____

MARIJUANA USE INVENTORY TEST

Related to your use of pot have you ever:		Yes	No
1.	Used pot in a.m.?	☐	☐
2.	Used pot once a day or more?	☐	☐
3.	Been high on pot throughout the day?	☐	☐
4.	Used pot alone?	☐	☐
5.	Hidden your use from family/friends?	☐	☐
6.	Used at inappropriate times or places, i.e. school, work, driving a car?	☐	☐
7.	Experienced any loss of short term memory or your ability to concentrate?	☐	☐
8.	Experienced unusual fears, paranoia?	☐	☐
9.	Experienced any physical problems i.e. sore throat, congestion, coughing?	☐	☐
10.	Had a loss of interest in school, work, or other meaningful activities?	☐	☐
11.	Neglect work, missed work, been fired?	☐	☐
12.	Neglect school, missed classes, dropped out?	☐	☐
13.	Begun dealing to finance your habit?	☐	☐
14.	Wasted money, neglected bills, in debt?	☐	☐
15.	Been arrested for possession, or related inappropriate behavior because of use?	☐	☐
16.	Harmed relationships with family/friends?	☐	☐

MARIJUANA USE INVENTORY TEST

17.	Been confronted for usage by family or friends?	☐	☐
18.	Been unable to limit/stop usage?	☐	☐
19.	Felt guilty because of your behavior while using?	☐	☐
20.	Recognized that you have a problem?	☐	☐
21.	Sought counseling/treatment for pot abuse or related problems?	☐	☐
22.	Experienced a real need to use or significant distress when not using?	☐	☐
23.	Needed increased amounts to achieve the desired effects?	☐	☐
24.	Experienced a significant reduced effect with regular use of the same amount?	☐	☐
25.	Switched to more potent pot, i.e. sensimilla, hash, etc. to achieve the desired effect?	☐	☐

Total Yes _____
Total No _____

Patient Signature _____Date_____

Counselor Signature _____

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FAILED APPOINTMENT POLICY & FINANCIAL COMPLIANCE POLICY

Revised date: March 14, 2022

The goal of Barth Clinic is to provide high-quality, timely care. Rapid access to appointments is important to you and your counselor. If you find that you will not be able to keep your appointment, please let us know as soon as possible. At a minimum, we need to be notified 48 hours (or two weekdays) before your appointment. This gives us enough time to find another patient who can use the appointment.

Unfortunately, there are patients who don't show up for their appointment or cancel their appointment with very short notice. Because of this, we have the following policy:

You will be charged a $45.00 non-refundable fee that must be paid before your next appointment will be scheduled and all future appointments will be cancelled if one of the following happens:

- **You don't show up for your appointment.**
- **You cancel your appointment with less than 48 hours (or two weekdays) notice.**

Your insurer will not pay this fee. It will not be applied to your bill; it is a separate charge that you will be responsible for. You will be charged this fee for each missed appointment or late cancellation.

In addition, if you arrive late to your appointment, it is possible that we will not be able to see you that same day. Late arrivals force following appointments to run late for patients who do arrive on time.

Barth Clinic is a private, for profit clinic offering complete substance abuse services. We operate solely on a fee for service basis. We are fully self-supporting. The exceptional services provided by the staff and family of Barth Clinic are made available by practicing fiscal responsibility. Please be advised, we understand the economic realities of today. We are open and willing to provide services in an open and cooperative agreement with all persons served. We must practice accountability at all levels. We must advise all persons treated at Barth Clinic, all accounts must be satisfied in full prior to any satisfactory completion reports can be forwarded to outside entities; i.e. courts, governmental agencies, institutions or other referring parties.

Barth Clinic is a preferred provider for most private insurance companies, along with the 4 MCO's; Molina, Coordinated Care, Community Health Plan of Central Washington and Amerigroup.

Thank you for the opportunity to be of service.

Print name: _____ Date: _____

I _____ acknowledge receipt of the above referenced policies.
Signature of Patient

If you need to talk with someone about your appointment or account, please call our office at (509)457-5653 or Toll Free at (877)457-5657.

Special Consent for Release of Sensitive Information
Barth Clinic

Client Name:		Other Names:
DOB:	Address:	Phone Number:

Purposes for Release

The purpose of this Consent is to request and authorize Barth Clinic to use the Collective Platform to electronically transmit and disclose the sensitive information described below to past, present, or future members of my Care Team through the Collective Network for purposes of enabling members of my Care Team to provide Treatment to me. (See reverse side for answers to some Frequently Asked Questions).

Consent to Release Sensitive Information

I hereby request and authorize Barth Clinic to disclose my sensitive information and records as described below through the Collective Platform operated by Collective Medical Technologies, Inc. to the members of my Care Team identified below who are connected to or participate in the Collective Network. This consent and request applies to information and records concerning diagnosis and treatment of me as a minor, if applicable.

Amount and Kind of Sensitive Information to be Disclosed [Check **ONE** of the following boxes]

☐ Option #1: Full Care Documentation. Any of the following types of sensitive information or records which are available in Barth Clinic's electronic record (e.g., clinical notes, discharge summaries, care plans, lab results, medications, etc.) to my Care Team for purposes of providing me Treatment, including:

- Substance use (alcohol or drug) diagnosis and treatment information and any information related to my treatment at, or any records from, any substance use disorder program (including medications, treatment plans, clinical assessments or tests, symptoms, diagnoses, progress notes, etc.)
- HIV/AIDS or sexually transmitted disease (STD) diagnosis or treatment information and records
- Mental health, behavioral health, and developmental disability diagnosis and treatment information and records, whether on an inpatient or outpatient, or voluntary or involuntary basis
- Adult day program service information

☐ Option #2: Limited Care Team & Care Encounter Information. Only my sensitive information limited to identifying: (1) the type of providers who are members of my Care Team, such as providers that specialize in substance use (alcohol or drug) treatment or referral services, mental health (inpatient or outpatient, HIV or sexually transmitted diseases, developmental disability services, adult day programs and Social Services Providers; **AND** (2) the dates, locations, and types of encounters with such providers (e.g., associated diagnosis, complaint, service or location codes or information, etc.).

To Whom My Sensitive Information May be Disclosed

The sensitive information and records described above may be disclosed to all of the past, present, and future members of my Care Team (including Health Care Providers, Behavioral Health Providers, and Social Service Providers), which may access my sensitive information indicated above to enable them to provide Treatment to me as part of my overall Care Plan.

I understand that:

- I am authorizing Barth Clinic to disclose the sensitive information I have designated above, for the purposes and to the parties described in this Consent.
- My decision to sign this Consent is voluntary, and I understand that I may refuse to sign this Consent. My refusal to sign will not affect my ability to obtain Treatment or payment or my eligibility for benefits.
- As required under federal law (42 CFR Part 2, § 2.13(d)), upon my request Barth Clinic will provide me with a list of entities to which my sensitive information has been disclosed under this Consent.
- I understand that I have a right to receive a copy of this Consent.
- I understand that I may revoke (i.e., take back) my Consent in writing at any time. My revocation will take effect upon receipt by Barth Clinic except to the extent that others have already acted in reliance upon this Consent.
- My Consent will expire either upon my death, or if and when I decide to revoke it.

Client Signature:		Date:
Legal Representative (if any)	Signature:	Name:
Reason Client is unable to sign (if applicable):		

Relationship to Client: ☐ Parent ☐ Guardian/Conservator ☐ Health Care Power of Attorney

☐ Other Legally Authorized Representative under applicable state law (specify: _____ _____)

Definitions and Frequently Asked Questions
Barth Clinic

What is the Collective Network?

Barth Clinic participates in the network operated by Collective Medical Technologies, Inc. ("**Collective**") which connects Health Care Providers, Behavioral Health Providers, Social Service Providers, and managed care and other health insurance organizations ("**Collective Network**"). The Collective Network enables health care providers and organizations to connect and collaborate by sharing electronic health information for their shared patients through Collective Medical's software applications so they can better coordinate their efforts to provide safe, convenient, integrated care to you.

What is the Collective Platform?

The "**Collective Platform**" is a technology platform underlying a suite of software applications which enable health care providers to share historical summaries about your health care visits,, recommendations for how to best meet your needs when you visit a health care provider, contact information of your health care providers, and other information that can help these providers deliver care to you or perform care coordination activities on your behalf. The Collective Platform can also alert your Care Team about certain health care events, like when you have an emergency department visit, or when you have been discharged from the hospital after an inpatient stay.

Who is my Care Team?

Your "**Care Team**" includes your past, current, or future treating providers who have attested to Collective that they have a treating-provider relationship with you. Your Care Team may include a variety of health care professionals or facilities, such as "**Health Care Providers**" which are authorized under state law to provide health care or medical services (e.g., doctors, nurses, pharmacists, hospitals, health centers, etc.), "**Behavioral Health Providers**" authorized under state law to provide mental health or substance use disorder or referral services (e.g., psychiatrists, psychologists, counselors, other mental health professionals or substance use counselors, certain social workers, etc.), or "**Social Service Providers**" authorized under state law to provide diagnosis, evaluation, treatment, or consultation services (e.g., social workers, nurses, or other individuals with such professional licensure or credentials as required under state law).

What kind of activities does the term "Treatment" include?

The term "**Treatment**" includes activities related to the provision or coordination of health care and related services by one or more members of your Care Team, including referral or consultation for any condition for which you may receive care, including medical, mental health, or substance use disorder. Your Care Team may work with you to develop a plan of care (or "**Care Plan**") that includes a summary of your diagnosis, treatment goals, and treatment activities. Treatment activities can include sharing your information as may be necessary for your Care Team to provide a referral, conduct an evaluation, provide updates about your health care encounters or visits or new services, programs or benefits for which you are eligible, or sharing changes or updates to your Care Plan.

Why doesn't this Special Consent Form cover my general medical information?

HIPAA and applicable state privacy laws permit Collective to enable health care organizations which have a relationship with you and which participate in the Collective Network to use the Collective Platform to share your general medical information for treatment, payment, or health care operations purposes (as those terms are defined by HIPAA) without your specific authorization or consent. Collective and the health care organizations that have a relationship with you cannot share certain categories of your "sensitive information" that are protected under state or federal law, unless you sign a specific consent form which meets applicable legal requirements. The purpose of this Special Consent Form is to enable you to authorize members of your Care Team to have access to this sensitive information to better enable members of your Care Team to provide Treatment to you.

Am I required to participate in the Collective Network or can I opt-out?

Your participation is voluntary, and you may refuse to allow your information to be shared through the Collective Platform. You may choose not to sign this Special Consent Form, in which case your Care Team will not be able to share your sensitive information through the Collective Platform. You may also choose to "opt out" of allowing Collective to share your general medical information between health care organizations you work with. If you are interested in learning more about opting-out, ask Barth Clinic for more information about opting-out of the Collective Network.

Will signing this Special Consent Form affect other consents or authorizations I have signed?

You may have signed other consent or authorization forms, and your signing this Special Consent Form does not limit or revoke those other consents or authorizations.

Washington State Department of Social & Health Services
DBHR Division of Behavioral Health and Recovery

DIVISION OF BEHVIORAL HEALTH AND RECOVERY (DBHR)

DBHR Target Data Elements
Gain Short Screening Setup

ADMINISTRATION TIME	STAFF IDENTIFICATION	DATE	AGENCY NUMBER

SECTION I CLIENT IDENTIFICATION

1. LAST NAME	2. FIRST NAME	3. MIDDLE NAME	4. OTHER LAST NAME

5. GENDER ☐ Male ☐ Female	6. DATE OF BIRTH	7. SOCIAL SECURITY NUMBER	8. WASHINGTON DRIVER'S LICENSE OR ID NUMBER

9. WHICH RACE/ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK A MAXIMUM OF FOUR THAT APPLY)

- ☐ Asian Indian
- ☐ Black/African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian (Native)
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Refused to Answer
- ☐ Samoan
- ☐ Thai
- ☐ Vietnamese
- ☐ White/European American
- ☐ Non – Federal Tribe

Tribal Code (No. 1) _____

Tribal Code (No. 2) _____

10. SPANISH/HISPANIC/LATINO (CHECK ONE)

- ☐ Cuban
- ☐ Mexican, Mexican American, Chicano
- ☐ Not Spanish/Hispanic/Latino
- ☐ Other Spanish/Hispanic/Latino
- ☐ Puerto Rican
- ☐ Refused to Answer

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

*The following questions are about common psychological, behavioral or personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions Yes or No.*

Mental Health Internalizing Behaviors (IDScr 1): During the past 12 months, have you had significant problems		
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	☐ Yes	☐ No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling sleep during the day?	☐ Yes	☐ No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	☐ Yes	☐ No
d. when something reminded you of the past, you became very distressed and upset?	☐ Yes	☐ No
e. with thinking about ending your life or committing suicide?	☐ Yes	☐ No
Each yes answer is "1" point IDS Sub-scale Score (0 to 5) _		
Mental Health Externalizing Behaviors (EDScr 2): During the past 12 months, did you do the following things two or more times?		
a. Lie or con to get things you wanted or to avoid having to do something?	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home?	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home?	☐ Yes	☐ No
d. Been a bully or threatened other people?	☐ Yes	☐ No
e. Start fights with other people?	☐ Yes	☐ No
Each yes answer is "1" point EDS Sub-scale Score (0 to 5) _		
Substance Abuse Screen (SDScr 3): During the past 12 months, did…..		
a. you use alcohol or drugs weekly?	☐ Yes	☐ No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	☐ Yes	☐ No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	☐ Yes	☐ No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	☐ Yes	☐ No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	☐ Yes	☐ No
Each yes answer is "1" point SDS Sub-scale Score (0 to 5) _		

Counselor:_____ **Eval:** ☐ **Yes** ☐ **No** **Initial:** ☐ **Follow Up:** ☐

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ☐
- Somewhat difficult ☐
- Very difficult ☐
- Extremely difficult ☐

Counselor Name:_____ Patient ID:_____

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Diabetes Questionnaire

Have you been diagnosed with Diabetes? _____Yes _____No

If no, please move to question **6.**

If yes:

2. Are you currently being monitored by a physician? _____Yes _____No

3. Are you taking Insulin? _____Yes _____No

4. Are you currently taking another form of medication? _____Yes _____No

5. Do you know your current A1C level? _____Yes _____No

6. If no diagnosis of diabetes has been made,
are you concerned you may have diabetes? _____Yes _____No

If yes, would you like assistance finding a physician? _____Yes _____No

Thank you for taking this brief Questionnaire!

Please Type an X in the Corresponding box below, Thank you!

BARTH AND ASSOCIATES

Social Needs Screening Tool

Patient ID:_____ Counselor:_____

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

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Advancing health equity in every community

13. How often does anyone, including family, threaten you with harm?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____
Greater than 10 equals positive screen for personal safety.

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