Restoring Hope – Healing from Trauma and Addiction, LLC

Adult Intake Form

Date: Referred By:

Client Name: Date of Birth:

Gender: Race/Ethnicity:

Address:

` Street City State Zip Code

Home/Primary Phone: Okay to leave a message (circle one) yes no

Work Phone: Okay to leave a message (circle one) yes no

Cell/Other: Email:

Spouse/partner’s Name: Gender: Date of Birth:

Relational Status: # of Children:

Others Living in Your Home:

Occupation: Employer:

Have you been mandated to attend treatment? If yes, by whom?

Do you want this person involved in your care? If yes, did you complete a ROI form

Current Concerns: Check all areas which apply

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Trauma/Trauma related symptoms |  | Life Transitions |  | Insecurity/Self-esteem |
|  | Anxiety/Stress |  | Anger |  | Spiritual Issues |
|  | Relationships |  | Grief |  | Health |
|  | Depression |  | Family  |  | Suicidal Thoughts |
|  | Substance use |  | Parenting |  | Sexuality |
|  | Other addictive behaviors |  | Career |  | Abuse |
|  | Divorce |  | School |  | Legal |

What is the major concern for which you are seeking counseling/treatment?

On a scale from 1 (mild) to 5 (severe), how would you rate your issues*?*

How long have these issues been a concern?

What are your goals for counseling/treatment?

Describe your personal strengths:

Describe your support system (family, friends, church, etc):

Have you received counseling/treatment in the past? If yes, what issues?

Was it helpful?

Medical Information:

Physician’s name: Phone:

Current medical or diagnosis (physical/mental) conditions:

List of medications, purpose and dosage:

Emergency Contact:

Name Relationship Phone

Insurance Information Sheet

Client Name: Birth Date: Gender:

(Circle One) Relationship to Insured: Self Spouse Child

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Status: SINGLE MARRIED OTHER:

Employment Status: Full-time Part-time Unemployed Student

Other: (please explain):

Insured’s Name: Birth Date: Please Print exactly as it appears on your Insurance Card

Insured Address: Home Phone: (Only list if different from client) (Only list if different from client)

Work Phone: Cell Phone:

(Only list if different from client) (Only list if different from client)

Insurance company name:

Policy Number: Group Number:

I, as a Client or Insured Family Member, give consent and acknowledgment that this and other client information will be released to Insurance Carriers that provide financial reimbursement for requested services with Restoring Hope – Healing from Trauma and Addiction, LLC

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Insured Family Member Name Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Insured Family Member Signature Date:

**ADMISSION POLICY**

Restoring Hope – Healing from Trauma and Addiction, LLC will admit persons into the outpatient (OP) or (IOP) intensive outpatient treatment program whom have presenting symptoms and environmental factors which indicate the severity of the symptoms can be safely and adequately treated with outpatient services. Restoring Hope follows the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013 to determine the appropriate level of care placement for persons with a mental health diagnosis, co-occurring disorders or substance use or other addictive disorders, as defined in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Washington, DC, American Psychiatric Association, 2000. DSM-5 diagnostic criteria. Individuals with substance use or other addictive disorders must have a diagnosis specifier of at least “mild” in order to be admitted into the outpatient program. Individuals may be admitted into an ASAM .5 Early Intervention Treatment Program with no substance use or addictive disorder diagnosis yet must meet the ASAM criteria for this level of care.

**CRITERIA FOR ADMISSION**

1. Any person age 12 and older.

2. Experiencing distress or impairment in daily functioning due to PTSD diagnosis, or toxic stress, or experiencing other trauma-related symptoms

3. Has a behavioral health disorder, substance use disorder, or other addictive disorder or co-occurring disorders whom presenting symptoms of sufficient severity to bring about impairment or distress in day-to-day social, vocational and/or educational functioning with any of the following:

a. Need for ongoing observation or assessment

b. Need for therapeutic interventions

4. Person who is experiencing emotional distress or psychiatric symptoms that may be reduced, controlled or improved through outpatient services and does not require 24-hour monitoring

5. The participant wants help and voluntarily admits her/himself for treatment.

6. The participant physically and emotionally and cognitively able to participate in outpatient treatment.

7. Following admission, should a client be found inappropriate for treatment due to the onset of an emotional, behavioral, or cognitive condition; or biomedical condition or complication that distracts from treatment, proper referral is made and the outcome of the referral is noted in the client’s record.

8. Third party pay coverage and/or ability to pay privately.

9. There shall be no discrimination in the admission of a client – either by sex, race, creed, color, religious preference, or handicap.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

**PARTICIPANT RIGHTS and RESPONSIBILITIES**

Restoring Hope – Healing from Trauma and Addiction, LLC will ensure and protect the fundamental human, civil, constitutional, and statutory rights of each participant. The following is a listing of your rights while receiving services here:

* The right to impartial access to treatment and services, regardless of race, creed, color, religion, gender, national origin, age, or disability.
* The right to a humane treatment environment that ensures protection from harm and provides privacy to as great a degree as possible with regard to personal needs and promotes respect and dignity for each individual.
* The right to communication in a language and format understandable to the participant.
* The right to be free from mental, physical, sexual and verbal abuse, neglect, and exploitation.
* The right to receive services within the least restrictive environment possible.
* The right to an individualized service plan, based on assessment of current needs.
* The right to actively participate in planning for treatment and recovery support services.
* The right to have access to information contained in one’s record, unless access to particular identified items of information is specifically restricted for that individual participant for clear treatment reasons in the participant’s treatment plan.
* The right to confidentiality of records and the right to be informed of the conditions under which information can be disclosed without the individual’s consent.
* The right to refuse to participate in any research project without compromising access to program services.
* The right to exercise rights without reprisal in any form, including the ability to continue services with uncompromised access.
* The right to have the opportunity to consult with independent specialists or legal counsel, at one’s own expense.
* The right to be informed in advance of the reason for discontinuance of service provision, and to be involved in planning for the consequences of that event.
* The right to receive an explanation of the reasons for denial of service

**Additional Rights:**

* The name, credentials, and title of the Primary Counselor and any other professionals involved in the client’s treatment.
* The level of care recommended as a result of the assessment including what that entails with regard to number of weekly treatment hours, types of classes involved, support group requirements, and procedures required in treatment.
* The tools utilized in the treatment process as needed including workbooks, videos, and reading materials.
* Potential risks involved with continued use, withdrawal symptoms to be aware of, relationship changes that may occur with recovery, and beneficial changes that also may result.
* Treatment alternatives including the progression of treatment that may include a higher and/or lower level of care, social support resources, and individual medical/psychological care.
* The client’s right to refuse to participate in outcome measures or any other research that may be being conducted while client is in treatment at this facility.
* The client’s right to refuse to participate in specific treatment procedures and will be given information regarding alternatives as well as potential outcomes of the absence of such procedures.
* Expectation that cost of services are due at the time of services unless prior arrangements have been made and agreed upon in writing. Client will be informed of all treatment costs, funding options, and criteria for funding options as available.
* The Client Rights and Responsibilities Form which includes rules regarding personal conduct, attendance, treatment participation, etc and the consequences of deviation from expectations.
* The Grievance Policy as it applies to client’s rights.

**RESPONSIBILITIES:**

The following list is a listing of your responsibilities while receiving services here:

* You are responsible for attending appointments as scheduled and giving a minimum of 24-hour notice if you cannot attend
* You are responsible for participating in treatment and following through with homework or other tasks assigned by your counselor
* You are responsible for expressing concern or complaints that you have to your counselor or the program administrator.
* You are responsible for maintaining personal boundaries and respecting the boundaries that may be set by your counselor
* You are responsible for adhering to the rules of confidentiality of other group or treatment participants.

I have read, understand and have received a copy of my rights and responsibilities

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

**Restoring Hope – Healing from Trauma and Addiction, LLC**

**Participant Notice & Rights**

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**General Information**

Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 V.S.C. § 1320d et seq., 45 CFR Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 CFR Part 2. Under these laws, Restoring Hope - Healing from Trauma and Addiction, LLC may not say to a person outside Restoring Hope - Healing from Trauma and Addiction, LLC that you attend the program, nor may Restoring Hope - Healing from Trauma and Addiction, LLC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Restoring Hope - Healing from Trauma and Addiction, LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Restoring Hope - Healing from Trauma and Addiction, LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Restoring Hope - Healing from Trauma and Addiction, LLC can share information for treatment purposes or for health care operations. However, federal law permits Restoring Hope - Healing from Trauma and Addiction, LLC to disclose information without your written permission:

A. Pursuant to an agreement with a business associate

B. For research, audit or evaluations

C. To report a crime committed on Restoring Hope - Healing from Trauma and Addiction, LLC premises or against Restoring Hope - Healing from Trauma and Addiction, LLC personnel

D. To medical personnel in a medical emergency

E. To appropriate authorities to report suspected child abuse or neglect

F. To appropriate authorities to report suspected elderly abuse or neglect

G. As allowed by a court order

For example, Restoring Hope - Healing from Trauma and Addiction, LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a business associate agreement in place.

Before Restoring Hope - Healing from Trauma and Addiction, LLC can use or disclose any information about your health in a manner, which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. You may revoke any such written consent in writing.

**Your Rights**

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. Restoring Hope - Healing from Trauma and Addiction, LLC is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency. You have the right to request that we communicate with you by alternative means or at an alternative location. Restoring Hope - Healing from Trauma and Addiction, LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Restoring Hope - Healing from Trauma and Addiction, LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances. Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Restoring Hope - Healing from Trauma and Addiction, LLC’s records, and to request and receive an accounting of disclosures of your health related information made by Restoring Hope - Healing from Trauma and Addiction, LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

**Restoring Hope - Healing from Trauma and Addiction, LLC’s Responsibility**

Restoring Hope - Healing from Trauma and Addiction, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Restoring Hope - Healing from Trauma and Addiction, LLC is required by law to abide by the terms of this notice. Restoring Hope - Healing from Trauma and Addiction, LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. (In the event of any revision to this notice, clients will be required to review, sign, and date revised notice)

**Complaints & Reporting Violations**

You may complain to Restoring Hope - Healing from Trauma and Addiction, LLC or the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. Complaints concerning potential violations of HIPAA regulations may be filed with any Restoring Hope - Healing from Trauma and Addiction, LLC staff member. Staff will then refer all complaints to Restoring Hope - Healing from Trauma and Addiction, LLC Privacy Officer/Executive Director. The Privacy Officer will review any and all complaints by means of interview with complainant. Complaints may be made either orally or in writing (If an oral complaint, client may be asked to provide written documentation of the incident in question). You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

For further information, contact: Leslee Whiteman

 850 E. Franklin Rd., Ste. 405

 Meridian, ID 83642

*Effective Date: This notice is in effect as of September 1, 2019*

I hereby acknowledge receiving a copy of this notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

**Clients have rights protected by State and/or Federal law, and Professional ethical standards. For information contact: Idaho department of health and welfare. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. Mailing address. P.O. Box 83720, Boise, Idaho 83720-0036. business OFFICE. 450 West State St., Boise, Idaho 83702. Telephone. (208) 334-5500. http://www.healthandwelfare.idaho.gov.**

**CONFIDENTIALITY OF PATIENT RECORDS**

The confidentiality of behavioral health 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 abuse or behavioral health patient 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 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 participant 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.

Individual licensure laws may require the release of confidential information if there is imminent danger of harm to self or others.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal Regulations.)

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Client Signature Date

**PROHIBITION ON RE-DISCLOSURE STATEMENT**

Notice to accompany disclosure. Each disclosure made with the patient’s written consent must be accompanied by the following written statement:

 This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[52 FR 21809, June 9, 1987; FR 41997, Nov. 2, 1987]

**Release of Information (ROI)**

Restoring Hope - Healing from Trauma and Addiction, LLC

850 E. Franklin Road, Suite 405 Meridian, ID 83642

Ph: 208-602-9296 Fax: 208-343-4993

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Client Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency requesting or needing information: **Restoring Hope** – **Healing from Trauma and Addiction, LLC**

I authorize the following person or business to release or disclose confidential information about me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of information to be disclosed: \_\_\_ Psychiatric \_\_\_Drug/Alcohol \_\_\_ HIV/AIDS

Description of information requested: All Verbal and Electronic \_

This release of information is good until **Discharge + 60 days**

I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization.

Copy requested and received: **[ ] Yes I want a copy [ ]  No I do not want a copy**

I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Client or guardian (individual over 14 both must sign) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

CONFIDENTIALITY AGREEMENT

I recognize that the services provided by Restoring Hope- Healing from Trauma and Addiction, LLC for its clients are private and confidential. Therefore, I agree to keep the information from any activity confidential. Additionally, I understand that this agreement is in effect both during and after my involvement in any activity related to the care and treatment of clients of Restoring Hope- Healing from Trauma and Addiction, LLC.

I have read, understand, and agree with this Confidentiality Agreement I recognize that disclosure or access of information by me may cause irreparable injury to Restoring Hope- Healing from Trauma and Addiction, LLC or clients, and be subject to disciplinary action.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Date

**Consent for Treatment**

**Restoring Hope – Healing for Trauma and Addiction, LLC**

I have chosen to receive behavioral health services in the form of individual/group counseling for myself and/or my child from Restoring Hope – Healing from Trauma and Addiction, LLC. My decision is voluntary and I understand that I may terminate these services at any time, if my participation has been mandated by a court of law, there may be consequences of terminating my services. I understand that I can ask for my services to be transferred to a different treatment provider, at which time I understand I would need to provide a signed release of information for my treatment information to be transferred.

**Nature of Behavioral Health Services**

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

**Compliance with treatment plan**

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

**Supervision**

I understand there are certain circumstances which may require Restoring Hope – Healing from Trauma and Addiction, LLC to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation, organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
4. Other special circumstances, such as preparation to testify in court

**Emergencies**

I understand I may reach Restoring Hope – Healing from Trauma and Addiction, LLC at 208-602-9296. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life threatening emergency situation, I may call 911.

I have read, discussed and understood all of the above.

Client Signature/Date Staff Signature/Date

**Restoring Hope – Healing from trauma and addiction, llc**

**Brief Substance Use Disorder Screening Tool**

|  |
| --- |
| Name: |
| Date: |
| The following questions are about your use of alcohol and drugs. Alcohol includes beer, hard liquors (whisky, vodka, etc.) and mixed drinks. Drugs include marijuana, cocaine, meth, heroin, inhalants (example: gas, glue, paint.), over use of prescription drugs (example: painkillers, valium, ADHD meds, etc.). Please circle yes or no if the questions below have EVER applied to your life. | Scale |
| Yes | No |
| 1. You used more alcohol and/or drugs than you wanted.
 | 1 | 0 |
| 1. You were not able to cut down or control your use of alcohol and/or drugs.
 | 1 | 0 |
| 1. You spent a lot of time getting, using, or having hangovers from the effects of alcohol and/or drugs.
 | 1 | 0 |
| 1. You had cravings, a strong urge to use alcohol and/or drugs.
 | 1 | 0 |
| 1. Getting high on alcohol and/or drugs caused you not get tasks done.
 | 1 | 0 |
| 1. You got high on alcohol and/or drugs even though you had frequent problems with other people.
 | 1 | 0 |
| 1. You gave up or reduced social, work, or recreational activities because of alcohol and/or drugs.
 | 1 | 0 |
| 1. You used alcohol and/or drugs in situations that are dangerous.
 | 1 | 0 |
| 1. You kept using alcohol and/or drugs even though you had physical or mental problems that were caused or made worse by alcohol and/or drug use.
 | 1 | 0 |
| 1. You needed more alcohol and/or drugs to get high OR the same amount had less effect.
 | 1 | 0 |
| 1. You had withdrawal problems with alcohol and/or drugs (being sick, throwing up, etc.), or took other drugs to avoid withdrawal problems.
 | 1 | 0 |

**Scoring Reference Guide**

0 – 1 No indication of a Substance Use Disorder

2 – 3 \*Indicates the possible existence of a Mild Substance Use Disorder

4 – 5 \*Indicates the possible existence of a Moderate Substance Use Disorder

6 – 7 \*Indicates the possible existence of a Severe Substance Use Disorder

*\* Client must be referred for an assessment at Restoring Hope- Healing from Trauma and Addiction, LLC*