The Caring Center of Wichita, LLC
SA Acknowledgement Form

Name:	Patient ID:

My initials below Indicate that I have reviewed with the counselor at Caring Center of Wichita, LLC verbally and an explanation was given for each of the identified admission requirements listed below. A copy of each shall be provided to me should I elect to receive such copy once it has been signed.

______ Notice of Privacy Practices and Consent

______ Patient Rights and Responsibility

______ Grievance Policy and Grievance Form

______ Fee Schedule

______ Services Agreement

______ Infections Disease (HIV/AIDS, Tuberculosis, Hepatitis, and STIs)

______ Drug Testing Policy

______ Treatment Contract

I have chosen to receive/or not to receive copies of the above information
(initial one of the options below)

______ Paper Copy

______ I have declined to receive copies

______________________________/__________ ______________________________/__________
Patient signature Date Counselor signature Date

The Caring Center of Wichita, LLC

Substance Abuse Concerns Checklist

Name: ______________________________ ID: ______________________ Date: _____________

Please mark all of the items below that apply and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concern checked.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse – physical, sexual, emotional. Neglect, or cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use – prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems – overeating under eating, appetite, vomiting
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores – quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outburst
- ☐ Irresponsibility
- ☐ Judgement problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriages, differ expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension

The Caring Center of Wichita, LLC

Substance Abuse Concerns Checklist

- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitively to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhabitations, laziness
- ☐ Relationship problems (with friends, relatives, work)
- ☐ School problems
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunction, conflicts, desires, differences, other
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems – too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolation
- ☐ Work problems, employment, workaholic/over working, can't keep a job, dissatisfaction, ambition

Any other concerns or issues? (If there are no other concerns, please indicate by "none.")

____

____

Please look back over the concerns you have checked and choose the ones you most want help with.

____

____

This is a strictly confidential Patient Treatment Record. Disclosure or transfer is expressly prohibited by law.

Personal and Substance Use History and Assessment

Patient ID: ______________________

Assessor's Name:	Date of Assessment:

General Information

Patient Name:			Date of Birth (DoB):
Other names (maiden, professional, etc.):			
Address:			
City:		State:	Zip code:
Mobile Phone:	Home Phone:	Email Address:	

Referred By:	Date of Referral:
Presenting issue(s):	
Emergency Contact:	Mobile Phone Number:
Primary Care Doctor:	Work Phone Number:

Highest Level of Education Completed:	Vocational Experience	Yes	No
Religious/Spiritual Affiliation:	Military Experience	Yes	No

Current Living Situation & Support Systems

Economic Resources

Gross Income:	Number in Household:	Client Identified Support System Available:

Personal and Substance Use History and Assessment

Patient ID: ____________________

Five-year Employment History

Employer Name	Dates of Employment	Reason for Leaving

Information on Immediate Family Members *(Parents, Siblings, Others)*

Name	Relationship	Age	Health	Substance Use	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Children

Name	Age	Biological	Adopted	Step	Foster

Personal and Substance Use History and Assessment

Patient ID: ____________________

Social and Family History

Marital Status (Choose One):						Currently in a Relationship?			Number of Marriages
Single	Cohabiting	Married	Separated	Divorce	Widowed	Yes	No	Years	

Significant Other information *(Parent, Guardian, or Representative if applicable)*

Name:	Relationship:
Address:	Mobile Phone:

History of Alcohol and/or Drug Problems? If yes, what?	Yes	No

Risk of Suicidal or Homicidal Behavior

History of Behavior	Yes	No	Details
Suicidal Thoughts/Plan?			
Attempts (Last 10-years)			

History of Behavior	Yes	No	Details
Homicidal Thoughts/Plan?			
Attempts (Last 10-years)			

Other Mental Health and Social issues

Problem	Yes	No	Problem	Yes	No
Anger/Aggression			Depressed Mood		
Feeling Anxious			Difficulty Concentrating		
Lacks Trust in Others			Problems w/Perfectionism		
Impulsive/Lacks Self-control			Difficulty w/Decision Making		
Fears/Phobias			Problems w/Socializing		
Unresolved Grief/Loss			Relationship Issue		
Racism/Sexism			Gambling Problems		
Discrimination Issues			Spiritual/Religious Issues		
Addictions (Sex, Food, Gambling)			Other:		

>>If at any time additional space is needed, please advise the counselor.<<

History or Pattern of Abuse

Patient ID: ___________________

Abuse	Yes	No	Victim? Y or N	Perpetrator (Who?)	Alleged or Documented	Age	Treatment History
Physical							
Abuse	**Yes**	**No**	**Victim? Y or N**	**Perpetrator (Who?)**	**Alleged or Documented**	**Age**	**Treatment History**
Sexual							
Abuse	**Yes**	**No**	**Victim? Y or N**	**Perpetrator (Who?)**	**Alleged or Documented**	**Age**	**Treatment History**
Emotional and/or Verbal							

Personal and Substance Use History and Assessment

Patient ID: ____________________

Treatment History

Previous Alcohol and Drug Treatment: Yes No	If yes, please see below:	
Substance Abuse Provider	**Dates of Service**	**Outcome**
Previous Mental Health Treatment: Yes No	If yes, please see below:	
Mental Health Provider	**Dates of Care**	**Outcome**

Medical History

Have you or any of your immediate family ever been diagnosed or treated for any of the following?

Condition	Yes No	Who	Condition	Yes No	Who
Diabetes	Yes No		Low Blood Sugar		
High Blood Pressure	Yes No		Low Blood Pressure		
Heart Problems	Yes No		Epilepsy		
Gastritis	Yes No		Ulcers		
Pancreatic	Yes No		Cancer		
Other:	Yes No		Other:		

Current Medications *(include all medications both prescribed and over the counter)*

Medication	Route	Dosage	Prescribing Doctor	Reason

Personal and Substance Use History and Assessment

Patient ID: ____________________

Risk Factors for Infectious Disease *(i.e. HIV, AIDS, and STDs)*

TB Skin Test in last 30-days Yes No	If positive, date of last chest x-ray:

TB Risk Assessment Questions	**Yes**	**No**
1) Have you had contact with someone who has infectious TB disease?		
2) Were you born in an area of the world where TB is common (i.e. Asia, Africa, or Latin America?		
3) Do you have inadequate access to healthcare, or have you been homeless in the last two years?		
4) Have you lived or worked in residential facilities? (For example in nursing homes, correctional facilities, or treatment facilities)		
5) Have you worked in a facility where you may have been exposed to TB? (Health care workers who serve high-risk symptoms)		
If any of the above TB Questions were answered yes, the patient should be evaluated for the following symptoms:	**Yes**	**No**
1) A cough lasting over three weeks?		
2) Sputum production of blood in cough?		
3) Unexplained loss of appetite or sudden weight loss?		
4) Fever, chills, or night sweats for no reason?		
5) Persistent shortness of breath?		
6) Increase fatigue?		
7) Chest pain?		

Other Risk-related Questions	**Yes**	**No**
Have you participated in any of the following high-risk behaviors? (Unprotected sex, multiple sex partners, sex with a prostitute, IV drug use, shared needles, anal sex, same-sex relationship)		
Have you been tested for HIV/AIDS?		
Have you been tested for Hepatitis B and/or C?		
Have you been tested for other sexually transmitted diseases?		
Would you like a referral to be tested for any of the above?		

Questions Related to Substance Use	**Yes**	**No**
Have you ever experienced blackouts from substance use?		
Do you have a family history of substance use?		
If so, who?		
Are you a Nicotine abuser?		
If so, do you use (circle) Cigarettes/Cigars or Smokeless Tobacco (Chew)		
How old were you when you first used Tobacco products?	Age:	
Have you made any attempts to quit or cut down?	Yes	No

Personal Substance Abuse History

Patient ID: ___________________

Key for Frequency of Use:	E=Experimented, used once or twice ever. R=Regular, used at least weekly.	O=Occasional, used less than once a month. D=Daily use. RX=Abused a prescription drug.

Key for Route Used: O=Oral SM=Smoked IV=Intravenous H=Huffed/Inhaled SN=Snorted/Snuffed

Drug Used	Age of First Use	Amount Used Now	Frequency of Use	Route Used	Longest and Last Period of Abstinence	Date and Time of Last Use	Behavior During Use	Effects on Relationships

>>If at any time additional space is needed, please advise the counselor.<<

Common Drugs Used may include: Marijuana, Hashish, Methamphetamines, Alcohol, Opiates, Inhalants, Steroids, Over-the-Counter (Coricidin, Robitussin, Dramamine), LSD, PCP, Club Drugs (Ecstasy, GHB, Ketamine), Heroin, Benzodiazepines (Xanax, Valium, Klonopin, Ativan), Tranquilizers (Thorazine, Haldol, Ativan), Barbiturates/Sedatives (Nembutal, Seconal, Tuinal, Quaaludes), MOMA, Mushrooms, Peyote, Narcotics (Hydrocodone, OxyContin, Codeine, Dilaudid, Demerol, Morphine)

Personal and Substance Use History and Assessment

Patient ID: ____________________

Legal History: Current & Pending

Pending Legal Charges? Yes No

Charge	Date of Arrest	Court Date	County	Attorney Involved

Legal History: Past

Past Legal Charges?	Yes	No		
Charge	**Convicted**		***Incarceration Dates***	***Supervising Officer (if applicable)***
	Yes	**No**		

Legal History: DUI

DUI Arrests?		Yes	No		Total Number of DUI Arrests?	
Within Last 30-Days?		Yes	No			
Date of Arrest	**BAC Level**	**Convicted?**		**Incarcerated?**		**Attorney Involved**
		Yes	No	Yes	No	

Driving History: (For DUI Evaluations)

Charge	Date	Convicted?		Incarcerated?		Attorney Involved
		Yes	No	Yes	No	

Patient Signature ____________________ *Date* ____________

Personal and Substance Use History and Assessment

Patient ID: ____________________

>>For Office Use Only<<

Information from collateral sources when available:

Treatment Techniques Utilized:	Cognitive Restructuring	Behavioral Intervention

Treatment Modality Recommended	ADIS/Early Intervention	
	Outpatient Level 1	
	Intensive Outpatient	
	Inpatient	
	Reintegration	
	Other:	

Client Response to the following questions"

What are you most concerned about today?
What is your primary goal for Treatment?
What positive characteristics can help you with this problem?
What barriers or roadblocks might prevent you from being successful?

Summary and Rationale for Recommendations:

_______________________________________ _______________

Counselor Signature *Date*

This is a strictly confidential Patient Treatment Record.

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Name: ______________________________ ID: ________________________ Date: ______________

Instructions: Please read each question carefully, then circle one of the numbers to the right to indicate how you have felt or behaved during the past week, including today.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people dislike me.	0	1	2	3
20. I could not get "going."	0	1	2	3

Co-occurring Disorders Program: Screening and Assessment
Document is in the public domain. Duplicating this material for personal or group use is permissible.

This is a strictly confidential Patient Treatment Record. Disclosure or transfer is expressly prohibited by law.

The Caring Center of Wichita, LLC
Consent for Release of Confidential Alcohol and/or Drug Treatment Information

I ____ authorize The Caring Center of Wichita, LLC and:

Person or Agency Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

to communicate with and disclose to one another the following information (nature and amount of the information will be as limited as possible):

Client's Initial Information to be released:

____ Name and Presence in Treatment
____ Evaluation & Recommendations
____ Diagnosis
____ Urinalysis & Breath Test Results
____ Social Security Number & Date of Birth
____ Medical Reports & Medication
____ Services Rendered
____ Entire Kansas Client Placement Criteria (KCPC) History & other bio psychosocial assessments

____ Progress Reports
____ Discharge Date, Summary, & Plan
____ Treatment Plan
____ Attendance Record
____ Emergency Related Information
____ Letter/Certificate of Completion

The purpose(s) of the disclosure (initial only those that apply):

____ Assessment/Evaluation
____ Family Support and Engagement
____ Legal Involvement
____ Billing & Reimbursement
____ Emergency Situation(s)
____ Disability Determination
____ Other (Please be specific)
____

Coordination of Care with (initial only those that apply):

____ Treatment/Service Provider
____ Employer's Employee Assistance Program (EAP)
____ School
____ Child Welfare and/or Custody
____ Medication Management

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C. F. R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken In reliance on It, and this consent automatically expires one year after the date of signature.

__________________________________/__________ __________________________________/__________

Patient/Guardian Signature Date Witness Signature Date

the SASSI INSTITUTE

Client ID/Name:________________________ Date:________________________

DSM-5 Diagnostic Criteria for Substance-Use Disorders Checklist*

For each item, mark whether the client has ever manifested evidence of the symptoms addressed for a given substance. SUD = A problematic pattern of substance use, leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period.

If YES is checked for any item, indicate the substance(s) being referred to for that symptom by placing a check in the appropriate column to the right:	**Alcohol**	**Cannabis**	**Hallucinogens**	**Inhalants**	**Opioids**	**Sedatives/ Hypnotics**	**Stimulants**	**Other**
1. Is the substance often taken in larger amounts or over a longer period than was intended? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
2. Is there a persistent desire or unsuccessful efforts to cut down or control use? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
3. Is a great deal of time spent in activities necessary to obtain a substance, or recovering from its effects? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
4. Does the client have a craving or strong desire or urge to use substances? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
5. Is there recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
6. Is there continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substance use? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
7. Are important social, occupational, or recreational activities given up or reduced because of substance use? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
8. Is there recurrent substance use in situations in which it is physically hazardous? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
9. Is substance use continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance use? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐

*American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Washington DC. American Psychiatric Association, 2013.

10-14-13NR

If YES is checked for any item, indicate the substance(s) being referred to for that symptom by placing a check in the appropriate column to the right.	Alcohol	Cannabis	Hallucinogens	Inhalants	Opioids	Sedatives/ Hypnotics	Stimulants	Other
For question 10: *First, indicate all substances showing* ***tolerance:*** 10. a) Does client have a need for markedly increased amounts of a substance to achieve intoxication or desired effect? ***or*** b) Does client experience a markedly diminished effect with continued use of the same amount of a substance? yes_____ no_____	☐	☐	☐	☐	☐	☐	☐	☐
Now, ***check all substances indicated which were used properly by prescription:***	N/A	☐	N/A	N/A	☐	☐	☐	☐
For question 11: *First, indicate all substances showing* ***withdrawal:*** 11. a) Has client experienced withdrawal syndrome, as manifested by the presence of: **2 or more signs or symptoms for alcohol or sedatives; 3 or more for cannabis or opioids; 2 or more plus dysphoric mood for stimulants**, when he/she hasn't had that substance in awhile? *These signs and symptoms may include: sick (nausea or vomiting), anxious, agitated or irritable, insomnia, fatigue, muscle aches, change in appetite, depressed, diarrhea, fever, sweating or high pulse rate.* ***or*** b) Has client continued to take a substance to avoid withdrawal, or taken some other substance in order to feel okay? yes_____ no_____	☐	☐	N/A	N/A	☐	☐	☐	☐
Now, ***check all substances indicated which were used properly by prescription:***	N/A	☐	N/A	N/A	☐	☐	☐	☐
For each substance sum and enter the total number of symptoms (0-11) marked yes. DO NOT count substances indicated as being properly used by prescription for items 10 & 11:								

Specify current severity by substance:		Alcohol	Cannabis	Hallucinogens	Inhalants	Opioids	Sedatives/ Hypnotics	Stimulants	Other
No Diagnosis = 0 – 1 criteria	**No Diagnosis**	☐	☐	☐	☐	☐	☐	☐	☐
Mild SUD = 2 – 3 criteria	**Mild SUD**	☐	☐	☐	☐	☐	☐	☐	☐
Moderate SUD = 4 – 5 criteria	**Moderate SUD**	☐	☐	☐	☐	☐	☐	☐	☐
Severe SUD = 6 or more criteria	**Severe SUD**	☐	☐	☐	☐	☐	☐	☐	☐

Specify remission status, if applicable.

How long client has been free of all symptoms (excluding #4):

☐ Early remission (past 3-11 months) ☐ Early remission & currently in controlled environment

☐ Sustained remission (12 months or more) ☐ Sustained remission & currently in controlled environment

Specify substance(s) in remission: ☐ Alcohol ☐ Cannabis ☐ Hallucinogens ☐ Inhalants ☐ Sedatives/Hypnotics

☐ Stimulants ☐ Opioids ☐ Opioids & currently on opioid maintenance therapy ☐ Other *Specify:*_______________

Form used with permission from Substance Abuse Subtle Screening Inventory -- SASSI Institute

Client ID#	Today's Date	Facility ID#	Zip Code	Administration

TCU Drug Screen V

During the last 12 months (before being locked up, if applicable) –

		No	Yes
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

- O None
- O Alcohol
- O Cannabinoids – Marijuana (weed)
- O Cannabinoids – Hashish (hash)
- O Synthetic Marijuana (K2/Spice)
- O Opioids – Heroin (smack)
- O Opioids – Opium (tar)
- O Stimulants – Powder Cocaine (coke)
- O Stimulants – Crack Cocaine (rock)
- O Stimulants – Amphetamines (speed)
- O Stimulants – Methamphetamine (meth)
- O Bath Salts (Synthetic Cathinones)
- O Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)
- O Dissociative Drugs – Ketamine/PCP (Special K)
- O Hallucinogens – LSD/Mushrooms (acid)
- O Inhalants – Solvents (paint thinner)
- O Prescription Medications – Depressants
- O Prescription Medications – Stimulants
- O Prescription Medications – Opioid Pain Relievers
- O Other (specify) ____________________

© Copyright 2014 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

Client ID#	Today's Date	Facility ID#	Zip Code	Administration

13. How often did you use each type of drug during the last 12 months?	Never	Only a few Times	1-3 Times per Month	1-5 Times per Week	Daily
a. Alcohol	O	O	O	O	O
b. Cannabinoids – Marijuana (weed)	O	O	O	O	O
c. Cannabinoids – Hashish (hash)	O	O	O	O	O
d. Synthetic Marijuana (K2/Spice)	O	O	O	O	O
e. Opioids – Heroin (smack)	O	O	O	O	O
f. Opioids – Opium (tar)	O	O	O	O	O
g. Stimulants – Powder cocaine (coke)	O	O	O	O	O
h. Stimulants – Crack Cocaine (rock)	O	O	O	O	O
i. Stimulants – Amphetamines (speed)	O	O	O	O	O
j. Stimulants – Methamphetamine (meth)	O	O	O	O	O
k. Bath Salts (Synthetic Cathinones)	O	O	O	O	O
l. Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)	O	O	O	O	O
m. Dissociative Drugs – Ketamine/PCP (Special K)	O	O	O	O	O
n. Hallucinogens – LSD/Mushrooms (acid)	O	O	O	O	O
o. Inhalants – Solvents (paint thinner)	O	O	O	O	O
p. Prescription Medications – Depressants	O	O	O	O	O
q. Prescription Medications – Stimulants	O	O	O	O	O
r. Prescription Medications – Opioid Pain Relievers	O	O	O	O	O
s. Other (specify) ________	O	O	O	O	O

14. How many times before now have you ever been in a drug treatment program? [DO NOT INCLUDE AA/NA/CA MEETINGS]

O *Never* O *1 time* O *2 times* O *3 times* O *4 or more times*

15. How serious do you think your drug problems are?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

O *Never* O *Only a few times* O *1-3 times/month* O *1-5 times per week* O *Daily*

17. How important is it for you to get drug treatment now?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

© Copyright 2014 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

Form approved for use by TCU Institute of Behavioral Research

The Caring Center of Wichita, LLC
Substance Abuse Treatment Contract

Name:	Patient ID:

As a patient of The Caring Center of Wichita, I agree to the following expectations and responsibilities as a part of the treatment process:

1. I will attend all required sessions, on time, as scheduled by my therapist. Two absences without notification during treatment will constitute grounds for dismissal from the program.

2. I will pay all fees In accordance with the "Fees and Services Agreement" that I signed. If legally required under a court order to participate in therapy, I understand that the total payment of fees is a direct part of successful completion of this program and a letter of completion will not be sent to the Identified court until those fees are paid In full.

3. I agree to be completely open and honest about my drug or alcohol use during treatment as I understand this is a medically recognized disease and my providers need to know and understand my symptoms.

4. While I am in therapy, my family members will be encouraged to attend scheduled family sessions with me should my therapist consider this to be beneficial to my treatment process.

5. I am NOT presently In need of any acute medical care and understand that nursing and medical services are NOT provided by the Caring Center of Wichita, LLC.

6. I understand that the Caring Center of Wichita, LLC office location does not have ADA compliant entrances which does limit accessibility. The Caring Center of Wichita, LLC is an English-speaking provider that does not have multi-language speaking staff. Referral will be made to another program that may better meet the needs of those with handicap or language barriers.

___________________________________/__________ ___________________________________/__________

Patient signature Date Counselor signature Date