HEALTH NEEDS HISTORY

Date: __ __/ __ __/__ __  Time In: __:__  Time Out: __:__  Interviewer Initials:____

Site:________________  Gender:  F    M Age:_________  Hispanic:       Yes  No
Race: □ American Indian or Alaskan Native  □ Asian or Pacific Islander  □ Black  □ White  □ Other_____________
Language spoken at home: □ English  □ Spanish  □ Haitian  □ French  □ Portuguese
□ Polish  □ Cape Verdean  □ Asian language

BACKGROUND
1) Do you have a primary care doctor?  Yes  No
2) Do you have health insurance?  Yes  No
   What kind?  Private  HMO/Managed Care  SSI/Disability  Medicare
               Medicaid  MA State Coverage  Unknown
3) Are you currently employed?  Yes  No  In school?  Yes  No

SAFETY/MENTAL HEALTH
1) Do you use seatbelts when you ride in a car?
   Never  Seldom  Sometimes  Nearly  Always
2) Do you have smoke alarms in your house?  Yes  No
3) In the past year have you experienced any violence, including being hit/slapped, kicked, stabbed, shot, or
   sexually violated?  Yes  No
4) Have you been physically threatened by a partner or ex-partner?  Yes  No
5) In the past month have often have you felt there is nothing to look forward to?
   Never  Seldom  Sometimes  Nearly  Always

ALCOHOL/DRUGS
1) On average, how many days per week do you drink alcohol (beer, wine, liquor?) _______
2) On a typical day when you drink, how many drinks do you have?  _______
   _____(days) x _____(drinks) = _______drinks per week
3) How many times in the past 30 days did you drink 4 or more (females)/ 5 or more (males) in a
   2 hour period?  _______
4) What drugs have you used in the past 30 days? (Circle all that apply)  NONE
   Heroin  Crack  Cocaine  Special K  Speed  LSD/Hallucinogens  PCP
   Paint/Glue Inhalant  Crystal Meth  Marijuana  Oxycontin  Ecstasy/Club Drugs  Benzos
   Vicoden/other opiates  Barbituates  Other prescription drugs  IVDU  Tobacco

BNI DOCUMENTATION
For patients screening positive for being above healthy drinking/drug use guidelines:
1) BNI Performed today?  Yes  No
2) Did you use the readiness ruler (“on a scale from 1 to 10, how ready are you to make a change”)?
   Yes  No
3) Prescription for change elements:
   Change item #1:_____________________________________________
   Change item #2:_____________________________________________
   Change item #3:_____________________________________________
ALCOHOL/DRUG REFERRALS: (please check appropriate box)

Patient not placed:  
☐ Refused referral  
☐ Detox bed unavailable today  
Could not be placed because:  
☐ No ID today  
☐ No SSN today  
☐ Managed Care not authorized today  
☐ No medications today  
☐ Psych clearance pending  
☐ Disciplinary problems/reasons today

Patient placed:  
☐ Outpatient alcohol or drugs services  
☐ Holding or transition  
☐ AA or NA  
☐ Admitted to hospital for detox or hospital inpatient drug services  
☐ Needle Exchange  
☐ Transportation provided  
☐ Suboxone  
☐ Methodone program

OTHER REFERRALS:
☐ Domestic Violence Referral/Safe House  
☐ Primary Care/ Family Medicine  
☐ Shelter  
☐ Tobacco  
☐ Psych  
☐ Social Work  
☐ Health Education Brochure (which?): __________________________
☐ Other: __________________________________________

ONLY FOR PATIENTS BEING PLACED IN DETOX:

Psychiatric History: In the past year, how many times have you been admitted to a psychiatric hospital? ______  
Date of most recent visit___/___/___  
Depressed Yes No  Suicidal Ideation Yes No  
Sleep disturbance Yes No  Anger Mgmt Prob. Yes No  
Appetite disturbance Yes No  Are you on any medications for any of these? (Psych meds) Yes No  

Medical History: Are you currently in substance abuse treatment of any kind?__________
Have you been to a detox before? Yes No  
Date of most recent visit___/___/___  Where?____________
Have you recently been thrown out of a detox facility or asked to leave? Yes No  
History of DTs Yes No  Seizures Yes No  Head Injury Yes No  
Cane/Crutches Yes No  Special Diet Yes No  Allergies Yes No  
Are you on medication of any kind? (must take to detox) Yes No  
Do you have them with you? Yes No  
What kind of transportation is available to you right now to get to the detox?____________________________

FOLLOW UP:
Contact OK in one month? Yes No  
Follow up interview date: ___/___/____  
F/U initials:____
Phone#1:__________________________
Phone#2:__________________________
Contact name:___________________
In the last month: # drinks per week_____; # binge episodes_____; Change in drinking habits? Yes No  
Currently using drugs? Yes No  
Change in drug use? Yes No  
Change in risk behaviors? Yes No   
Action taken on any referrals? ☐ Contact only  ☐ Couldn't get through  ☐ Changed mind  ☐ Started, quit
Change plan success(es)? Yes No  
please describe:____________________________
In treatment now? Yes No