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 Homicidal Ideation 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 be 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