ARC-ip – 2020 Digital Intake and Screening Summary Form – DATA ENTRY

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| **Client Name: Progdate** | **Site Hours** | **M or F DOB: Age Race** |
| **Court/PO:**  **PM/Case #:** | **Judge:** | **Attorney:  (correct Spelling) Atty Fax?** |

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| LEGAL HX -**PAST** OFFENSE Type | **DATE OF OFFENSE(S) WITH PENALTY** | **COURT** | **DIP/ TX** | **SEVERITY** |
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| **Presenting Problem: OVI/ RO/ PC** | **Pulled over for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Normal or Unusual Day? Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| **BAC: \_\_\_\_\_\_ OR DRUGS:\_ \_\_\_\_\_\_** | What were **you doing** PLUS **use night of arrest**- how much over what period? | | |  |
| Substance Use  **Alcohol** |  | | |  |
| **Drugs** |  | | |  |
| **Tx Hx: Drug/Alc. -- -- -- -- -- -- -- -- --  Mental Health** | * **- - - - - - - - - - - - -   Where is Tx? Dates of Tx? Completed/Noncomplete** | | |  |
| **Medical Problem Pertinent Medications** | **Problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Med(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Use back (Intake) if need more space** | | |  |
| **Audit Score** | **0-7** No Problem /**8-15** Mild Prob. /**16-19** Moderate/ **20<** Severe Prob | | |  |
| **MAST  1 -2 -3 – 4** | Social Consequences - Blackouts – Work Problems – Problems with Spouse – Psychiatric Help – Emotional Regret – Lost a Job or Friends – Fights – Neglected Responsibility – Hospitalized – Detox/ Withdrawal - Family Concern Problems w/ Spouse – Gone for Help – Before Noon Drinking | | |  |
| **DAST   1 -2 -3 – 4** | Abused Prescriptions – Used Illegal Drugs – Used More Than One Drug At Once - Blackouts – Work Problems – Problems w/ Spouse – Psychiatric Help – Emotional Regret – Lost a Job or Friends – Fights – Neglected Responsibility – Hospitalized – Detox/ Withdrawal - Family Concern /Problems w/ Spouse – Gone for Help | | |  |
| **RECOMMENDATION**  **NO assess or tx** | |  | **Further Assessment or ARC ASSESS?** Why? (RISK FACTORS) | **CONT. W/ TX (only if actively in TX)** Where?  When started? |  |
|  | |  | Where? | Completed Treatment?  Tx dates:  Where: |  |

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| **NEED COMPREHENSIVE** | **What Medication/ Medical Problem & Why it affects driving?** |

**Client Participation:** Quiet Interactive Guarded **Attitude**: Positive Neutral Negative Disruptive Other\_\_\_\_\_\_\_\_\_\_\_

**Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Risk Factor\_\_\_\_\_\_\_\_\_\_Remedial Score\_\_\_\_\_\_\_\_\_\_  
This is not how they are participating, this is what they said in group that is significant**    
 **COUNSELOR SIGN**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_Serv.Super\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
I have been informed of the recommendations being made: W. L. Thomas PsyD, LICDC-CS, ICRC  
CLIENT SIGN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_Interview times\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***INTAKE*** *This information should be filled out by DIP staff to guarantee DIP standards are being met.*  **Client Name/ID #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (ID # is DOB yearmoday–Prog Date-Initials yearmoday- ex:20011215-20190103-WLT  **Date intake completed:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  | |  |
| Is the client currently taking any prescription drugs? If **yes,** list type of medication and amount brought to the program. | **Type of medication** | **Amount** | | **🞎** | **Yes** | **🞎** | **No** |
|  |  | |
| Is the client currently taking any over-the-counter medications? If **yes,** list type of medication and amount brought to the program. | **Type of medication** | **Amount** | | **🞎** | **Yes** | **🞎** | **No** |
|  |  | |
| **Does the client have any special dietary requirements? If yes, list:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **🞎** | **Yes** | **🞎** | **No** |
| **Does the client have any known allergies to medications? If yes, list medicine and reactions:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **🞎** | **Yes** | **🞎** | **No** |
| **Does the client have any food reactions? If yes, list food and reactions:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **🞎** | **Yes** | **🞎** | **No** |
| **Is the client currently pregnant?** | | | 🞎 **n/a** for males | **🞎** | **Yes** | **🞎** | **No** |
| **Does the client have any special needs? If yes, list needs:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Luggage Search YES OR NO (CIRCLE ONE) Initials of Searcher:** | | | | **🞎** | **Yes** | **🞎** | **No** |
| **Name/address** and **telephone number** who we can contact in case of an emergency:  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # including area code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_ Relationship to DIP Participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  | |  |
| **Client Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Staff Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |