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: \_\_\_\_\_\_ ORDRUGS:\_ \_\_\_\_\_\_** | 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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |