

FLINT ODYSSEY HOUSE, INC.
Biopsychosocial Assessment

DATE OF INTERVIEW: _____ CODAP NO: _____
DATE OF ADMISSION: _____ UNIVERSAL I.D.: _____

This interview is assigned to provide essential information that is necessary to determine who is an appropriate candidate for the FLINT ODYSSEY HOUSE PROGRAM. It is imperative that the following questions are answered thoroughly with a full description of the individual history. If the information obtained leaves any doubt concerning the individual acceptability, consult with the Admissions Administrator.

S.S.# _____ REFERRED BY: _____
NAME: _____ MARITAL STATUS: _____
ADDRESS: _____ SEX: _____ RACE: _____ DOB: _____ AGE: _____
RELIGION: _____ INS & #: _____
WHO WERE YOU LIVING WITH PRIOR TO ADMISSION? _____
PHONE: (____) _____ INCOME/OCCUPATON: _____

Emergency Contact

Name: _____ Telephone #: _____
Address: _____

Presenting problem/complaint. What is the major problem you have trouble with?

Any precipitating event or factors that lead you to make this decision at this time? Why are you seeking treatment now (i.e. legal, CMH, protective services, family pressure)?

Do you have particular preferences in regards to the type of treatment you receive and/or the gender of the person providing the service? _____

Who was the client referred by? (Who initiated them seeking treatment now?)

Church, family resource center, family or friends, health care provider, info & referral service (IARC), Michigan WORKS, police or law enforcement, prisoner reentry, school, self, social service organization

Frequency of use does matter. Flint/Saginaw Odyssey House does not provide detoxification services or crisis stabilization. Therefore, the client must be adequately detoxed and baseline/stable with their mental illness prior to admission to treatment. If there are any questions concerning the types of drugs that require detoxification, feel free to consult with the Admissions Personnel. The most commonly recognized pharmacologically and clinically are methadone, Valium, Librium, alcohol, barbiturates, and T's and blues (talwin and byribenzamine).

DRUG HISTORY /USE	Route of Use	Substance of Preference	Frequency And dosage used	Age of First Use	Date Last Used	# days used last 30
<u>HALLUCINOGENS</u>						
MARIJUANA						
PCP/ANGELDUST						
LSD/ MESCALINE						
<u>OPIATES</u>						
HEROIN						
CODIENE						
MORPHINE						
OPIUM						
OTHER						
<u>SYTHETIC OPIATES</u>						
METHADONE						
DIAUDID						
DARVON						
PERCODAN/PERCOCET						
T'S & BLUES						
OTHER						
<u>AMPHETAMINES</u>						
CRACK COCAINE						
METHEDRINE						
DEXEDRINE						
DIET PILLS						
OTHER						
<u>SEDATIVE HYPNOTICS</u>						
ALCOHOL						
BARBITUATES						
TRANQUILIZERS						
<u>OTHER DRUGS</u>						
GLUE,GAS,LACQUER						
THINNER						
TABACCO						

Drug Definitions

Synthetic narcotics: Dilaudid, Percodan, Demerol, Darvon, Darvocet, Vicodan, Toridol, Tranquilizer, Valium, Librium, Xanax, etc.

Amphetamines: Crank, Preludin, Desoxyn, **Barbiturates:** Nembutal, Tuinol, Seconol, Quaaludes. Etc.

ROUTE OF USE DEFINITIONS

1-Oral, 2-Smoking, 3-Inhalation, 4-Injection

Current Substance of Choice

Primary: _____ Secondary: _____ Tertiary: _____

Prior Treatments	Year	Outcome	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. Has there ever been a time during your drug use that you used more than intended? ___Yes ___No
2. Has there ever been a time during your drug use that your tolerance has increased? ___Yes ___No
3. Has there ever been a time during your drug use that you missed important social, occupational, or recreational events to continue your drug use, or seeking drugs? ___Yes ___No
4. Have you had unsuccessful attempts to stop or decrease your use? ___Yes ___No
5. Has there ever been a time during your drug use that you have suffered withdrawal symptoms, or used to avoid withdrawal? ___Yes ___No
6. Have you continued to use regardless of persistent or recurrent physical, psychological or criminal problems. ___Yes ___No
7. Do you fail to fulfill responsibilities at work, school or home. ___Yes ___No
8. Do you use in situations, which are physically hazardous? ___Yes ___No
9. Do you suffer recurrent social or interpersonal problems that are substance related. ___Yes ___No
10. During your drug use have you self medicated for symptoms of depression, mental illness etc. ___Yes ___No

Alcohol/Drug Related Problems/Behaviors/Symptoms

(Circle those that apply)

<u>Physical</u>	<u>Emotional</u>	<u>Behavioral</u>
Blackouts	Depression	A.M. Use
Memory Problems	Confusion	Sneaking
Tremors/Shakes	Concentration Problems	Gulping
Seizures	Anxiety	Loss of Control
Dt.'s	Irritability/Restlessness	Relief Use
Hallucinations	Aggressiveness	Impulsive Use
Overdose	Mood Swings	Use less than before
Appetite Problems	Impulsivity	Use More than before
Nausea/Vomiting	Euphoria	Use despite negative consequences
Sexual problems	Relaxation	Associate with using friends
Injuries	Extreme jealousy	Plan activities around use
Accidents	Paranoia	Loss of interest in activities
Other medical problems	Feelings of guilt/shame	Change of performance work/school
	Suicidal thoughts	Work/school lateness/absenteeism
	Homicidal thoughts	Job loss due to use
	Other	Frequent arguments
		Separation/divorce due to use
Describe: _____		Financial problems
_____		Legal problems
_____		Physically abusive to self/others
_____		Suicide attempts
_____		Homicide attempts

CURRENT/PAST LIVING SITUATION

Where are you currently staying?

- Emergency shelter* Hotel/Motel* Transitional Housing* ½ Way or ¾ Way House

*Provide Name & Date _____

- Friends/Relatives who: Car/ Street/ Park/ Abandoned Building Psychiatric Facility
 own rent Public Building Adult Foster Care
 Correctional facility Substance Abuse Treatment Hospital
 Other _____

Has the client been without housing before?

- Never Before 1 or 2 times More than 2 times in 2 years At least 4 times in 3 years

Date of present homelessness: _____

Reason for homelessness: (select only one)

Criminal activity, domestic violence, eviction, health/safety, loss of childcare, loss of job, loss of public assistance, loss of transportation, medical condition, mental health, mortgage foreclosure, no affordable housing, release from institution, substance abuse, substandard housing, under employment/low income, utility shutoff

Secondary reason for homelessness: (select one or more)

Criminal activity, domestic violence, eviction, health/safety, loss of childcare, loss of job, loss of public assistance, loss of transportation, medical condition, mental health, mortgage foreclosure, no affordable housing, release from institution, substance abuse, substandard housing, under employment/low income, utility shutoff

Did client live in an institution prior to 18 years? Yes No

Previous Address (Street, City, Zip)	Dates	Reason for Leaving	Was Your name on the lease?

Actual or pending eviction? Yes No **If so, Date:** _____

Have you been living with family/friends? Yes No

If so, length of time ? 1 week or less, more than a week but less than a month , 1-3 months
 More than 3 months but less than one year 1 year or more

If so, history of living with family/friends? First time 1 or 2 times in the past (Chronic) 4 times in past year More than 3 months but less than 1 year (Long term) 2 years or more

EMPLOYMENT/EDUCATION BACKGROUND & INTERESTS

WORK HISTORY

Employer/Job Title Start with most current	Date	# of Hours/week	pay rate /Hour	Reason for Leaving

If currently working, please provide work schedule and phone #:

Are you currently available and willing to work? Yes No

If unable to work, please explain: _____

Do you possess job skills? Yes No

What are they? _____

What are your employment interests/goals? _____

Means of transportation used prior to admission: _____

Special circumstances related to most recent income: (laid off, self employed, suspended, disabled, retired, social security, etc.)

Do you have personal representative/conservator/guardian/payee? **Yes** **No**

If so, list name, address and phone number: _____

EDUCATION HISTORY

How much schooling have you completed?(circle the highest level completed)

- | | | | |
|------------------------|------------------------|-------------------|------------------|
| Never Attended | 11 th Grade | Trade Licensing | Doctorate Degree |
| Elementary School | 12 th Grade | Some College | |
| Middle School | GED/ Equivalent | Associate Degree | |
| 9 th Grade | High School Diploma | Bachelor's Degree | |
| 10 th Grade | Vocational Training | Master's Degree | |

If currently attending school, please specify:

Name of School: _____ Area of Study _____

of credits accumulated: _____ Projected completion date: _____

Class Schedule: _____

Is the client interested in any of the following? (circle all that apply):

GED Completion High School Diploma College Vocational Training

FINANCIAL INFORMATION

In the last 30 days, have you received any money from the following sources?

Paid Labor/ Cash Benefits	Head of Household	OtherAdult
Paid Employment	\$	\$
Day Labor	\$	\$
Temporary Assistance to Needy Families or Family Independence Program	\$	\$
Social Security (survivors, retirement, old age)	\$	\$
Social Security Disability Insurance	\$	\$
Supplemental Social Security	\$	\$
State Disability Assistance	\$	\$
Veterans Administration Disability Payment	\$	\$
Veteran's Pension	\$	\$
Earned Income Tax Credit	\$	\$
Refugee Assistance	\$	\$
Other Pensions/payments	\$	\$
Other Income Sources		
Retirement	\$	\$
Investment	\$	\$
Savings	\$	\$
Alimony/Child Support	\$	\$
Private Disability Insurance	\$	\$
Unemployment Compensation	\$	\$
Workman's Compensation	\$	\$
Chore Care Provider	\$	\$
Other	\$	\$
Non-Cash Benefits		
Food Stamps/ EBT Card	\$	\$
Women/Infants & Children (WIC)	\$	\$
Food Pantries	\$	\$
Other	\$	\$
Any of the following benefits been cut?		
FIP/TANF	\$	\$
SSI	\$	\$
SSDI	\$	\$
Unemployment benefits	\$	\$
Food Stamps	\$	\$
WIC	\$	\$
Other	\$	\$

Total Income for past 30 days \$: _____

DEBTS

To Whom:	Amount	Status (overdue,shutoff)
Consumers Energy		
Child Support		
Credit Cards		
Medical Bills		
Phone/Cell Phone		
Legal Fees/Tickets		
Past Money Judgments/Evictions		
City of Flint/Water		
Other		

MEDICAL HISTORY

Family physician or last doctor visit (i.e. emergency room, urgent care clinic, etc.)

NAME: _____ ADDRESS: _____

TELEPHONE #: _____

ANY OTHER TYPES OF DOCTORS SEEN: _____

LAST VISIT: _____

Can we contact your Doctor about your treatment? _____, *****If yes must sign release*****

PLEASE CHECK ALL MEDICAL PROBLEMS THAT APPLY: (current or history)

- | | |
|--|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Edema (swelling, fluid retention) |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Fractures, Broken Bones |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Abscesses (I.V. drug use) |
| <input type="checkbox"/> Back/Spinal Injuries | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Lung Disease (TB, asthma) | <input type="checkbox"/> Circulatory |
| <input type="checkbox"/> Sight: Glasses ___ Contacts ___ | <input type="checkbox"/> Coordination |
| <input type="checkbox"/> Hearing or Ear Problems | <input type="checkbox"/> Sickle Cell Disease/Trait |
| <input type="checkbox"/> Female Problems (PMS, Dysmenorrhea, etc.) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pregnant Due Date: _____ | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Cancer, Tumors, Cysts | <input type="checkbox"/> Skin problems, Lice, Rashes |
| <input type="checkbox"/> Seizures or Epilepsy | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Allergies, Specify _____ | <input type="checkbox"/> Vertigo (dizziness, fainting, room spinning) |
| (food, medication, environmental, latex, rubber) | |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Other (describe) _____ | |

NUTRITION HISTORY

1. Is your appetite: Excellent Good Fair Poor
 2. How many days per week do you normally eat: Breakfast _____ Lunch _____ Dinner _____
 3. Do you ever skip meals? Yes No If yes, how often? _____
 4. Describe any problems with digestion or food related allergies: _____
-
5. Do you ever binge eat, purge or use laxatives? Yes No If yes, describe the frequency: _____
-
6. Do you regularly take vitamins or amino acids? Yes No If yes, indicate the amounts and frequency: _____
-

List any/all disabilities: _____

Have you adjusted to your disability? (Describe) _____

Health condition compared to people your age:

Excellent Very Good Good Fair Poor Don't know

Are you a survivor of domestic violence? Yes No

Extent of domestic violence: Within the past 3 months, 3-6 months ago, 6-12 months ago, more than a year ago, don't know, refused

Do you have an advanced directive that may impact the course of your treatment? Y N

Explain _____

Have you had any overdose or blackout from any type of drug requiring medical care? (If so, what drug and where did you receive medical care) _____

Have you ever been a patient at a mental hospital or under the care of a psychiatrist in an Out Patient Clinic? If yes, can we contact this Doctor for copies of your records? _____,

*****If yes client must sign release*****

DATE

HOSPITAL/ DR

REASON and/or DIAGNOSIS

CURRENT MEDICATIONS:

Name

Dose

Duration

Any Side Effects

Medications taken in the past six months? _____

HAVE YOU EVER ATTEMPTED SUICIDE?

___ Yes ___ Yes (recently) ___ Thought about it seriously ___ Never

(If so, how was suicide attempted and what Hospital were you treated at?)

Do you currently have any thoughts of hurting yourself or anyone else? _____

If so, have you thought about how you would do this? (Describe) _____

CAN YOU MAKE AN AGREEMENT NOT TO ATTEMPT OR THREATEN SUICIDE WHILE IN THIS PROGRAM? (Speaking to staff and not to other residents)

Yes ___ No ___

Legal-Documents

Do you have the following documents with you?	Head of Household	Other members
Birth Certificate		
Driver's License		
State Identification		
Social Security Cards		
Diploma/Degrees/school records		
Immunization Records		
Divorce Judgment/Decree		

Do you need assistance obtaining any of the above documents? Yes No

LEGAL INFORMATION:

Have you ever been incarcerated? ___ Yes ___ No

CHARGE	Time Served	Institution	Status	Year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HAVE YOU EVER BEEN INVOLVED IN ANY VIOLENT CRIME? (murder, assault with a deadly weapon, attempt to do great bodily harm, **criminal sexual conduct**)

___ Yes (give detailed information) ___ No

HAVE YOU EVER ATTEMPTED ARSON? (Describe)

___ Yes (past) ___ Yes (recently) ___ Thought About It Seriously ___ Never

1. Are you currently on probation or parole or under charges/supervision of protective services? **Y N**

2. Length of probation or parole or other legal involvement? _____

3. Release Signed for Probation/Parole Agent? ___ Yes ___ No

4. Release Signed for CPS/Foster Care Worker? ___ Yes ___ No

*******If releases are signed notify client the above shall be notified at the time of discharge*******

PROBATION, PAROLE, OR PROTECTIVE SERVICE WORKER: (circle correct one or both)

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: _____

City: _____ State: _____

Zip: _____ Phone #: _____

Zip: _____ Phone #: _____

MILITARY INFORMATION

Military

Branch: _____ Type discharge: _____
 Date drafted/enlisted: _____ Rank at discharge: _____
 Discharge date: _____ Combat experience: Yes No
 What combat zone _____ How long in combat: _____
 Months served on active duty: _____ Receiving Veteran's Benefits: Yes No High

Training completed? Yes No Type of training _____

Special circumstances related to learning? (i.e. learning disabilities, gifted program, special education, etc.): _____

FAMILY HISTORY INFORMATION

	<u>Name</u>	<u>Age</u>	<u>Living Where</u>	<u>Can we contact them</u>
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____

*******Client must sign a release for each person they agree for us to contact*******

Do you have children? No Yes If so: How many ? _____

Will they be coming into the program with you? _____

Name:	Age	Father/Mother	Where/Who do they live?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Marital Status: (Circle correct answer)

Single, Unmarried & living w/ significant other, Legally married, Separated, Divorced, Widowed
 Length of time: _____

Marital Status of your Parents: (Circle correct answer)

Single, Unmarried & living w/ significant other, Legally married, Separated, Divorced, Widowed
 Length of time: _____

Special circumstances related to primary caretaker:

Family Chemical Dependence History:

1. Describe the alcohol/drug problems of others within your family:

<u>Who/Relationship</u>	<u>Type of Problem</u>	<u>Recovery/Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Describe your family's beliefs/attitudes towards alcohol/drug usage: _____

3. How have you been affected by your family's use of alcohol/drugs? _____

SOCIAL INFORMATION

1. Please describe your abilities and/or interests: _____

Nationality/Ethnic Background: _____

Current Organization Memberships: _____

Other interests: _____

2. Describe any problems/limitations which prevent you from engaging in these activities:

3. What activities would you like to participate in the future? _____

4. What other relationships or natural supports do you have? _____

5. How have they been of support or help to you? _____

6. Can we contact them? _____

*******Client must sign a release for each person they agree for us to contact*******

Spiritual Status

1. What is your religious preference? _____
2. How important is religion to you? _____
2. Do you regularly attend worship services? _____
4. Do you believe in a God/Higher Power? _____
5. Do you see that your life has a purpose? _____ Please explain: _____

6. Do you practice any other forms of spirituality? _____

Sexual Status

Sexual Experience Inventory	Yes	No
I believe in using birth control?		
I can freely discuss sexual matters without feeling guilt/shame?		
I believe masturbation is a sin?		
I have engaged in sexual intercourse?		
I believe that sexual expression is a healthy aspect of human relationships?		
I believe that it is O.K. not to be sexually active?		
I have engaged in masturbation?		
I am aware of the term "safe sex" and use precautions when I engage in sexual activity?		
I have engaged in homosexual experimentation/relationships?		
I regularly use birth control devices?		
I feel good about who I am sexually?		
I believe in abortion?		
I am afraid of sexually expressing myself?		
There are things I have done sexually that I feel guilty about?		
I have lost friends because of my unwillingness to engage in sexual activity?		
I am confused about my sexual identity?		
My use of alcohol/drugs has had a negative impact on my sexuality?		
I have engaged in prostitution as a way to get money and/or drugs		

Mental Health Status Observations:

<u>Appearance</u>	<u>Physical Presentation</u>	<u>Mood</u>	<u>Affect</u>	<u>Attitude</u>
Unremarkable	Unremarkable	W.N.L.	W.N.L.	Cooperative
Bizarre	Unusual Movement	Agitated	Labile	Negative
Disheveled	Motor Agitation	Elevated	Elated	Demanding
Unclean	Other (describe)	Irritable	Flat	Guarded
Inappropriate		Angry	Sad	Cynical
		Sad	Incongruent	Withdrawn
		Despondent	Blunted	Suspicious
				Apathetic

<u>Speech</u>	<u>Thought Process</u>		
W.N.L.	No Disturbance		
Halting	Tangential	<u>Memory</u>	<u>Intelligence</u>
Soft	Flight of Ideas	Intact	Above Average
Slurred	Racing	Impaired	Average
Loud	Circumstantial	Unknown	Below Average
Pressured	Blocking		
Rapid	Slowed		
Impaired			

		<u>Judgment</u>	<u>Perceptions</u>
		Unremarkable	W.N.L.
		Impaired	Auditory
<u>Concentration</u>	<u>Insight</u>	Poor Management	Visual
W.N.L.	Acknowledges Problem		Tactile/Offactory
Distracted	Projects Problems		Illusions/Delusions

Trauma History

Please describe any strong memories, traumatic events, abuse, neglect, domestic violence and/or sexual abuse episodes that have occurred to you by either siblings, parents, relatives, partners, others:

Client Strengths: _____

Client Needs: _____

Current Suicidal/Homicidal Ideations: _____

Orientation: _____

Functional areas to be considered for treatment (on a scale of 0-4)

0-no need to address 1-address at Out Patient 2-minimal need (prior to discharge)
3-moderate need (90-180 days) 4-immediate need (Initial Treatment Plan first 90 days)

- A. Physical Health _____
- B. Nutrition _____
- C. Mental Health _____
- D. Education/Vocation _____
- E. Behavior _____
- F. Relationship/Social _____
- G. Legal _____
- H. Spirituality _____
- I. Recreational _____
- J. Chemical Dependency _____
- K. Parenting _____

What areas that need improving can not be met by the program?

Need _____	Where referred _____	Date referred _____	Outcome _____
Need _____	Where referred _____	Date referred _____	Outcome _____
Need _____	Where referred _____	Date referred _____	Outcome _____
Need _____	Where referred _____	Date referred _____	Outcome _____
Need _____	Where referred _____	Date referred _____	Outcome _____
Need _____	Where referred _____	Date referred _____	Outcome _____

Discharge Criteria (what needs to occur that will let you know you are ready for discharge?)

I fully understand that I could be discharged from Flint Odyssey House Residential Treatment Program if any of the information I have given here is not true, or if I have held any information back. All of the information I have given during this interview is true and complete to the best of my ability. I understand and agree to these terms, as evidenced by my signature below:

Client Signature (Date)

Intake Therapist (Date)

Accepted: _____ Denied: _____

Reasons for acceptance or denial: _____
If not appropriate for admission referred to: _____

Clinical Director (Date)

Case Manager (Date)