NATIONAL INSTITUTE ON DRUG ABUSE

TREATMENT PROGRAM MONOGRAPH SERIES • Number 5

CLINICAL RECORD SYSTEM FOR DRUG ABUSE TREATMENT PROGRAMS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Alcohol, Drug Abuse, and Mental Health Administration

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Division of Community Assistance
National Institute on Drug Abuse
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FOREWORD

The National Institute on Drug Abuse is developing a series of publications designed for the treatment program manager and clinicians in the field. The Treatment Program Monograph Series attempts to provide straightforward presentations relevant to the operational aspects of the clinical setting.

The fifth monograph in the series, Clinical Record System for Drug Abuse Treatment Programs, delineates the uses of good client record keeping systems, provides a core set of record forms tailored for use by drug treatment programs, instructs field personnel in establishing and maintaining an effective record system, and demonstrates the application of the record system to various functions of program management.

Clinical records have long been a concern of the Institute; in recent years, a great deal of effort has been expended at the individual program and Single State Agency level to make client record systems both a valuable treatment tool and a reliable repository of program management information. With the publication of this manual, I hope that greater use of effective client record systems will occur.

Robert J. Roberton
Director
Division of Community Assistance

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I. INTRODUCTION TO A PROBLEM-ORIENTED CLIENT RECORD SYSTEM

In its ongoing effort to improve the quality of care in drug treatment programs, the Division of Community Assistance of the National Institute on Drug Abuse has consistently emphasized the significance of client record systems. Through continual field supervision, many common deficiencies in existing client records have been identified and documented, and technical assistance in developing and implementing effective client record systems has been provided to over 45 drug treatment programs and Single State Agencies (SSA's). In each of these cases, the client record systems have been tailored to the needs and configurations of individual programs. It has become clear, however, that the development of a generic model of client records, although not completely replacing on-site technical assistance, would help meet the basic needs of programs and Single State Agencies in a cost-effective fashion. This manual presents such a model.

The drug treatment field has become highly diversified, encompassing a vast array of drug treatment programs, a proliferation of modalities and treatment environments, a number of unique client populations, a broad continuum of treatment objectives and philosophies, and a wide melange of professional/paraprofessional skills and techniques. This diversity precludes the possibility that any generic client record system will automatically meet all the unique needs and aspirations of all treatment programs and Single State Agencies. Changes, revisions, and modifications, therefore, are encouraged in the use and implementation of the system described in the manual in order to tailor the system more precisely to individual program and SSA needs.

1. Overall Purpose Of The Client Record System

The client record system is aimed primarily at enhancing the therapeutic thrust of counseling staff. The overall purpose of the system is to record and organize relevant client information in order to design an effective treatment plan tailored to the needs of each individual client. The client record system, therefore, should not be viewed as merely another data collection effort but, rather, as a tool to foster and maximize positive change in client behavior, attitudes, and lifestyle.

In these days of proliferating documentation requirements, the spread of paperwork is an alarming phenomenon. Among drug-treatment program staff--and especially among clinical and counselor staff--additional paperwork demands are seen not only as a symptom of intrusive bureaucracy but also as antithetical to the therapeutic process. Frequently, there is a common perception among line counseling staff that paperwork is inimical to the clinical process and that the complex and often difficult interchange between counselor and client is impeded by attempts at formal documentation.

Excessive paperwork is not defensible. Documentation of the therapeutic process, the treatment plan, counselor activity, and client progress is, however, a critical necessity in drug treatment programming. Continuity of care when a counselor leaves the program requires that adequate documentation be provided for the counselor who assumes responsibility for the case. Supervision, counselor training, the use of outside professional help, and adherence to Federal and State requirements all require adequate documentation of client background, program and counselor activity, and client progress. However, the major advantage in using a client record system is the opportunity to improve and expand the therapeutic process to enhance staff capability to promote positive client behavioral change.

In terms of paperwork, it should be noted that the model system described in the manual should replace existing client record forms and not be superimposed upon the forms presently in use. Consequently, there may be a reduction in paperwork or, at a minimum, no increase in the paperwork burden for clinical staff. The maintenance of the system is neither arduous nor overly time-consuming.

2. The Concept Of A Problem-Oriented Client Record System

The concept of client record keeping on which this manual is based is commonly known as "problem-oriented record keeping." The concept was introduced in the late 1960's by Dr. Lawrence Weed, a physician in an acute-care general hospital. Although developed with hospital settings in mind, the problem-oriented system is equally useful in ambulatory care facilities. The system was first proposed to correct some deficiencies in traditional record keeping, notably the practice of grouping records by source (i.e., provider--nurse, physician, laboratory, etc.), the failure to link treatment strategies with defined problems, and the lack of a well-defined data base on each patient. Dr. Weed's concept of the ideal health record includes the following major elements:

- Collection of basic minimum data on each patient
- A statement of the patient's major problems, ranked in order of importance and numbered
- A treatment plan, the action components of which are numbered to correspond to the problems identified
- Progress notes likewise numbered and used to track the client response to treatment

Major virtues of the problem-oriented client record, as adapted for use in a drug treatment program, include the following:

- It ensures that relevant client data are obtained by the counselor or intake worker and that salient aspects of client demographics are covered, e.g., prior drug use history, physical condition, legal, psychosocial, education, and employment. Thus, the counselor will not be "working in the dark."
- It organizes the data collected to facilitate the identification of significant client problems.
- It provides a structured opportunity to assess client weaknesses, problems, and strengths.
- It provides the framework for developing action treatment plans addressed to resolving specific client problems.
- It structures the recording of progress notes that should reflect the application of the treatment plan and documents change in client behavior, if any.
- It provides for a regular and systematic review of the treatment plan and program activities focused upon the client.
- It helps create feedback loops among client, counselor, medical, and supervisory staff, encouraging continuous monitoring and evaluation of treatment planning and interventions.

It should be emphasized that a client record system is a tool and not an end in itself. Client records, by themselves, are not a substitute for effective therapy, good treatment planning, or seasoned clinical judgment. Forms or records do not themselves induce behavioral change, but they can be a critically important element in the total armament of effective counseling.

3. Need For The Problem-Oriented Client System In Drug Treatment Programs

The quality of client record systems in drug treatment centers varies considerably from program to program and from State to State. Some treatment centers are already using a system similar to that described in this manual. In other programs, the client record is a formidable collection of forms, counselor notes, urinalysis reports, correspondence, and other documents that are too bulky and disorganized to be of clinical merit. In other locales, programs collect only client information that is required by the Client Oriented Data Acquisition Process (CODAP) or by external agencies responsible for funding or accreditation--information too sparse and incomplete to assist the counselor in dealing effectively with the client.

Field observation reveals the fact that, in some programs, counselors may concentrate only on client data that they feel are relevant to their particular clinical orientation. For example, counselors who are interested in or successful with family therapy techniques may tend to collect or emphasize data relating to the client's childhood or current family situation, ignoring or neglecting problems relating to employment, or chronic health problems. The client record system presented here promotes a balanced approach to client history and the assessment of all salient aspects of the client's background, thus assuring that the treatment plan takes into account all major client problems.

Generally speaking, defects in existing record systems may be summarized as follows:

- Information about the client is collected haphazardly by the counselor or intake worker and may be sparse, sketchy, or irrelevant.
- Important facts about the client, for example, his/her medical history and health status assessment, may not be present in the client record.
- Forms used to collect data and document treatment may be poorly designed or overly complicated.
- Treatment plans are inadequate and not directly related to the client's identified problems.
- Goals set for the client may not be measurable, objective, or realistic.
- The client's responses to treatment and program activities are not properly documented. Existing progress notes may be vague and generalized and may not address specific problems and interventions.
- Case conferences and peer review of client progress are severely impeded by the lack of a concise but complete client record.

These and other defects jeopardize the client record system's three major functions:

- As a tool facilitating quality care for the individual client

- As the source documents permitting periodic evaluation and improvement of the program's overall treatment practices

- As evidence that the program complies with Federal Funding Criteria and other Federal and State regulations governing drug treatment

4. Response To A Demonstrated Need--A Generic Client Record System Manual

Over the past several years, the National Institute on Drug Abuse, through its contractor, Macro Systems, Inc., has assisted over 45 programs and SSA's in upgrading client record systems. Field experience and specific knowledge gained during this effort are reflected in this manual, which is designed to:

- Show counselors how to collect salient client information, how to use it to best advantage, and how to document treatment interventions and client progress

- Permit Single State Agency officials and program administrators an overview of the system and its uses in clinical supervision, program evaluation, and reporting

- Outline procedures necessary to install and maintain the system for record-keeping personnel

Again, it should be emphasized that this manual is generic in nature and presents forms and procedures specifically designed for use in drug treatment programs. In contrast to the technical assistance provided to individual programs and SSA's in the past, the system elements presented here do not reflect any particular program modality, environment, or treatment philosophy. Thus, program administrators are advised that some minor modifications of forms and procedures will have to be made in order to tailor the system to each program's unique needs.

Forms found in the manual have been designed to comply with the requirements of various Federal agencies and private accrediting bodies, including:

- Federal Funding Criteria for Drug Treatment Services and Central Intake Units, 21 CFR (Code of Federal Regulations) 1402, 1403

- Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Chapter I, Part 2

- Standards for Drug Abuse Treatment and Rehabilitation Programs, Joint Commission on Accreditation of Hospitals, 1975

- Food and Drug Administration's Methadone Regulations, 21 CFR Chapter 1

- Drug Enforcement Administration's Methadone Regulations, 21 CFR Parts 1301, 1304, 1305, 1306

- Narcotic Treatment Program Standards and Methadone in Maintenance and Detoxification (proposed regulations, Federal Register, Vol. 42, No. 208, October 28, 1977)

In implementing the record system, programs must also include modifications necessary to comply with the unique reporting requirements imposed by:

- Single State Agencies
- State licensing authorities
- Local governments
- Local Health Systems Agencies
- Mental Health Centers
- Program governing bodies
- Other funding agencies

These latter requirements may not be very different from those already incorporated into the system presented in this manual. The Single State Agency official responsible for assisting programs with client records will be able to advise administrators on the necessary modifications.

5. The Client Record System And Confidentiality

Any system for gathering, maintaining, and using data on drug program clients must be guided by and operate within the principles of confidentiality. Two points are paramount in safeguarding the confidentiality of client information.

- All data pertaining to the client--from his/her application to the program through all subsequent phases of treatment and discharge--are confidential and remain permanently confidential.

- Therefore, except in those very special circumstances outlined in the Federal Regulations governing confidentiality (see below), no information on the client can be released, either orally or in writing, to anyone outside the program without the specific written consent of the client. Each release of information to external sources must be authorized separately by the client. No blanket authorizations are acceptable.

The confidentiality of records of alcohol and drug abuse program clients is protected by Federal regulations that have the force of law.

This manual does not attempt to spell out all the myriad ramifications of the confidentiality regulations or situations in which a possible conflict with these regulations might arise. This work has already been done, and program personnel are strongly recommended to obtain copies of two important publications:

- Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Chapter 1, Part 2

- Confidentiality of Alcohol and Drug Abuse Patient Records, A Self-Paced Programmed Instructional Course; published by the National Drug Abuse Center for Training and Resource Development, 1902 North Moore Street, Arlington, Virginia 22209, April 1976.

The first publication listed is, of course, the Federal regulations, and, at best, Federal regulations are not light reading. Each rule is followed by an explanatory passage that is designed to interpret the preceding regulation. Complex as they are, these regulations remain the controlling authority and must be read carefully by key program personnel. Violations of these regulations are subject to severe sanctions.

The other publication is, as its subtitle indicates, a self-teaching manual. Included in this publication are the regulations and explanatory passages, together with review materials, test questions, and answers to these questions. The material is clearly written and possibly the easiest way to become familiar with the regulations while learning to use them on a daily working basis in the program setting.

This manual discusses only those aspects of confidentiality that impact on client records and does not address other areas of clients' rights, such as the right to withhold information from the treatment staff or the right to examine the record.

This manual attempts to show how the concept of confidentiality impacts on the creation of the individual client record, the operation and control of the total client record system, and the program's role in responding to requests for information from various sources. Chapter II contains a sample authorization form for the release of information contained in client records. This authorization, when duly signed by the client, should itself become a part of the permanent client record. Chapter III discusses how confidentiality may be protected in utilizing records for clinical and program management. Appendix B details best practices for assuring confidentiality in designing and operating a filing system for client records.

6. Benefits Anticipated From Using The Integrated Client Record System

The client record system presented here is not proposed as a panacea for all the ills that may beset a program. There is no substitute for clinical skill and expertise. However, significant and important benefits can be anticipated from a well-planned and organized system:

- Written documentation of the client's background treatment objectives, and progress during treatment makes possible continuity of care when counselors leave or counselor assignments change. Important aspects of the interchange among the counselor, other staff members, and the client will have been captured and treatment can continue without undue interruption or backtracking.

- A good record is especially helpful in the case of a readmitted client for facilitating continuity of care and ensuring that the client and counselor will not have to begin again from ground zero.

- The record system is the core mechanism of communication and review among all program staff concerned with client treatment, e.g., medical staff; line counselors; education, vocational, and other specialists; outside mental health professionals; clinical supervisors; and program managers.

- A complete and organized record serves as a tool for clinical supervisors to support and direct counseling skills. The record, as structured in this manual, permits supervisors to review periodically and challenge, where appropriate, the strategies the counselor has adopted, to oversee support services--medical, educational, social--initiated by the counselor, and to ensure appropriate follow-through.

- The process of completing the record is a valuable discipline for counselors. Repeated practice in the tasks of gathering data, identifying and listing problems, formulating appropriate treatments, and noting the client's response to treatment will substantially upgrade the counselor's skills and tend to strengthen clinical judgment.

- Client records serve as primary source documents for researchers conducting outcome and follow-up studies, epidemiological surveys, and evaluations of certain types of treatment. Because these studies add to the state of knowledge about drug addiction and treatment, clinicians should ensure that their records are acceptable to researchers.

- The system presented here is designed to facilitate report preparation. Time required to prepare CODAP and the Food and Drug Administration methadone reports should be substantially shortened, if this sytem is faithfully followed.

An effective client record system will enable program management and clinical staff to make appropriate decisions regarding:

- The adequacy of the current treatment regimen

- The need to provide special services to clients

- The advisability of terminating or reducing program activities that are not impacting effectively upon clients

- The need for counselor training or upgrading

- The quality of clinical supervisions

- The desirability for input from outside mental health professionals

- The effectiveness of current counselor/client caseload

In sum, a number of benefits may result from a well-planned client record system, however, the overarching value of the system is its capability to fuse diverse treatment elements into an effective, cohesive, and therapeutic client-oriented focus.

II. CLIENT RECORD FORMS

The forms and procedures of the Client Record System have been designed to facilitate the gathering, organizing, and documentation of information pertinent to identifying a client's problems; establishing and continually evolving a Treatment Plan; designing appropriate intervention strategies around each identified problem; and subsequently assessing the client's progress toward goals and problem solutions. For these reasons, the system requires data in the record to be primarily problem oriented; that is, data are to be collected, recorded, and filed with respect to a specific client problem.

Furthermore, it should be noted that the client record is, in the broadest sense, a complete record of all the events that take place in the treatment of the client. Consequently, the client record system neither discriminates against nor favors any particular form of therapy or intervention that clinical staff selects. The system is designed to record those services the program provides to the client and to document client progress.

At first glance, the forms presented in this chapter may appear to be numerous, lengthy, and detailed. Two points, however, should be made: First, these forms are not intended to be superimposed on an existing record system but, rather, to replace the system program staff are now using; appendix B suggests an implementation plan that programs might adopt. Second, the forms have been designed so that answers to most questions can be indicated by checks or various simple codes and, thus, will not involve the counselor in lengthy or irrelevant written exercises.

The client record will consist of the following core sets of forms:

- Initial Interview Form--An intake instrument that gathers salient background information about the client
- Health Questionnaire and Physical Examination Forms
- In-Depth Interview Forms--Forms exploring in some detail the client's background in five significant areas: drug use history, legal, psychosocial, educational, and employment/vocational histories
- Treatment Plan Form--A form on which problems, goals, and action plans are are noted
- Treatment Plan Review Form--The treatment plan is periodically evaluated on this form
- Progress Notes--A document recording client progress as related to problems defined on the Treatment Plan as well as specific services or interventions provided by the program
- Discharge Summary--A form recapitulating the treatment rendered to the client and the client's response and indicating the client's status upon leaving the program

Special Forms--A group of ancillary forms documenting urinalysis results for both drug-free and methadone maintenance modalities, medication administration, physician's orders, and readmission information

Exhibit I, following this page, illustrates how the sequence of core client record forms parallels the client treatment cycle. The exhibit also shows time frames for completion of various sections of the record.

As mentioned in the first chapter, any release of information contained in the record to outside persons or institutions must be authorized in writing by the client. Because legitimate requests for information may be submitted at any time during or after the treatment process by third-party payors, probation officers, or referral agencies, the client's rights and options should be carefully explained to him/her during the Initial Interview. Federal confidentiality regulations are very specific as to what must be included in a written authorization for release of information. Accordingly, a suggested format for authorization has been developed and is presented in exhibit II, following exhibit I. Note that this format covers all the required points:

- Name of the program making the disclosure
- Name or title of person or organization to which disclosure is made
- Name of the client
- Purpose or need for disclosure
- Extent or nature of information to be disclosed
- Statement that consent is subject to revocation at any time by the client and specification of date, event, or condition upon which it will expire without express revocation
- Prohibition of redisclosure
- Date of signature of consent
- Signature of client or person authorized to sign for client

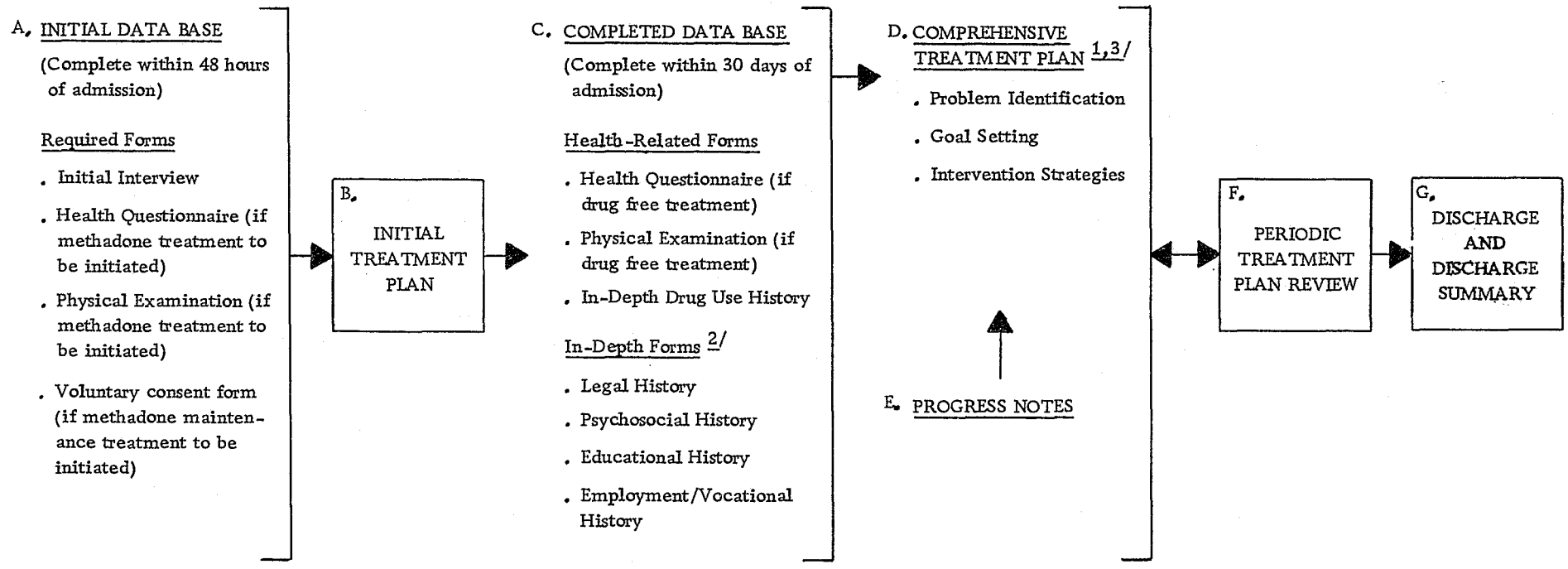
This format should be examined by the program's attorney or legal advisor to ascertain that it complies with any State or local statutes relating to confidentiality of client records. Written authorizations for release of information should be filed permanently in the client record, together with copies of the information that was actually released.

* * * *

The remainder of this chapter is devoted to brief discussions of the core forms--their purpose and background, general description, procedural recommendations for use, and additional special notes. In appendix C, the entire set of blank forms is reproduced with specification sheets that summarize this information in a more concise fashion. This appendix may be removed from the manual, and the specification sheets may be used as a memory assist until counselors achieve full familiarity and confidence in using this client record system.

EXHIBIT I

RELATIONSHIP OF CLIENT TREATMENT CYCLE AND COMPREHENSIVE CLIENT RECORD SYSTEM



Notes: 1/ Each drug program should establish policies on the time period within which the client work-up and first comprehensive treatment plan should be completed after admission of the client to the program. Federal Funding Criteria establish a maximum of 30 days for the completion of all required steps.

2/ Based on the results of the Initial Interview, each client situation, and specific State criteria, a determination is made of what in-depth forms are to be completed.

3/ The Comprehensive Treatment Plan continuously evolves over the entire course of treatment of the client.

EXHIBIT II

Client Record Manual

SAMPLE CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____ authorize _____
(name of patient or participant) (name of the program making the disclosure)

_____ to disclose to _____
(name of person or organization to which disclosure is to be made)

_____ the following information _____

_____
(nature of the information)

The purpose or need for such disclosure is _____

_____

_____

_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below.

Specification of the date, event, or condition upon which this consent expires.

_____

_____

Executed this _____ day of _____, 19____.

_____
Signature of patient or participant

_____
Signature of witness

_____
Signature of parent, guardian, or authorized representative (when required).

A. DATA BASE FORMS

1. Initial Interview Form

(1) Purpose

This form collects information on predetermined data base topics (demographic, medical, addiction, legal, employment, educational, psychosocial) upon an applicant's initial contact with the program. Questions are designed to:

- Determine whether the applicant is eligible for admission and, if so, to select the most appropriate modality
- Provide data sufficient to formulate an initial or preliminary Treatment Plan
- Provide data sufficient to complete CODAP admission report

(2) Background

New clients may be aloof, hostile, or possibly intoxicated. They may be apprehensive about their forthcoming treatment and distrustful of program staff, particularly if they have been referred as an alternative to imprisonment. Whatever their state, a probing and lengthy interview focused upon sensitive questions may be unproductive on the first visit. The Intake Interview will primarily determine client eligibility and will also provide an opportunity for the counselor to become acquainted with the client, to make an initial evaluation of the priority of the problems the client may present, and to plan some initial steps for dealing with the client's primary problems.

(3) Description

The form is a seven-page document (see exhibit III, following this page), including the following major sections:

- Demographic data
- Education
- Health
- Drug use history
- Drug use treatment history
- Alcohol use and treatment history
- Employment
- Military history
- Source of referral
- Disposition
- Initial assessment

Note that, under "Employment," the form asks for detailed information on sources of income. This is primarily to accommodate programs that charge clients on a sliding fee scale and/or that are actively seeking third-party reimbursements. Most of the questions are brief, and answers can be checked off or coded on the form.

(4) Procedures

The Initial Interview Form should be filled out by the intake counselor or primary counselor at the time the client applies for admission. Normally, the interview takes no longer than one hour. If the program utilizes a central intake unit physically separate from

INITIAL INTERVIEW

Name (Last, first, middle initial):

Client Number:

Address:

Street Apartment

City County State ZIP Code

	Month	Day	Year
Date of Interview:			
Date of Birth:			

Telephone Number:

Length of Time at Present Address:

Place of Birth:

Sex: ☐ Male ☐ Female

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Mother's Maiden Name (Last, first, middle initial):

Wife's Maiden Name (Last, first, middle initial):
or Husband's Name

In Case of Emergency, Notify:

Name (Last, first, middle initial):	Relationship:
Address:	Telephone Number:

If client is a minor, do we have permission to contact parents/guardian? ☐ Yes ☐ No--Why?

What other people can be contacted? _____

Race/Ethnic Background:
☐ White (Not Hispanic origin)
☐ Black (Not Hispanic origin)
☐ Hispanic--Puerto Rican
☐ Hispanic--Mexican
☐ Hispanic--Cuban
☐ Hispanic--Other
☐ American Indian
☐ Asian or Pacific-Islander
☐ Alaskan Native

Marital Status:
☐ Never married
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Living Arrangements:
☐ Alone
☐ With parents
☐ With spouse
☐ With others

Homemaker: Maintains a household with one or more dependents? ☐ Yes ☐ No
Number of dependents: ☐☐ Ages of dependents: _____

Creed:
☐ Catholic
☐ Islamic
☐ Jewish
☐ Protestant
☐ Other
☐ None

EDUCATION

Highest School Grade Completed:
☐ None
☐ Elementary through grade ____
☐ High school through grade ____
☐ College--number of years completed ____

Training Schools Attended:
☐ None
☐ Vocational
☐ Business
☐ Technical
☐ Other

☐ Presently Attending School
Type of program: ☐ Education ☐ Training
Date of enrollment: _____
Area of study: _____

☐ Not Attending School

HEALTH

Have you ever had psychiatric treatment? ☐ No ☐ Yes--Explain: _____

How would you rate your present state of health? ☐ Good ☐ Fair ☐ Poor

Do you have any of these communicable diseases? ☐ Tuberculosis ☐ Hepatitis ☐ Venereal disease ☐ None of these
☐ Other (specify): _____

Do you feel you have any other medical problem? ☐ No ☐ Yes--Indicate nature of problem: _____

Are you pregnant? ☐ No ☐ Yes ☐ Don't know

Additional Comments

Initial Interview--Page Two	Client Name:	Client Number:

DRUG USE HISTORY

Frequency:
0 - No use during past month
1 - Once per month
2 - Once per week
3 - Two to three times per week
4 - More than three times per week
5 - Once daily
6 - Two to three times daily
7 - More than three times daily

How Taken:
1 - Oral
2 - Smoking
3 - Inhalation
4 - Intramuscular
5 - Intravenous

Severity:
0 - Not a problem at time of admission
1 - Primary
2 - Secondary
3 - Tertiary

Types of Drugs Used	Past History: Year and Age of First Use (Year)	Past History: Year and Age of First Use (Age)	Past History: Year of First Regular Use	Past History: Maximum Use/Dose and Frequency	Current Use (During One Month Prior to Admission): Current Use (Yes or No)	Frequency of Use (Use Code)	Usual Dosage	Usual Route of Administration (Use Code)	Degree of Severity (Use Code)
Heroin									
Non-Rx Methadone									
Other Opiates or Synthetics									
Alcohol									
Barbiturates									
Other Sedatives, Hypnotics, Methaqualone									
Amphetamines									
Cocaine									
Marihuana/Hashish									
Hallucinogens (Specify, if Possible)									
Inhalants									
Over-the-Counter Drugs									
Tranquilizers									
Other(s) (Specify):									

Current Drugs of Preference: Primary: _____

Secondary: _____

Current Cost of Drugs Per Day: $_____

Initial Interview--Page Three	Client Name:	Client Number:

DRUG USE TREATMENT HISTORY

● Number of Prior Treatment Experiences: _____

Date of Admission	Voluntary	Involuntary	Name and Address of Treatment Facility	Type of Program Modality/ Environment	Discharge Date	Completed	Not Completed	Reason Not Completed (Use Code)

Longest Period Drug Free:

Length of Time Continuously on Drugs Since Last Withdrawal or Use:

● Number of Months Since Last Treatment Experience:

Type of Program Abbreviations:

Modality:
- Detoxification = Detox
- Methadone Maintenance = MM
- Drug Free = DF
- Other = Oth

Environment:
- Residential = Res
- Day Care = DC
- Hospitalized = In-Pt
- Prison = Pris
- Outpatient = OP

Reason for Leaving Codes:
1. = Completed Treatment--Goals fully achieved
2. = Completed Treatment--Goals partially achieved
3. = Left with facility advice
4. = Left against facility advice
5. = Noncompliance with facility rules
6. = Jailed
7. = Transferred
8. = Referred
9. = Other

Additional Comments

Initial Interview--Page Four	Client Name:	Client Number:

ALCOHOL USE AND TREATMENT HISTORY

Frequency of Alcohol Consumption: (In any amount or kind)

☐ Every day ☐ 2-3 times per week ☐ Weekends only ☐ 1-2 times per month ☐ Binges (Specify frequency): _____

Indicate Kind and Amount Consumed on Above Occasions:

☐ Wine: _____
☐ Liquor: _____
☐ Beer: _____
☐ Combination (Specify): _____

Usual Type of Drinking:

☐ Always with others ☐ Usually with others ☐ Sometimes with others ☐ With others and alone equally ☐ Sometimes alone ☐ Usually alone ☐ Always alone

Longest Dry Period During Last Three Months: _____

Hospitalized/Detoxified for Alcohol Use? ☐ No ☐ Yes--How many times? _____

Additional Notes

_____
_____
_____
_____
_____

LEGAL

Have you ever been arrested? ☐ No ☐ Yes ● Arrests During Last 24 Months: ☐☐

Do you have a current legal involvement? ☐ No ☐ Yes ☐ Probation ☐ Parole

(If client has either current or past legal involvement, please complete full Legal History as part of initial Interview.)

If Client Is a Minor:

Have you ever been officially declared a juvenile delinquent or in need of supervision from the juvenile court?

☐ No ☐ Yes--When: _____ Under what circumstances: _____

_____

Have you ever been committed to an institution for juvenile delinquency or a place for supervision by a juvenile court?

☐ No ☐ Yes--How old were you at your first arrest? _____

Additional Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Initial Interview--Page Five	Client Name:	Client Number:

EMPLOYMENT

Current Status: ☐ Employed: ☐ Full-time (35 or more hours per week) ☐ Part-time (less than 35 hours per week)
☐ Unemployed: ☐ Looking--has sought employment in last 30 days ☐ Not Looking--has not sought employment in last 30 days
☐ Retired
☐ Leave of absence
☐ Other (specify): _____

Number of Months Employed in Last Two Years: _____

Usual Occupation When Employed:
☐ Professional, technical, managerial ☐ Office, clerical, sales ☐ Craftsman ☐ Entertainer, musician ☐ Operative ☐ Service worker ☐ Laborer ☐ Other ☐ No work experience ☐ Student ☐ Housewife

Source of Income: (Check all that apply and indicate amount)

	Client's Income	Spouse's Income	Family Income
☐ None			
☐ Monthly salary, if employed	$_____	$_____	$_____
☐ Unemployment Insurance--Number of weeks remaining: _____	_____	_____	_____
☐ Workmen's Compensation--Number of weeks remaining: _____	_____	_____	_____
☐ Veterans benefits	_____	_____	_____
☐ General assistance	_____	_____	_____
☐ Social Security Insurance	_____	_____	_____
☐ Social Security Disability	_____	_____	_____
☐ Supplemental Security Income	_____	_____	_____
☐ Family/friends	_____	_____	_____
☐ Illegal activities	_____	_____	_____
☐ Savings	_____	_____	_____
☐ Aid to Families with Dependent Children (AFDC)	_____	_____	_____
☐ Child support/alimony	_____	_____	_____
☐ Other (specify): _____	_____	_____	_____
Total Monthly Income	$_____	$_____	$_____

Do you have health insurance? ☐ None ☐ Medicaid: #_____ ☐ Medicare: #_____ ☐ CHAMPUS
☐ Blue Cross/Blue Shield #_____ ☐ Other private insurance, specify name of company: _____
Name of subscriber, if other than applicant: _____ Policy #_____ Name of subscriber, if other than applicant: _____
☐ Health Maintenance Organization or Prepaid Group Plan--Name: _____ Number: _____
☐ Other public funds for health care, specify: _____

Have you ever been declared eligible to receive benefits from:

☐ None	Yes	No	Receiving Benefits		Yes	No	Receiving Benefits
General Relief	☐	☐	☐	SSI-State Suppl.	☐	☐	☐
Medicaid	☐	☐	☐	Food Stamps	☐	☐	☐
ADC	☐	☐	☐	State Title XX	☐	☐	☐
SSI	☐	☐	☐				

Are you the surviving dependent (spouse or child) of a veteran who was killed during a war?
☐ No ☐ Yes--Deceased veteran's name: _____

MILITARY HISTORY

Were you ever a member of the armed forces? ☐ No ☐ Yes--Indicate: Rank/rating: _____
Length of service: _____ Date of discharge: _____ Type of discharge: _____
Duties performed: _____
Were you ever overseas? ☐ No ☐ Yes--Where? _____
Were you ever incarcerated while in the military? ☐ No ☐ Yes--Reasons: _____

Initial Interview--Page Six	Client Name:	Client Number:

SOURCE OF REFERRAL

- ☐ Self-referral
- ☐ General hospital
- ☐ Mental hospital
- ☐ Community Mental Health Center
- ☐ Social/community services agency
- ☐ Private physician or mental health professional
- ☐ C.I.U. or another drug treatment program
- ☐ Family or relative
- ☐ Friend
- ☐ Employer
- ☐ School
- ☐ NARA I
- ☐ NARA II
- ☐ TASC
- ☐ County/state probation
- ☐ County/state parole
- ☐ Federal probation
- ☐ Federal parole
- ☐ Police
- ☐ Other (Specify): _____

If accepted for treatment, do you have adequate transportation to this clinic? ☐ No ☐ Yes--What type? _____

Driver's License: ☐ None ☐ Revoked ☐ Currently valid ☐ Expired ☐ Suspended until _____ Why? (Explain): _____

DISPOSITION

☐ Accepted--Date of next appointment: _____

☐ Rejected--Reasons: _____

☐ Referred to: _____ Date of appointment: _____

☐ Refused treatment--Reasons: _____

Note: When an applicant is found to be ineligible or inappropriate for admission (i.e., rejected or referred), the reason and the course of action taken must be recorded.

Admission Type:
- ☐ First admission
- ☐ Readmission
- ☐ Transfer admission from: ☐ CODAP ☐ Non-CODAP

Modality Admitted to:
- ☐ Detoxification
- ☐ Methadone Maintenance
- ☐ Drug free
- ☐ Other

Environment Admitted to:
- ☐ Prison
- ☐ Residential
- ☐ Day care
- ☐ Outpatient
- ☐ Hospital

INITIAL ASSESSMENT

1. Truthfulness and Accuracy of Client's Responses During Interview:

2. Client Characteristics Requiring Consideration In Developing Treatment Plan:

Initial Interview--Page Seven	Client Name:	Client Number:

3. Apparent Areas of Client Strength:

4. Apparent Areas of Client Weakness:

5. Other Significant Observations: (Note: Must include any prior history of mental illness)

6. List Apparent Problems and Current Priority of Each: (Note--Use these problems to initiate Treatment Plan)

7. Staff Member Responsible for Monitoring Treatment (Primary Counselor):

Date:	Signature:
Date Reviewed:	Signature of Physician (Required for Methadone Program):

other program components, CIU personnel will interview the applicant and send a copy of the Initial Interview form to the treatment component before the client appears for treatment.[1/]

No special instructions are needed for completing the form. A number of items are marked by a large black dot; these items are required for completing CODAP (Client Oriented Data Acquisition Process) Reports and must be completed.

There is no need for the counselor to follow slavishly the order or the phrasing of questions as they appear on the Initial Interview form. If the person conducting the Initial Interview will also be the client's primary counselor, he may be primarily interested in using this first meeting to establish rapport with the client and may conduct an unstructured interview, making brief notes and filling out the form later. If the client is too distraught to answer some questions or doesn't know or remember some answers, other documents that may accompany him (i.e., from referring agencies, probation officers, etc.) can be searched for the missing information. In any event, adequate information must be gathered to determine whether the client is eligible for admission.

To relieve the client's apprehensions and enhance the building of rapport, the counselor should explain at the outset that information acquired during any program contact is held in confidence and that the client's privacy is protected by Federal regulations having the force of law. The client should be informed that information relating to the fact of his addiction, his treatment at the program, or even his application to the program will not be released to anyone outside the program without his specific, written authorization (see exhibit II, following page 9).

After all data items have been entered on the form, the counselor should give special attention to the last section of the form, the initial assessment, found on pages 6 and 7 of exhibit III. This assessment will be the basis for scheduling immediate treatment interventions and the development of an initial Treatment Plan. Accordingly, at the end of the Initial Interview, the counselor is asked to evaluate:

- Truthfulness And Accuracy Of The Client's Responses--Is the client evasive or unwilling to give answers on certain topics? Does he/she appear to minimize the severity of the drug and/or alcohol problem or any other problem area--legal, education, etc.?

- Special Client Characteristics--The Initial Interview form is designed to capture basic client information to determine eligibility. At this time, however, the counselor or intake worker should begin the process of identifying those unique client characteristics that may impact upon the selection of the appropriate modality or upon the development of a preliminary Treatment Plan. For example, is the client presently employed, does he/she have any physical handicaps or apparent emotional difficulties, is the client demonstrably aggressive, does the client require constant or frequent medical attention? Immediately after the Initial Interview is completed, the counselor should note client characteristics that would be relevant in developing the interim Treatment Plan.

- Client Strengths And Weaknesses--In the attempt to identify client weaknesses and problems, a corollary effort to identify client strengths should be undertaken. Almost every client will have demonstrable strengths as well as problems. These strengths may include, for example, the fact that the client has a strong and enduring relationship to someone who may figure in enhancing the efficacy of the treatment process. Other examples may include a strong interest or skill in

1/ In the case of admission to methadone maintenance, however, this form must be reviewed, dated, and countersigned by the program physician prior to administration of methadone.

repairing automobile engines, in body-building, music, photography, or other areas or disciplines. These interests or involvements or skills are demonstrable strengths that can be used as basic departure points by counselors to achieve behavioral change.

- Other Significant Observations--In this section, the counselor interviewer should record observations of client behavior or attitudes exhibited throughout the Initial Interview that could impact on future treatment. For example, how candid and responsive was the client; was he hostile, distant, evasive; was the client open; was it easy to establish rapport; was there any evidence that the client was motivated to change his lifestyle; is the client ready to take some responsibility for change? These observations on the part of the interviewing counselor should become a part of the permanent client file and should play a role in developing the initial Treatment Plan.

- List Of Apparent Problems And Current Priority--This section is used to generate the Treatment Plan.

- Designation Of The Staff Member Responsible For Monitoring The Client's Treatment--The names of the primary counselors should be recorded here.

These sections of the Initial Interview form can be filled in with brief, concise statements; no lengthy expositions are necessary.

(5) Special Notes

It should be pointed out that, although the plan of this manual is to present all the data base forms in one group, the counselor's next step after completing the Initial Interview is to construct a preliminary Treatment Plan (see page 16 and following). This preliminary plan may be brief, stating, for example, that the client's problem is heroin abuse, the immediate goal is detoxification, and the action plan is to get the client started on a detoxification regimen, with whatever supportive services are appropriate based on this initial assessment.

If the immediate action plan calls for methadone maintenance or administration of any other medication, a Health Questionnaire and Physical Examination (see page 13 and following) must be completed, and a written consent to methadone treatment (see page 23) must be obtained, prior to the client's receiving any medication.

Information captured on the Initial Interview is the beginning of a continuum; the same areas of the client's background will be explored at length as the treatment process starts in earnest.

2. Health-Related Data Base Forms

(1) Purpose

Medical and health data on the client are regarded as indispensable for treatment for two main reasons: these data minimize the risk that an individual will enter treatment with an undetected serious illness, condition, or contagious disease; and, second, they assist in identifying problems or conditions that may influence the choice of treatment modality and/or environment and the supportive services rendered to the client. Federal Funding Criteria require the collection of medical and health data on each client accepted for treatment; in the

case of methadone maintenance, the physical examination must be completed prior to enrollment and medication.

(2) Description

The health/medical portion of the data base is recorded on two special forms as shown on exhibits IV and V, following this page.

- Health Questionnaire--A three-page form expanding the information given on the first page of the Initial Interview form by documenting the client's personal and family medical history, history of illness and symptoms, and review of organic systems.

- Physical Examination--A three-page form on which a physician indicates the client's general health status, confirms the presence or absence of physical manifestations of drug addiction, and notes the laboratory tests that have been ordered. The physician must also note any impressions and recommendations, which will be followed in formulating the Treatment Plan.

(3) Procedures

The Health Questionnaire may be completed by the intake or primary counselor, by paramedical staff, or, in some cases, by the clients themselves. (JCAH criteria state that a medical history must be obtained by medical or paramedical personnel.) The Physical Examination Form must be completed by a licensed physician. Time frames for completion of these forms are as follows:

- The Health Questionnaire should be completed prior to the Physical Examination.

- In methadone or other maintenance programs, both forms must be completed before the client can be given methadone or other medication.

- In residential programs, both forms should be completed immediately to verify that the client has no communicable disease.

- Drug-free programs must complete both forms within 21 days after the client has been admitted.

Because some confusion exists regarding the necessity of physical and laboratory examinations, the National Institute on Drug Abuse has develped a matrix relating needed physical examinations to different drugs of abuse, routes of administration, and treatment modalities. This matrix is shown on exhibit VI, following exhibit V. In some outpatient drug-free programs, the physician can waive the necessity for physical and laboratory examinations, after reviewing the health questionnaire. In this case, the Health Questionnaire (exhibit IV) should be modified to include a statement to that effect, signed and dated by the physician. Note that both positive and negative results of physical and laboratory examinations must be recorded. Positive results require follow-up and documentation thereof.

(4) Special Notes

Many programs contract physical and laboratory examinations to outside providers. Regardless of where examinations are performed, the program should ensure that the provider fills out the appropriate form and forwards it to the program so that it can be

HEALTH QUESTIONNAIRE	Client Name:	Client Number:

How would you rate your present state of health? ☐ Good ☐ Fair ☐ Poor

Do you have any of these communicable diseases? ☐ Tuberculosis ☐ Hepatitis ☐ Venereal Disease ☐ None

☐ Other (Specify): _____

Do you feel you have any other medical problem? ☐ No ☐ Yes--Indicate nature of problem: _____

_____

Are you presently receiving medical care? ☐ No ☐ Yes--Indicate:

Where: ☐ Private physician ☐ Clinic ☐ Hospital

Name of provider: _____

Address: _____

How long: ☐ In past month ☐ In past 6 months ☐ In past 12 months ☐ Over 12 months

If medical treatment involves use of drug(s) of any kind, indicate: Substance(s): _____

_____ How long used: _____

FAMILY HISTORY

Provide as much data as possible:

	Alive	Deceased	Cause of Death If Known
Father			
Mother			
Brothers or Sisters			

	Alive	Deceased	Cause of Death If Known
Husband			
Wife			
Child(ren)			

Which, if any, blood relative has ever had:

Cancer	Stroke
Tuberculosis	Epilepsy, fits, or convulsions
Diabetes	Sickle Cell trait/Disease
Heart trouble	Alcoholism
High blood pressure	Other drug problems

PAST HISTORY

Instructions: Place a checkmark (✓) in the boxes where applicable, and enter date of occurrence in space provided.

Immunization History:
☐ Tetanus immunization (Date: _____)
☐ Childhood immunizations completed: _____
☐ Other (Specify): _____

Weight: Maximum weight: _____ (Date: _____) Minimum weight: _____ (Date: _____)
Recent weight loss: ☐ No ☐ Yes--How much: _____

Injuries: ☐ Broken bones _____ ☐ Lacerations _____ ☐ Head injuries _____

Allergies: ☐ Hay fever or asthma _____ ☐ Hives _____ ☐ Eczema _____

Are you allergic to:

Penicillin	☐	Yes	☐	No	
Sulfonamides	☐		☐		
Aspirin	☐		☐		
Other antibiotics	☐		☐		

Any foods: _____ ☐ Yes ☐ No

_____

Other: _____ ☐ ☐

_____

Surgery: ☐ T&A _____ ☐ Appendectomy _____ ☐ Blood transfusions _____ Age
☐ Other (Specify): _____ _____

_____ _____

_____ _____

Previous Hospitalizations, Including Psychiatric: _____

_____

Health Questionnaire--Page 2	Client Name:	Client Number:

Habits: Do you use any of the following:

Substance	Age First Used	Frequency/Amount of Present Use
Coffee		
Tea		
Cola drinks		
Nicotine		
Sleeping medication (Specify):		
Medication for pain or headaches (Specify):		
Herbal preparations		
Other over-the-counter drugs (Specify):		

Give food intake for the past 24 hours:

Breakfast: _____

Lunch: _____

Dinner: _____

Other snacks: _____

Do you sleep well? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you crave any food or substance? _____

HISTORY OF ILLNESS OR SYMPTOMS

Instructions: Place a checkmark (✓) beside any applicable area and indicate the age of occurrence in the space provided.

Illnesses:

- ☐ Measles ____
- ☐ German measles ____
- ☐ Chicken pox ____
- ☐ Diphtheria ____
- ☐ Typhoid fever ____
- ☐ Mumps ____
- ☐ Whooping cough ____
- ☐ Scarlet fever ____
- ☐ Rheumatic fever ____
- ☐ Anemia ____
- ☐ Sickle Cell anemia ____
- ☐ Jaundice ____
- ☐ Gall bladder disease ____
- ☐ Thyroid disease ____
- ☐ Cancer ____
- ☐ Bright's Disease or kidney infection ____
- ☐ Infected veins ____
- ☐ Bleeding tendency ____
- ☐ High or low blood pressure ____
- ☐ Polio ____
- ☐ Ulcers ____
- ☐ Bedsonia or nonspecific urethritis ____

- ☐ Diabetes ____; Insulin type and dosage: _____; Diet: _____
- ☐ Epilepsy ____; Medications taken: _____
- ☐ Hepatitis ____; Where treated: _____ Positive HAA? _____
- ☐ Malaria ____; Where treated: _____
- ☐ Syphilis ____; Where treated: _____
- ☐ Gonorrhea ____; Where treated: _____
- ☐ Tuberculosis ____; Date of last TB test: _____; Date of last chest x-ray: _____
- ☐ Overdose ____; Number of times: _____; Where treated: _____

Instructions: Place a checkmark (✓) beside the problems you now have or have had in the past.

SKIN:
- ☐ Infections/abscesses
- ☐ Ringworm

EYES:
- ☐ Wear glasses
- ☐ Double vision
- ☐ Loss of vision
- ☐ Eye injury

EAR, NOSE, AND THROAT:
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Infections
- ☐ Dizziness
- ☐ Deafness
- ☐ Buzzing or ringing in ears
- ☐ Severe nosebleeds
- ☐ Difficulty in swallowing
- ☐ Sinus trouble
- ☐ Do you sniff drugs?

HEART AND CHEST:
- ☐ Pain in chest
- ☐ Shortness of breath
- ☐ Rapid heart rate, strongly felt
- ☐ Inability to sleep without several pillows
- ☐ Spitting up phlegm or mucus
- ☐ Frequent colds or sore throat
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough, fever
- ☐ Spitting up of blood
- ☐ Night sweating

(Symptom table continues, next page)

Health Questionnaire--Page 3	Client Name:	Client Number:

STOMACH:

- ☐ Poor appetite
- ☐ Nausea, vomiting
- ☐ Vomiting blood
- ☐ Pain, gas
- ☐ Bowel habits: ☐ Constipation ☐ Diarrhea
- ☐ Take laxatives--How often: _____
- ☐ Hemorrhoids
- ☐ Tarry, light gray, or white stools
- ☐ Jaundice--Yellowing of skin and whites of eyes

URINARY:

- ☐ Pain on urination
- ☐ Difficulty in urinating or retention
- ☐ Need to get up to urinate at night
- ☐ Blood in urine
- ☐ Infections, gonorrhea, or syphilis
- ☐ Stones

MUSCLE, BONE, EXTREMITIES:

- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness
- ☐ Deformities
- ☐ Bone pain in spine
- ☐ Muscle pain along spine
- ☐ Cramps in legs
- ☐ Swelling of ankles and hands
- ☐ Blueness of lips and nails
- ☐ Numbness or tingling

OTHER:

- ☐ Slurred speech
- ☐ Anxiety
- ☐ Fatigue
- ☐ Depression
- ☐ Sleeplessness
- ☐ Feeling tired after sleeping
- Usual hours of sleep: _____
- ☐ Headaches
- ☐ Convulsions
- ☐ Paralysis
- ☐ Tremors
- ☐ Staggering gait
- ☐ Difficulty in remembering places and events

QUESTIONS FOR WOMEN

BREASTS: ☐ Lumps ☐ Pain or tenderness

OB/GYN:

LNMP (Last normal menstrual period): _____

Duration--How many days: _____

Interval: _____

☐ Clots ☐ Discharge ☐ Heavy flow
☐ Spotting ☐ Pain

Birth control method: _____

Last Gyn exam: _____

Pregnancies: _____

- ☐ Miscarriages: _____
- ☐ Stillbirths: _____
- ☐ Abortions: _____

Any born with congenital defects?

☐ Yes ☐ No

Additional Notes

Date:	Signature of Interviewer:
Date of Review:	Signature of Physician (Required for Methadone Program):

EXHIBIT V(1)

PHYSICAL EXAMINATION	Client Name:	Client Number:

Height:	Weight:	Temperature:	Pulse:	Respirations:	Blood Pressure:

General Appearance:

Physiology	Normal	Abnormal	Description of Abnormal Findings
Skin, General Appearance			
Scalp and hair distribution			

Check, if present, and describe:

- ☐ Tattoos
- ☐ Track marks ☐ New ☐ Old
- ☐ Thrombosed veins
- ☐ Brawny edema
- ☐ Subcutaneous abscesses: ☐ Acute ☐ Healed
- ☐ Puffy hand sign

Eyes			
EOM			
Fundi			

Check findings:

Sclera: ☐ Normal ☐ Icteric

Pupil size: ☐ Normal ☐ Myotic ☐ Mydriatic ☐ Reactive ☐ Nonreactive

Nystagmus: ☐ Absent ☐ Present

Ears--Canal and drums			
Nose			
Mouth and throat			
Teeth			
Neck, including thyroid			
Lymph Nodes:			
Cervical			
Axillary			
Epitrochlear			
Inguinal			
Heart			
Peripheral pulses			
Lungs			
Breasts			
Abdomen			

Check findings:

Liver: ☐ Palpable ☐ Not palpable ☐ Enlarged ☐ Tender ☐ Non-tender

(continues next page)

Physical Exam--Page 2	Client Name:	Client Number:

Physiology	Normal	Abnormal	Description of Abnormal Findings
Abdominal findings (continued) Spleen: ☐ Palpable ☐ Not palpable Kidneys: ☐ Palpable ☐ Not palpable			
Herniations			
Spine			
Extremities			
Joints			
Edema			
Varicosities, thrombophlebitis			
Neurological (DTR's, Babinski, Romberg)			
Cranial Nerves			
Gait			
Balance			
Coordination			
Motor strength			
Check findings: Mental status: ☐ Alert ☐ Somnolent ☐ Noticeably high Speech: ☐ Clear ☐ Slurred			
Anus and rectum (including prostate)			
Male genitalia			
Pelvic exam			

Summary Documentation of Current Physiological Addiction

Addictive Drug Used:

Heroin/Other Narcotics:

Urine results: _____

Daily heroin consumption: _____

_____

Time last used heroin: _____

_____

Toxic State:

- ☐ New tracks
- ☐ Contracted pupils
- ☐ Constipation

Withdrawal State: (Check if present)

- ☐ Dilated pupils
- ☐ Rhinorrhea
- ☐ Lacrimation
- ☐ "Gooseflesh"
- ☐ Anorexia, nausea, vomiting
- ☐ Diarrhea
- ☐ Fever
- ☐ Diaphoresis
- ☐ Other (Specify): _____

_____

Barbiturates/Sedatives:

- ☐ Slurred speech
- ☐ Nystagmus
- ☐ Staggering gait
- ☐ Positive Romberg

- ☐ Anxiety
- ☐ Tremulousness
- ☐ Insomnia
- ☐ Orthostatic hypotension
- ☐ Delerium
- ☐ Convulsions
- ☐ Fever
- ☐ Other (Specify): _____

_____

Physical Exam--Page 3	Client Name:	Client Number:

Impression:

Laboratory Tests Ordered:

- ☐ CBC and differential
- ☐ STS
- Urinalysis: ☐ Routine and microscopic ☐ Toxicology (drugs)
- ☐ SMA 12
- ☐ Chest X-ray

As appropriate:

- ☐ HAA
- ☐ Sickle cell
- ☐ Pap smear
- ☐ GC culture
- ☐ EKG
- ☐ Biological test for pregnancy
- ☐ Tuberculin skin test
- ☐ Hematocrit only

For Program Use Only

Results Received

☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Recommendations:

Date:	Physician's Signature: M. D.

Required for Methadone Program:

I have reviewed all the documented evidence on this client to verify a two-year history of addiction and current physiologic dependence. In my judgement, the client fulfills the requirements for admission to a methadone maintenance program.

Date:	Physician's Signature: M. D.

EXHIBIT VI

Client Records Manual

PHYSICAL/LABORATORY
EXAMINATION MATRIX 1/

	Opiates		Amphetamines		Sedative-Hypnotics				Cocaine		
	Parenteral	Oral	Parenteral	Oral	Parenteral	Oral	Inhalants	Marihuana	Parenteral	Nasal	Hallucinogens
Residential	L1	L1	L1	L1	L1	L1	L1	L2 2/	L1	L2 2/	L2 2/
	P1	P1	P1	P1	P1	P1	P1	P1	P1	P1	P1
Outpatient	L1	L2 3/	L1	L2	L1	L2	L1	L2	L1	L2	L2
	P1	P1	P1	P1	P1	P1	P1	P2	P1	P2	P2

KEY: L1 = Mandatory laboratory testing (tuberculin skin test may be used in lieu of a chest X-ray; however, if the tuberculin skin test is positive, then a chest X-ray is required).

L2 = Laboratory testing at discretion of physician (tuberculin skin test may be used in lieu of a chest X-ray; however, if the tuberculin skin test is positive, then a chest X-ray is required).

P1 = Mandatory physical.

P2 = Physical at discretion of physician.

Notes: 1/ A medical history is required in all cases (applicable to every cell of the matrix).

2/ As this is a residential setting, the following laboratory tests are required: tuberculin skin test, hematocrit, and serological test for syphills.

3/ For methadone maintenance programs, laboratory testing (L1) is mandatory.

L2 supplements L1 in the following instances: (1) outpatient heroin detoxification, and (2) readmission (within six months) of patient who had previous laboratory examinations.

permanently filed in the client's record. Health data are necessary both to the program's medical director and to the counseling staff to ensure that all aspects of treatment are consonant with the client's physical condition. For example, a program would not recommend any strenuous vocational training or recreational activity for a client who has a heart condition or high blood pressure.

Ideally, the client file should contain all appropriate client information. Common practice in many programs throughout the nation reveals the fact that separate files are frequently maintained by medical and counseling departments. This bifurcation often results in the diffusion of relevant client data and frequently impedes the development of a comprehensive treatment plan. It is recommended that all client data be contained within the client file.

3. In-Depth Interview Forms

(1) Purpose

In-Depth Interviews are conducted to expand salient information on specific areas of client characteristics touched on during the Initial Interview so that a comprehensive treatment plan can be devised. It is unlikely, both logistically and psychologically, that all relevant facts about the client will come to light during the initial meeting. In-Depth Interviews capitalize on the growing trust and rapport between the client and the counselor.

It should be noted that a preliminary Treatment Plan is developed based upon information derived from the Initial Interview. In-depth client data emanating from these interviews will be used to complete a comprehensive Treatment Plan addressing major client problems and tailored to the unique characteristics of each client.

(2) Background

Although not all of the information contained in these In-Depth Interview forms is required by the Federal Funding Criteria, the forms do promote collection of required and useful information, and their use is, therefore, strongly recommended. A Drug-Use History and Psychosocial History must be completed for every client, as specified by the Federal Funding Criteria. The need for the remaining interviews can be determined on the basis of the Initial Interview. For example, if a client has completed high school and some college and is presently employed, there may be no need to schedule In-Depth Educational and Employment/Vocational Interviews. The particular treatment modality and the program's target population also dictate which In-Depth Interviews should be conducted. Short-term detoxification programs, for example, may wish to omit certain interviews or portions thereof. Programs focusing upon adolescent polydrug users might wish to expand substantially the educational history forms. Program directors should exercise their own judgment in determining which In-Depth Interviews are most pertinent and which require deletion or amplification.

(3) Description

The five In-Depth Interview forms are shown in exhibits VII - XI.

- Drug Use History, exhibit VII, a one-page form that can be used in conjunction with the second, third, and fourth pages of the Initial Interview form to assess the client's drug use problem. The form documents drug(s) most frequently abused; and the client's perception of their effect on his/her social, physical, and mental state; and other related data.

DRUG USE HISTORY	Client Name:	Client Number:

Please refer to Initial Interview, pages two, three, and four, for Drug and Alcohol History obtained at that time.

Which drug causes you the most problems in the following areas:

Social: Family _____ Job _____
Friends _____ Education _____
Legal _____ Financial _____

Physical: _____

Mental: _____

Which drug causes you the most overall harm? _____

What is the main reason for your starting to use drugs? ☐ Friends' influence ☐ Kicks ☐ Medical
☐ Other (Specify): _____

Do you have any feelings about why you continue to use drugs? _____

_____

Have you ever lost consciousness while using drugs? ☐ No ☐ Yes--How many times? _____

Have you used alcohol to the point of intoxification? ☐ Constantly ☐ Frequently ☐ Sometimes ☐ Seldom ☐ Never
Have you been drunk continuously for several days? ☐ ☐ ☐ ☐ ☐

Does any member of your family have a drug problem? ☐ No ☐ Yes--Indicate:

Name(s): _____ Relationship: _____
_____ _____
_____ _____

How many of your present friends are drug users? ☐ All ☐ Most ☐ Some ☐ Few ☐ None
How many of your present friends are alcohol users? ☐ ☐ ☐ ☐ ☐

When using drugs or alcohol are you generally: ☐ Alone ☐ With one or two others ☐ In a group

How many times have you stopped using drugs "on your own" in the street? _____

What was your motivation? _____

Why did you return to drugs? _____

Why have you enrolled in treatment at this time? (Check all that apply)

☐ Want to get off drugs
☐ Want to avoid arrest
☐ Want to improve mental health
☐ Want to be self-supporting and not depend on family for support
☐ Forced by the courts
☐ Couldn't support habit
☐ Getting disgusted with lifestyle
☐ Want to avoid criminal activity
☐ Want to improve physical health
☐ Want to get Public Assistance
☐ Pressured by family or friends
☐ Shortage of drugs on the street
☐ Other (Specify): _____

If you stopped using drugs, do you believe your life would be: ☐ Substantially improved ☐ Somewhat improved ☐ Unchanged ☐ Worsened

What expectations do you have of the program? _____

_____

_____

ASSESSMENT OF DRUG USE HISTORY

Include truthfulness of client responses; attitude toward drug use and proposed treatment. List all problems on Treatment Plan.

_____

_____

_____

_____

_____

_____

Date:	Signature:

- Legal History, exhibit VIII, a three-page form expanding on information already documented on page four of the Initial Interview form and reviewing the client's probation status; existence of outstanding fines, traffic violations, and warrants for arrests; adult conviction record; and history of incarceration.

- Psychosocial History, exhibit IX, a four-page form facilitating the collection of data on the client's family and other relationships, living arrangements, sexual orientation, ability to manage money, recreational preferences, and expressed interest in recovery.

- Educational History, exhibit X, a two-page form exploring, in greater detail, information found on the first page of the Initial Interview form identifying the client's interests, likes, or dislikes in relation to school and capturing educational background data, e.g., on absenteeism, hyperactivity, learning disabilities, etc.

- Employment/Vocational History, exhibit XI, a one-page form relating to the fifth page of the Initial Interview form and documenting the client's degree of job satisfaction, relationship with employer and other employees, longest period of employment, salary, reason for leaving, and degree to which the client's drug habit interfered with job performance.

(4) Procedures

No special instructions are necessary for filling out In-Depth Interview forms. Most information can be checked off or quickly coded. These interviews are somewhat time consuming and obviously cannot all be completed in one day. To set priorities for conducting interviews, the Initial Interview, especially the initial assessment section, should be consulted. For example, if, according to the Initial Interview, the client has an immediate and serious legal problem, has completed GED courses, but is not presently employed, the priority for conducting In-Depth Interviews might be:

- Legal history
- Drug use history
- Psychosocial history
- Employment/vocational history
- Educational history

Whatever the priority, all In-Depth Interviews should be completed within 30 days after the client has enrolled in the program. Note that, like the Initial Interview form, each In-Depth Interview form has a space reserved on the last page for assessing the client's problem in that particular data base topic area. The counselor should take care to make these notations carefully and thoughtfully, as these assessments will be used in establishing the Treatment Plan. Assessments will be made based on the information documented on the form, on other information volunteered by the client, and on the counselor's own observations.

(5) Special Notes

In formulating questions to be included in these interview formats, thoughtful consideration was given to hundreds of questions, and great care was taken to include information considered useful by practicing professionals. Although the questions as they appear on the forms are structured so that they can be answered by "yes," "no," or some other short reply, the careful counselor will avoid relegating the client's response to a series of monosyllables and will rephrase the question in an open-ended fashion so the client will expand on his answer. Questions should not be considered as an end in themselves but, rather, as catalysts for discussions between the counselor and the client.

LEGAL HISTORY Page One	Client Name:	Client Number:

Please refer to Initial Interview, page five, for information obtained at that time.

True Name (Last, first, middle): ______
Alias #1: ______ Alias #2: ______

Presently on probation? ☐ No ☐ Yes--Complete as many of the following sections as are necessary for each probation.

☐ Federal
☐ State
☐ Local

Name of Judge/Court: ______
Probation Officer: *
Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

Length of probation: ______ How much of that time has been served? ______
Has probation been extended for any reason? ☐ No ☐ Yes--Why? ______

Is probation in danger of being revoked? ☐ No ☐ Yes--Why? ______

☐ Federal
☐ State
☐ Local

Name of Judge/Court: ______
Probation Officer: *
Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

Length of probation: ______ How much of that time has been served? ______
Has probation been extended for any reason? ☐ No ☐ Yes--Why? ______

Is probation in danger of being revoked? ☐ No ☐ Yes--Why? ______

☐ Federal
☐ State
☐ Local

Name of Judge/Court: ______
Probation Officer: *
Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

Length of probation: ______ How much of that time has been served? ______
Has probation been extended for any reason? ☐ No ☐ Yes--Why? ______

Is probation in danger of being revoked? ☐ No ☐ Yes--Why? ______

Presently on parole? ☐ No ☐ Yes--Where: ______

☐ Federal
☐ State
☐ Local

Length of parole: ______ How much of that time has been served? ______
Has parole been extended for any reason? ☐ No ☐ Yes--Why? ______

Is parole in danger of being revoked? ☐ No ☐ Yes--Why? ______

Parole Officer: *
Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

* Note: An authorization form must be completed and signed by the client prior to release of any information.

Legal History--Page Two	Client Name:	Client Number:

Does client have any outstanding fines? ☐ No ☐ Yes--Indicate:

Amount	Charges	Amount Paid	Amount Owed	Location of Court	Name of Judge

Does client have any outstanding traffic violations? ☐ No ☐ Yes--Indicate:

Violation	Date	Location	Hearing Date	Court	Judge

Does client have any outstanding warrants? ☐ No ☐ Yes--Reason for warrant: _____

Where: _____ Would client like to clear up these warrants? ☐ No ☐ Yes--When: _____

Any pending cases? ☐ No ☐ Yes

Date of Incident	Cited	Arrested	Charge(s)	Trial Phase (See Below)	Has client entered plea? No	Guilty	Not Guilty	Next Court Date	Where

Trial phases, enter one: 1 = Arraignment; 2 = Preliminary; 3 = Pretrial; 4 = Trial; 5 = Sentencing

Incarcerated? ☐ No ☐ Yes--How long in jail: _____

Is client out on bail? ☐ No ☐ Yes--How much was bail: $_____ City: _____

Does client have an attorney? ☐ No ☐ Yes: ☐ Public defender ☐ Private attorney

Does client need an attorney? ☐ No ☐ Yes

Name of Attorney: _____

Address: _____

City: _____ State: _____ ZIP Code _____ Telephone: _____

An authorization form must be completed and signed by client and attorney prior to release of any information to attorney.

Has client ever been in a court-referred drug rehabilitation or detox program? ☐ No ☐ Yes--Indicate:

☐ Inpatient ☐ Outpatient Where: _____

How long: _____ Date of completion: _____ Did client complete treatment? ☐ Yes ☐ No:

If program not completed, is court aware that client left? ☐ Yes ☐ No

Is client seeking entrance to residential drug facility? ☐ No ☐ Yes--Will residence in such facility be induced through:

☐ Court ☐ Parole ☐ Probation ☐ Client's commitment ☐ Family ☐ Other: _____

Legal History--Page Three	Client Name:	Client Number:

Official Adult Record:

☐ No Adult Convictions

☐ Adult Convictions (Prior Only)(Not Arrests)--List below, most recent first:

Date of Conviction	Type of Offense	Check Disposition: Fine	Check Disposition: Suspended Sentence	Check Disposition: Probation	Time Served	Name of Institution	Parole	Where	How Long

Have you ever spent any time in jail, even if not convicted? ☐ No ☐ Yes--About how much time altogether during your life (estimate)? _____

ASSESSMENT OF LEGAL HISTORY

Include truthfulness and accuracy of client's responses, client's attitude toward any apparent problems, and the priority of any proposed course of action. List all problems on Treatment Plan.

Date:	Signature of Interviewer:

PSYCHOSOCIAL HISTORY Page One	Client Name:	Client Number:

Relationships:

1. Childhood Family Structure:

2. Present Family Structure:

3. Significant Others:

Name/Relationship	Your Relationship with Them			Aware of Your Habit		Drug User	
	Good	Fair	Poor	Yes	No	Yes	No

4. At present, which of the individuals designated in questions 1, 2, and 3 do you consider to be most significant in your life, and why? _____

5. What are your reasons for designating "good" relationships in answer to 1,2, and 3? _____

6. What are your reasons for designating "poor" relationships in answer to 1,2, and 3? _____

7. How do the people listed in 1, 2, and 3 perceive your problem? _____

8. Are any of the people listed aware that you are receiving treatment? ☐ No ☐ Yes--What are their expectations?

9. Are any of the people listed willing to become involved in your treatment? ☐ No ☐ Yes--Specify: _____

10. How do you perceive problems that are presently faced by family members in areas such as education, employment, legal involvement, health, drug usage, etc. ? _____

(Note to Counselor: Can these be verified? ☐ Yes ☐ No)

Psychosocial History--Page Two	Client Name:	Client Number:

11. How would you rate your relationships with the following: Males: Good Fair Poor Females: Good Fair Poor
Friends/peers ☐ ☐ ☐ ☐ ☐ ☐
Authority figures ☐ ☐ ☐ ☐ ☐ ☐

12. What are your reasons for designating "good" relationships in question 11? _____

13. What are your reasons for designating "poor" relationships in question 11? _____

14. Past Living Arrangements (Including Childhood)
(1) How many places did you live? _____
(2) If you lived in more than one place, what were the reasons for moving? _____
(3) What was the longest period that you lived in any one place? _____
(4) With whom did you live during this longest period? _____
(5) If at any time you did not live with your natural family, with whom did you live? _____

15. Living Arrangements--During the 12-month period prior to entering this treatment program:
(1) How many places did you live? _____
(2) What was the longest period that you lived at any one place? _____
(3) With whom did you live during this longest period? _____
(4) With whom are you living now? _____

16. Sexual Orientation
(1) What were your impressions of sex during your early life? _____
(2) From whom did you learn about sex? _____
(3) Have your impressions about sex changed? _____ In what way? _____ Why? _____
(4) How would you classify yourself sexually? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other
(5) How would you rate your degree of satisfaction with your sex life? ☐ Satisfied ☐ Dissatisfied
(6) Do you believe that drugs interfere with your sexual activity? ☐ No ☐ Yes--Explain: _____

17. Money Management
(1) How do you generally handle money when you have it? Specify: _____
(2) Do you presently owe money? ☐ No ☐ Yes--To whom? _____ How much: _____

Psychosocial History--Page Three	Client Name:	Client Number:

18. Recreational Activities:

(1) In the past year have you engaged in any of the following activities? (Check all that apply)

	Frequency				Frequency		
	Daily	Weekly	Less than Weekly		Daily	Weekly	Less than Weekly
Parties	☐	☐	☐	Spectator sports events	☐	☐	☐
Dancing	☐	☐	☐	Sports activities--Specify:			
Watching television	☐	☐	☐	_____	☐	☐	☐
Writing	☐	☐	☐	Camping	☐	☐	☐
Painting or sculpting	☐	☐	☐	Physical conditioning	☐	☐	☐
Theatre	☐	☐	☐	Hobbies--Specify: _____	☐	☐	☐
Listening to music	☐	☐	☐	_____	☐	☐	☐
Playing musical instrument	☐	☐	☐	Other--Specify:			
Movies	☐	☐	☐	_____	☐	☐	☐
Reading	☐	☐	☐	_____	☐	☐	☐
Museums or art galleries	☐	☐	☐	_____	☐	☐	☐
				_____	☐	☐	☐

(2) How do you currently spend your leisure time? _____

_____

_____

_____

19. Abuse History:

(1) Were you an abused child? ☐No ☐Yes--How: ☐Mentally ☐Physically ☐Emotionally ☐Sexually

By whom? _____

(2) Have you been abused since you have been an adult? ☐No ☐Yes--How: ☐Mentally ☐Physically ☐Emotionally ☐Sexually By whom? _____

(3) Do you think you have the potential for abusing others? ☐No ☐Yes--Explain: _____

_____

20. Interest in Recovery:

(1) Do you believe you have any serious problems? ☐No ☐Yes ☐Maybe

If Yes or Maybe, specify: _____

_____

If Yes or Maybe, do you believe that you need help for these problems? ☐No ☐Yes ☐Maybe

(2) Do you believe that other people (family, parole officer, etc.) feel that you have any serious problems?

☐No ☐Yes Maybe

If Yes or Maybe, specify: _____

_____

(3) Do you believe that other people feel that you need help for these problems? ☐No ☐Yes ☐Maybe

(4) In the past, have you received treatment for psychological problems somewhere other than a drug program?

☐No ☐Yes--Indicate:

Where: _____

By whom: _____

Dates of attendance--From _____ to _____ Nature of problem: _____

_____

(5) Are you presently receiving treatment for psychological problems somewhere other than a drug program?

☐No ☐Yes--Indicate:

Where: _____

By whom: _____

Dates of attendance--From _____ to _____ Nature of problem: _____

21. Is there anything about which we haven't asked you that you think we should know? _____

_____

_____

_____

Psychosocial History--Page Four	Client Name:	Client Number:

22. Note to Counselor: Review responses to questions regarding client's military history (Initial Interview, page five) for psychosocial follow-up.

PSYCHOSOCIAL ASSESSMENT

Include client's strengths and weaknesses. Evaluate current status and priorities. List all problems in Treatment Plan.

Date:	Signature of Interviewer:

EDUCATIONAL HISTORY Page One	Client Name:	Client Number:

Please refer to Initial Interview, page one, for Educational History obtained at that time.

IF PRESENTLY ENROLLED IN SCHOOL, Indicate:

Degree of Interest: ☐ High interest ☐ Average interest ☐ Little interest
Progress: ☐ Above average ☐ Satisfactory ☐ Unsatisfactory

IF NOT PRESENTLY ENROLLED IN SCHOOL, Indicate:

Name of last school attended: _____ Last grade attended: _____

Note: Complete the following sections as appropriate:

Elementary School:

How well did you do in elementary school? ☐ Good ☐ Fair ☐ Poor

What were the best and worst things about it (school, teachers, other students, curriculum, etc.)? _____

Did client: ☐ Graduate ☐ Drop out--Why? _____

High School:

How well did you do in junior high? ☐ Good ☐ Fair ☐ Poor; How well did you do in senior high? ☐ Good ☐ Fair ☐ Poor

What were the best and worst things about it (school, teachers, other students, curriculum, etc.)? _____

Did client receive diploma? ☐ Yes ☐ No--Why not? _____

G.E.D.:

Have you completed the G.E.D. courses? ☐ Yes ☐ No

Have you taken the tests? ☐ No ☐ Yes--Are the scores available? ☐ No ☐ Yes--Where? _____

Did you receive a certificate? ☐ No ☐ Yes

Additional Notes

Educational History--Page Two	Client Name:	Client Number:

College:

How well did you do in college? ☐ Good ☐ Fair ☐ Poor

Name of Institution	Courses or Name of Major/Minor

If client received degree, specify: _____

Vocational School/Special Training:

Name of Institution	Course of Study/Training	Year	Check One: Formal School	Check One: OJT
			☐	☐
			☐	☐
			☐	☐

What qualifications or licenses does client have? _____

If client is untrained or unskilled:

Have you ever taken any vocational skills or interest tests? ☐ No ☐ Yes--When: _____

What did they show? _____

General Background Information:

Did you change schools often? ☐ No ☐ Yes--Why? _____

How often did you miss school? _____ Why? _____

Were you hyperactive during school years? ☐ No ☐ Yes--Did you receive medication for it? ☐ No ☐ Yes

Have you ever had a learning disability? ☐ No ☐ Yes--Explain: _____

Are you interested in more schooling? ☐ No ☐ Yes--What would you like to study? _____

Do you plan to enroll in the near future? ☐ No ☐ Yes--Indicate:

If Applicable:

- Name of institution: _____
- Type of program: _____
- Projected date of enrollment: _____ Have you been accepted? ☐ Yes ☐ No
- Will you need financial assistance or tutoring? ☐ Yes ☐ No
- Have you used your GI educational benefits? ☐ Yes ☐ No--Are you still eligible? ☐ No ☐ Yes

ASSESSMENT OF EDUCATIONAL HISTORY

Include client's needs, capabilities, and interests. Outline realistic goals. Indicate priority of problems. List all problems on Treatment Plan.

Date:	Signature of interviewer:

EMPLOYMENT/VOCATIONAL HISTORY	Client Name:
	Client Number:

Please refer to Initial Interview, page five, for Employment Information obtained at that time.

IF PRESENTLY EMPLOYED, Indicate:

Degree of Satisfaction: ☐ Highly satisfied ☐ Satisfied ☐ Dissatisfied

Reason for above opinion: _____

_____

If dissatisfied, are you looking for other employment? ☐ No ☐ Yes--What kind of work? _____

_____

Relationship to employer: ☐ Good ☐ Fair ☐ Poor
Relationship to other employees: ☐ ☐ ☐

How many days have you missed in the last month? _____

Does your employer know you have a drug problem? ☐ No ☐ Yes--Is your job in jeopardy? ☐ No ☐ Yes

PAST HISTORY:

What was the longest period that you held a job? _____ What type of job was it? _____

_____

What was the approximate weekly salary for the job? _____

Was this salary about average for most jobs you have had? ☐ Yes ☐ No

Why did you leave the job? _____

Resigned: ☐ Didn't like the work ☐ Couldn't take the pressure ☐ No opportunity for advancement
☐ To change job ☐ Drug use interfered with job ☐ Job interfered with drug use
☐ Other (Specify): _____

Fired: ☐ Poor performance of duties ☐ Couldn't get along with co-workers ☐ Use of drugs
☐ Couldn't get along with boss
☐ Other (Specify): _____

Approximately how many other jobs have you had? _____ What kinds of jobs have they been? _____

_____

What has been the average length of stay on these jobs? _____ Why did you usually leave these jobs?

_____

When unemployed, did you: Look for work? ☐ Yes ☐ No Enter training program? ☐ Yes ☐ No

If No to both of these, how did you spend your time? _____

_____

How many of your present friends are employed? ☐ All ☐ Most ☐ Some ☐ Few ☐ None

Have you ever been bonded? ☐ Yes ☐ No

Do you know if you can be bonded? ☐ No ☐ Yes--How much: _____

Do you have any past military skills? ☐ No ☐ Yes--What are they: _____

_____

ASSESSMENT OF EMPLOYMENT/VOCATIONAL STATUS

Evaluate client's capabilities, interests, and handicaps, if any. Indicate priority of problems. List all problems on Treatment Plan.

Date:	Signature:

Because the in-depth forms will be completed subsequent to intake but within the first 30 days following clients' enrollment, the counselor may choose to collect these data during regularly scheduled counseling sessions. The counselor is not required to ask the questions in a strict sequential manner or to pursue the collection of the data through a formal interrogation. Many counselors conduct a "normal" counseling session and take notes, which are then used to complete the forms. It is conceivable that, during these interviews, the counselor may wish to stop collecting further data to concentrate on a specific area that requires therapeutic intervention--and plan, at a later date, to collect the remaining information. For example, when asked to discuss family relationships, a client may react sharply and emotionally in discussing his mother or father. An alert counselor may decide that it is more appropriate to explore this particular relationship than to continue questioning the client about other psychosocial areas.

After completing an in-depth interview and identifying a problem, the counselor should compare that particular interview with other completed sections of the data base. It may be that data collected elsewhere in the record will help to clarify an identified problem.

In summary, the necessary in-depth interviews should be completed as part of the counseling process--as an integral aspect of the counselor's therapeutic intervention rather than as a separate or independent effort.

B. TREATMENT FORMS

Because the three forms discussed in this section are so closely interrelated, they are shown side by side on a fold-out page, exhibit XII, following page 22. These forms have been filled out for a hypothetical client for demonstration purposes.

1. Treatment Plan Forms

(1) Purpose

The end result of capturing comprehensive client information is the Treatment Plan, which calls for a careful assessment of client strengths, weaknesses, and problems; the formulation of a specific therapeutic action plan; and the application of the appropriate mix of available program or external resources. Central to this approach are a skilled and experienced counselor staff, strong clinical supervision, and program direction that supports clinical efforts.

In many cases, the client has multiple problems and the program can provide differential but limited services. The Treatment Plan determines the order in which the client's problems should be addressed and identifies program resources as well as external resources that can be brought to bear on the individual constellation of client strengths and problems.

(2) Background

A formal Treatment Plan is a requirement of the Federal Funding Criteria, the proposed Federal regulations governing methadone treatment, and the Joint Commission on Accreditation of Hospitals. When properly completed and utilized, it becomes the single most important section in the client record, providing evidence that the program is approaching client treatment in an organized fashion--identifying client problems, establishing goals, formulating intervention strategies, and tracking progress. The Treatment Plan serves all providers of service as a constant reference point and as security against losing track of problems and their planned resolution in an ever-changing therapeutic regimen.

Clinically, the Treatment Plan is a deliberately constructed blueprint identifying appropriate interventions on the part of the program and its staff to assist the client in changing his/her behavior and lifestyle. Depending upon client progress and other variables, this plan is continuously assessed and revised to meet current problems and needs.

(3) Description

The Treatment Plan form is divided into the following columns:

- Statement of Problem--This column will show a list of client problems to be addressed during treatment. A notation is made of the date each problem was identified. Each problem is numbered according to a fixed numbering system that links the problem with data base topics described earlier in this chapter. The problem numbering system is explained on the left margin of the Treatment Plan Form. Numbers assigned to problems thus do not refer to the priority of the problem. The counselor should enter in this column a short and concise statement identifying the problem. If another counselor or the supervisor wishes to review the documentation upon which the problem is based, a review of the appropriate section of the In-Depth Interview should suffice.

- Statement of Goal--This column shows for each problem a goal or set of goals that will ultimately resolve or diminish the problem. Goals are classified as long term (180 days or more) or short term (90 days or less). For example, if the problem is a low reading level, the goal may be identified as obtaining a GED (long term) or raising the reading level from fourth- to fifth-year level (short term).

- Action Plan--This column documents the specific activity (e.g., methadone maintenance, group and individual counseling, or enrollment in a remedial reading program) that will link the problem and the goal--i.e., the action plan. The staff member responsible for seeing that the plan is carried out is also noted.

- Target and Actual Dates for Completion of Action Plans--These are very important because they not only serve to remind staff members of when some action should be initiated (e.g., a telephone call or an appointment with an outside provider or with a member of the client's family), they also can collectively provide a means of estimating an average time for completion of a certain activity.

(4) Procedures

A Treatment Plan is prepared, or at least initiated, as soon as any problem is identified. A tentative plan, as stated earlier, should be completed immediately after the initial intake. Problems are gathered from the assessment section of each of the previously discussed Data Base Forms.

For each problem, the counselor, working with the client as much as possible, should determine a goal the client will be able to attain (as a step) in resolving the problem. The goal should be attainable and stated in terms of measurable criteria of expected performance or behavior. Once each goal is established, the means of attaining that goal, or action plans, should be planned and written. Thus, if a client's problem is, at least in part, "lack of high school education," the goal could be "attain high school education or equivalent." Each action plan could then be broken into several steps, as indicated in the following example:

- Test to determine aptitude and strengths by Department of Education
- Provide remedial education in mathematics by a qualified staff member or by referral to an outside agency
- Enroll in Metro High School GED program
- Support GED progress in individual counseling

Special instructions in writing a Treatment Plan and using the Treatment Plan form follow:

- Enter problems on the Treatment Plan as soon as they are identified, even though a goal or action plan cannot be developed immediately.
- If the program uses the Treatment Plan as a written "contract" between the client and the program, have the client sign the Treatment Plan where indicated. Such a use is not mandated but is recommended to increase the client's commitment.
- Discuss the Treatment Plan with the client, whether client sees the plan or not.
- Update the Treatment Plan from the ongoing Progress Notes as new problems emerge, old problems are clarified and resolved, and/or treatment goals and action plans change.
- As goals are attained, note this fact on current Treatment Plan sheet.

(5) Special Notes

It is important to remember that the Treatment Plan is not an immutable, fixed set of parameters limiting the counselor's perceptions of the client. The Treatment Plan is expected to change over time as old problems are solved and new ones emerge or as previously identified problems change in priority. For example, at a client's original stage of treatment, primary problems may relate to drug use and psychosocial status. As the same client nears the end of the treatment phase, his primary problem may be related to obtaining a job. The Treatment Plan will reflect this change in priority of problems and goals and concomitant changes in the services or interventions that the program intends to provide.

As indicated in the procedures section, the Treatment Plan ideally should be signed by the client. It should also actually be negotiated by the client and counselor, with strong input from the client on his perceptions of major problems, reasonable goals, and preferred actions or interventions. This will foster a goal common to all treatment programs--that of putting the client back in control of his own live. It should be noted that the client record system does not dictate to the counselor whether he/she should be supportive or engage in confrontation. The system neither suggests nor precludes whether high or low demands should be made of the client. This lies within the province of program policy and clinical assessment--the system will, however, record program and counselor activity, regardless of philosophy or orientation.

Methadone programs should be aware that proposed Federal regulations governing methadone administration require an initial Treatment Plan that specifies the staff member primarily responsible for monitoring the plan. The supervising counselor must review,

date, and countersign the plan. The proposed regulations also require that the initial Treatment Plan include:

- Realistic short-term goals
- Behavioral tasks expected of the patient in order to complete these goals
- Supportive services needed and the projected frequency with which these services will be provided

When appropriate, the Treatment Plan and Progress Notes must also deal with the patient's mental and physical problems, apart from drug abuse, and shall include reasons for prescribing any medication for emotional or physical problems.

2. Progress Notes

(1) Progress Notes

Progress Notes are kept to track the client's response to treatment in terms of the problems identified on the Treatment Plan. Also, Progress Notes provide documentary evidence that person-to-person services were actually provided to the client. From a clinical perspective, properly completed Progress Notes establish the strong thread of continuity in a complex biopsychosocial therapeutic regimen, including maintenance of a feedback mechanism to the focal point of the record, the Treatment Plan. Interplay between the Progress Notes and the Treatment Plan is particularly effective when observations made on the Progress Notes are problem oriented, with each problem addressed in the ongoing notes paralleling the Treatment Plan's statement of problems.

The Progress Notes afford clinicians the opportunity to reassess old information and to expand, in detail, anything outlined on the Treatment Plan. They also follow the same planning process inherent in the development of the Treatment Plan, e.g., gathering of an additional data base, assessment of client needs and strengths, and formulation of action plans. Progress Notes reflect important changes in the client's life that occur during treatment, e.g., marriage, childbirth, arrest, or change in employment status. Where appropriate, information contained in the Progress Notes is used to revise or update the basic Treatment Plan. Finally, Progress Notes serve as the primary tool for reviewing client progress on the most current basis.

(2) Description And Procedures

The Progress Note is written on a single-page form (exhibit XII). These notes may be made by the primary counselor or by any other provider of care--e.g., the physician, nurse, or vocational counselor--and should be signed and dated.

A Progress Note is written after each counseling session or intervention or following any other service provided on behalf of the client. In addition, special rules for writing Progress Notes apply so that notes are organized and readily identifiable. These rules are:

- Each entry into the Progress Notes is numbered to correspond with the number of the Data Base Topic and the stated problem.
- Each Progress Note should clearly reflect the type of service rendered, e.g., individual counseling, family counseling groups, or telephone discussion.

Progress Notes written following a person-to-person contact with a client should be structured in the DAP format:

- D--Data; Data may be either subjective or objective. Subjective data are usually recordings of the client's statements, noted in quotation marks. If client statements are lengthy, carefully paraphrase the statement. Subjective data are placed first to ensure that the client's point of view will be taken into consideration at the outset. Objective data are factual observations, usually about the client's behavior and appearance; for example, "The client did not make eye contact during the interview--broke into tears." Objective data may also include information such as dirty urine reports or information received from other counselors or outside agencies.

- A--Assessment; The interpretive section of the Progress Notes includes the counselor's analysis of and conclusions about the client's current situation. The assessment is based upon the subjective and objective findings, modified by the counselor's review of the previous Progress Notes on the same subject and the current Treatment Plan.

- P--Plan; The plan may reflect appropriate changes in the Treatment Plan. If, in the counselor's judgment, the original Treatment Plan for a problem should continue, he/she should so state, and no modification will be required on the Treatment Plan. However, if the counselor amends the goal or therapy in any way, this change should be noted immediately on the Treatment Plan sheet, including the date of the amendment. If a new problem arises, this should also be added to the Treatment Plan, dated, with statements concerning the problem, the goal, and the proposed therapy.

Progress Notes may be written after important data have been received pertaining to the client, although no direct client/counselor interviewing session has occurred. The type of contact, e.g., telephone, should be noted.

(3) Special Notes

Progress Notes are generally tied to the action plan and document client and counselor efforts to reach the stated goals. Accurate and current Progress Notes are an important part of the total record system, for Progress Notes substantiate changes that may be made in the Treatment Plan. The counselor or other service provider should develop the habit of writing notes in the "DAP" manner and should take time to complete a Progress Note at the conclusion of every encounter with the client before his memory of new data and analysis of these data have become clouded. Progress Notes will probably be the largest single "writing task" the provider must perform in generating the record. Note: standard clinical practice dictates that all entries in the client record should be considered permanent. If corrections must be made, do not erase; instead, cross out the original entry and write in the correct one. (This direction applies to all forms.)

3. Treatment Plan Review Form

(1) Purpose

The Treatment Plan Review (TPR) form is a clinical tool to facilitate case management, trace progress made by a client, and document appropriate modifications to the Treatment Plan. Completion of the review also serves as an effective counselor training device. It affords an opportunity for staff to provide consultation and technical assistance to

each other regarding treatment approaches. Finally, Federal Funding Criteria require that outpatient programs review treatment plans at least once every 90 days. Day care and residential programs must review at least once every 30 days. Note that the proposed methadone regulations require the physician to review, date, and sign the Treatment Plan at least once a year.

(2) Background

The TPR form is useful for conducting a number of different evaluation activities:

- Clinician Review--Performed by the primary counselor only; facilitates self-evaluation by the counselor of case management effectiveness and structures discussion with client.

- Peer Review--Performed by other counselors who may be consulted by the primary counselor because they have previous knowledge of the client or special skills in dealing with certain problem areas.

- Supervisor Review--Performed by the primary counselor's supervisor; provides a management review of counselor's effectiveness and facilitates supervisor's training of counselor. The supervisor may challenge the counselor's assessment of client problems or the treatment plan. The supervisor may suggest alternative approaches and techniques to advance client progress.

- Case Conference Review--Performed by a group of senior clinical and/or medical staff; allows for "brainstorming" especially complex or difficult client cases, with different perspectives provided by specialists such as physicians, nurses, or vocational or educational specialists and provides the clinician with an opportunity to receive technical assistance and consultation.

These will be discussed at greater length in the following chapter.

(3) Description And Procedures

The Treatment Plan Review is similar in appearance to the Progress Note form. To complete the form, identify each unresolved problem on the Treatment Plan and review it, using the index code, by tracing it through all Progress Notes and data base questions completed since the preceding TPR to determine, in the following sequence:

- Whether the problem still exists and is the same or should be restated

- Whether goals should remain the same or be redefined

- Whether the intervention strategies or action plan should remain the same or be restated

- Whether the action plan should be employed in a new manner with different emphasis or utilizing other techniques

(4) Special Notes

As mentioned above, TPR is required both by the Federal Funding Criteria and by the proposed methadone regulations. It should be particularly noted that the requirements are for reviewing of Treatment Plan, not for rewriting Treatment Plans. If the Treatment Plan has

been continually updated through the use of Progress Notes, as outlined earlier in this chapter, the Treatment Plan, at review time, should be completely current. If this is the case, the program must only document this review, file the review sheets in the Progress Note section of the record, and enter the date of the review in the appropriate space on the Treatment Plan. For a client who presents particular problems and is not responding to treatment, a case conference may be arranged (see chapter III) and the Treatment Plan substantially revised as a result. Exhibit XII, following this page, shows a Treatment Plan, Progress Note, and TPR Form filled out for a hypotehtical client, John Jones.

C. DISCHARGE SUMMARY

(1) Purpose

This form documents the client's status at the time of discharge from the program and certain other information important in generating program statistics.

(2) Description And Procedures

The Discharge Summary, as shown in exhibit XIII, following exhibit XII, is a one-page form with data items that may be checked off or quickly coded. It is filled out by the primary counselor at the time of the exit interview or whenever a client leaves the program with or without having completed treatment. Most items are marked by a large black dot, signifying that they are required for CODAP reporting. At present, the Joint Commission on Accreditation of Hospitals requires programs to record a narrative discharge summary as well, covering the following points:

- Reason for admission
- Brief summary of treatment and client's response
- Reason for discharge
- Rehabilitative status or condition upon discharge
- Discharge instructions given to the client
- Followup or aftercare planned

This information should be entered as the final Progress Note in the client's folder.

(3) Special Notes

Information shown on this form may be compared with data obtained at entry to see whether the client's overall status has changed. Also, in the case of readmitted clients, the Discharge Summary is useful in quickly assessing the results of the last treatment episode. Note that, in the case of clients discharged before completing treatment (e.g., for infractions of discipline, persistently dirty urines, etc.), written notice of the intended discharge must be given the client, who then has the right to appeal the program's decision. Notices of this nature, as well as any written response from the client, should also become a part of the permanent client record.

These 12 forms constitute the core of the client record. Exhibit XIV, following this page, is a sample schedule for completing these forms.

D. SPECIAL FORMS

Included in this section are forms that have been designed for special cases, some of which are mandatory for inclusion in the client record. These eight special forms include:

EXHIBIT XII

SAMPLE TREATMENT PLAN, PROGRESS NOTES, AND TREATMENT PLAN REVIEW

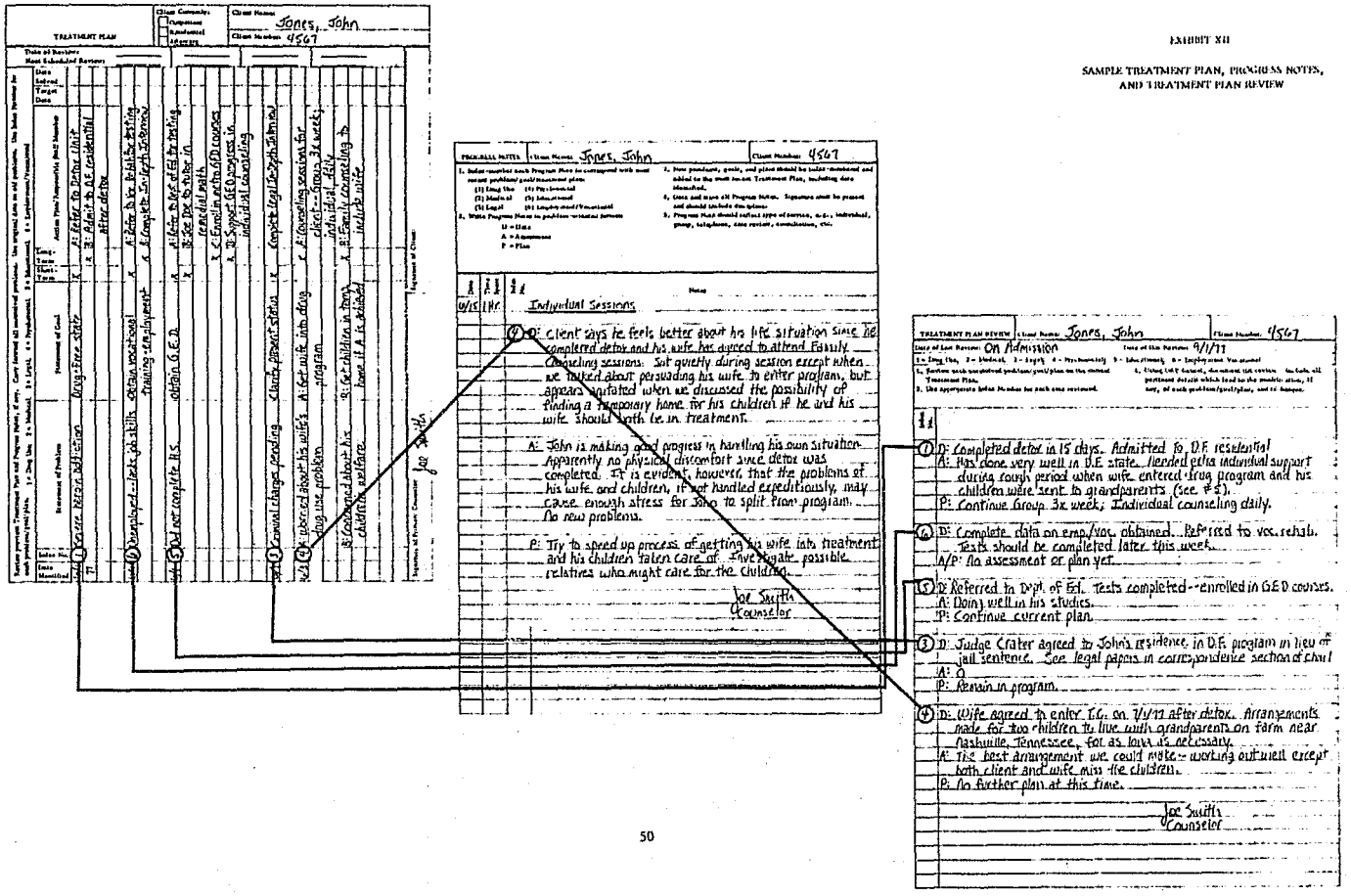


EXHIBIT XIII

DISCHARGE SUMMARY
(With CODAP Information)

Client Name:

Client Number:

Date of Admission:

Date of Discharge:

Reason for Discharge:
- ☐ Completed treatment--no drug use
- ☐ Completed treatment--some drug use
- ☐ Transferred to other CODAP clinic within program
- ☐ Transferred to non-CODAP clinic within program
- ☐ Referred to outside program
- ☐ Client discharged for noncompliance to program rules
- ☐ Client left without completing treatment
- ☐ Incarcerated ☐ Death

Current Employment Status:
- ☐ Full-time (35 or more hours per week)
- ☐ Part-time (less than 35 hours per week)
- ☐ Retired
- ☐ Unemployed--has sought employment in last 30 days
- ☐ Unemployed--has not sought employment in last 30 days
- ☐ Leave of absence

Number of Months Employed Since Admission: ☐☐

Number of times arrested during treatment: ☐☐

Drug Use at Time of Discharge:

(See codes on page three of Data Base)

	Use at Discharge	Severity at Discharge	Frequency Last 30 Days	Usual Route of Administration
None				
Heroin				
Non-Rx Methadone				
Other opiates or synthetics				
Alcohol				
Barbiturates				
Other sedatives, hypnotics				
Amphetamines				
Cocaine				
Marihuana/hashish				
Hallucinogens				
Inhalants				
Over-the-counter				
Tranquilizers				
Other				
Drug unknown				

Educational Status at Time of Discharge:

Last formal year completed: ☐☐

Currently in educational or skill development program ☐ Yes ☐ No

Training program completed during treatment ☐ Yes ☐ No

Marital Status:
- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Living Arrangements:
- ☐ Alone
- ☐ With parents
- ☐ With spouse
- ☐ Other (Specify): _____

Maintaining household with one or more dependents? ☐ Yes ☐ No

Public Assistance:
- ☐ None
- ☐ General Relief
- ☐ Medicaid
- ☐ ADC
- ☐ SSI
- ☐ Food Stamps
- ☐ SSI-State Supplement
- ☐ State Title XX

Current Gross Weekly Legal Income:

Personal: $_____ Family: $_____

Alcohol Use at Time of Discharge:

Drinks Per Occation: Wine: ☐☐ Drinks or ☐☐ Bottles
Liquor: ☐☐ Drinks or ☐☐ Pints
Beer: ☐☐ Cans

For the alcoholic beverage used most frequently, how often does the client drink: (use code below)

- ☐ As many as 5 drinks or more
- ☐ As many as 3 to 4 drinks
- ☐ As many as 1 to 2 drinks

1 = Nearly every time
2 = More than half the time
3 = Less than half the time
4 = Once in a while
5 = Never

Modality at Discharge:
- ☐ Detoxification
- ☐ Maintenance
- ☐ Drug free
- ☐ Other

Environment at Discharge:
- ☐ Prison
- ☐ Day care
- ☐ Residential
- ☐ Outpatient

Date:

Signature of Interviewer:

EXHIBIT XIV

Client Record Manual

SAMPLE SCHEDULE FOR COMPLETING CORE CLIENT RECORD FORMS

Form	Completed By	When Completed
Initial Interview	Primary Counselor and Specialized Providers	First day
In-Depth Interviews	Primary Counselor and Specialized Providers	Over several weeks after admission, depending on individual client needs but not later than 30 days after admission
Health Questionnaire	Nurse, Physician's Assistant, Counselor, or Client	Prior to physical examination
Physical Examination	Physician	After decision has been made to enroll client but within 21 days of admission; the exam should be performed prior to administration of methadone or any other medication
Treatment Plan	Primary Counselor	Initial Plan: following completion of the Initial Interview, Health Questionnaire, and Physical Examination; Complete Plan: within 30 days after admission, utilizing data gathered in the In-Depth Interviews
Progress Notes	Any program service provider who has a substantive interaction with the client	Immediately following contact with client or receipt of important data about the client
Treatment Plan Review	Primary Counselor, Supervisor, or Case Conference Committee	When needed, but at least every 30 days for inpatient and every 90 days for outpatient
Discharge Summary	Primary Counselor	At termination

- Urinalysis Results--Drug-free modality
- Methadone Administration/Urinalysis Reports
- Physician's Order Sheet
- Consent to Methadone Treatment Form
- Medication Administration Sheet
- Readmission Interview
- Readmission Medical History
- Readmission Physical Examination

1. Urinalysis Results

Urine testing results are used as a clinical tool both for diagnosis of addiction and in the determination of treatment plans. Urinalysis results received from laboratories should be posted directly to flowsheets designed to accumulate such data, for one client, over several weeks or months duration. This accumulation of many weeks of data on one sheet of paper reduces the bulk of the client folder, eliminates counselor time for recording such data, and provides, at a glance, a pattern of urinalysis results over time. Many programs simply paste the urinalysis strips received from the laboratory onto this form, thus eliminating the task of transferring laboratory data by hand.

There are two forms that may be used, depending upon program modality:

- Urinalysis Results/Drug-Free Modality
- Methadone Administration/Urinalysis Reports

Examples of these forms are found in exhibits XV and XVI, following this page. No special instructions are needed for completion.

Urinalysis results should also be indicated in the Progress Notes, keyed to drug use problems.

2. Physician's Order Sheet

The Physician's Order Sheet is required when the treatment of the client involves medication or other therapy for which the physician alone is responsible, and when there is any change in prescribed medication. It is recommended that physician's orders be written on this form as well as indicated in Progress Notes so that the physician will be able to identify readily and locate notes he/she has previously written. An example of this sheet is included in exhibit XVII, following exhibit XVI.

3. Consent To Methadone Treatment Form

Federal law requires that clients sign a formal consent to methadone treatment. The Food and Drug Administration's Consent to Methadone Treatment form is shown on exhibit XVIII, following exhibit XVII. This form must be duly signed and witnessed before methadone can be administered, and the form should be filed permanently in the client record.

4. Medication Administration Sheet

This form is recommended for documenting the administration of any medication other than methadone and the clinical reason for administering the medication. In many drug-free residential programs, clients may be using prescribed medications for a variety of reasons. The program may desire to keep the medication in a central location and provide the medication to the client at appropriate times. This form, therefore, records the date, time, and dosage of the medication administered.

URINALYSIS RESULTS Drug Free Modality	Client Name:	Client Number:

Date of Sample	Results Positive for:																		Negative	Comments or Remarks (For Extensive Notes, Use Progress Note Form)
		Morphine	Methadone	Cocaine	Dilaudid	Codeine					Amphetamine	Barbiturate		Quinine	Other					

EXHIBIT XVI

METHADONE ADMINISTRATION/URINALYSIS REPORTS

Client Name:

Record Number:

Prescribed Dosage (Enter amount from Physician's Order Sheet):

Year: Month:

Day	Dosage	Admin. By	Comment
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			

Urinalysis--Enter Results of All Urinalysis Reports

	Clean	Methadone	Opiates	Quinine	Cocaine	Barbiturates	Amphetamines	Benzodiazepines				Other

PHYSICIAN'S ORDER SHEET	Client Name:
	Record Number:

Note: Physician's orders must be dated, including time, and signed legibly; telephoned orders should be later countersigned.

For RN Use Only
T = Transferred to Administration Sheet

Date	Time	Physician's Orders and Signature	T ✓	Signature of RN

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

CONSENT TO METHADONE TREATMENT

(Provisions of this form may be modified to conform to any applicable State law)

Form Approved
OMB No. 057R 0098

DATE

NAME OF PATIENT

NAME OF PRACTITIONER EXPLAINING PROCEDURES

NAME OF PROGRAM MEDICAL DIRECTOR

I hereby authorize and give my voluntary consent to the above named Program Medical Director and/or any appropriately authorized assistants he may select, to administer or prescribe the drug methadone as an element in the treatment for my dependence on heroin or other narcotic drugs.

The procedures necessary to treat my condition have been explained to me and I understand that it will involve my taking daily dosages of methadone, or other drugs, which will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that methadone is a narcotic drug which can be harmful if taken without medical supervision. I further understand that methadone is an addictive medication and may, like other drugs used in medical practice, produce adverse results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, but I still desire to receive methadone due to the risk of my return to the use of heroin or other drugs.

The goal of methadone treatment is total rehabilitation of the patient. Eventual withdrawal from the use of all drugs, including methadone, is an appropriate treatment goal. I realize that for some patients methadone treatment may continue for relatively long periods of time but that periodic consideration shall be given concerning my complete withdrawal from methadone use.

I understand that I may withdraw from this treatment program and discontinue the use of the drug at any time and I shall be afforded detoxification under medical supervision.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a methadone treatment program, since the use of other drugs in conjunction with methadone may cause me harm.

I also understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when in the Program or Medical Director's professional judgment it is considered advisable.

(See reverse of this sheet for additional consent elements)

FORM FD 2635 (12/72)

FEMALE PATIENTS OF CHILD-BEARING AGE	PATIENTS UNDER 18 YEARS OF AGE
To the best of my knowledge, I ☐ am ☐ am not pregnant at this time. Besides the possible risks involved with the long-term use of methadone, I further understand that, like heroin and other narcotic drugs, information on its effects on pregnant women and on their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effects. It has been explained to me and I understand that methadone is transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking methadone, I or the unborn child may show signs of withdrawal which may adversely affect my pregnancy or the child. I shall use no other drugs without the Medical Director or his assistants' approval, since these drugs, particularly as they might interact with methadone, may harm me or my unborn child. I shall inform any other doctor who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a methadone treatment program in order that he may properly care for my child and me. It has been explained to me that after the birth of my child I should not nurse the baby because methadone is transmitted through the milk to the baby and this may cause physical dependence on methadone in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of methadone. It It is essential for the child's physician to know of my participation in a methadone treatment program so that he may provide appropriate medical treatment for the child. All the above possible effects of methadone have been fully explained to me and I understand that at present, there have not been enough studies conducted on the long term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform the Medical Director or one of his assistants immediately if I become pregnant in the future.	The patient is a minor,____ years of age, born,_____. The risks of the use of methadone have been explained to (me/us) and (I/we) understand that methadone is a drug on which long-term studies are still being conducted and that information on its effects in adolescents is incomplete. It has been explained to (me/us) that methadone is being used in the minor's treatment only because the risk of (his/her) return to the use of heroin is sufficiently great to justify this treatment. (I/We) declare that participation in the methadone treatment program is wholly voluntary on the part of both the (parent(s)/guardian(s)) and the patient and that methadone treatment may be stopped at any time on (my/our) request or that of the patient. With full knowledge of the potential benefits and possible risks involved with the use of methadone in the treatment of an adolescent, (I/we) consent to its use upon the minor, since (I/we) realize that otherwise (he/she) shall continue to be dependent upon heroin or other narcotic drugs.

I certify that no guarantee or assurance has been made as to the results that may be obtained from methadone treatment. With full knowledge of the potential benefits and possible risks involved, I consent to methadone treatment, since I realize that I would otherwise continue to be dependent on heroin or other narcotic drugs.

SIGNATURE OF PATIENT	DATE OF BIRTH	DATE
SIGNATURE OF PARENT(S) OR GUARDIAN(S)	RELATIONSHIP	DATE
SIGNATURE OF WITNESS		DATE

The existence of this form helps guard against adverse drug reactions and against the prescribing or scheduling of some activity that might be temporarily contraindicated during the period of medication. Medication administration should be noted on the Progress Notes, keyed to health problems.

Exhibit XIX, following this page, presents a copy of the Medication Administration Sheet.

5. Readmission Interview And Readmission Medical History And Physical Examination

These short forms for readmission interviews and readmission medical history and physical examinations are recommended for programs that have a high readmission rate or whose clients are readmitted within a short time after discharge. Before adopting these forms, however, the program should formulate a specific written policy for their use, including:

- Specified period of time in which these forms may be used, e.g., readmission up to six or nine months after discharge
- Specification of any types of clients for whom these would not be used

Note that the physician should review the readmission medical history in order to decide whether a physical examination is necessary. For methadone maintenance clients, a readmission physical examination is required if the readmitted client has been out of the program longer than six months. Use of the shortened forms for medical history and physical examination should be at the option of the examining physician. Examples of these forms are included in exhibits XX, XXI, and XXII, following this page.

* * * *

The forms presented in this chapter provide an organized and logical format for recording data on clients. Together, these forms constitute the major component of the total client record system. The next chapter discusses in greater detail the clinical and program management uses of these forms.

MEDICATION ADMINISTRATION SHEET (Do Not Use for Methadone Administration)	Client Name:		Client Number:
Date / Time	Name of Medication (Record Exact Dosage, Quantity, Strength, Etc.)*	Signature	Comments

* Note: Any change in medication must be signed or countersigned by the program physician.

EXHIBIT XX

READMISSION INTERVIEW

Name (Last, first, middle initial):

Address:

Street Apt.

City State ZIP Code

Birthdate: Month Day Year Sex: ☐ Male ☐ Female

MA/Ins. Nos.:

Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

TO BE OBTAINED FROM PREVIOUS RECORD

Record Number: _____

Date of Last Admission: _____ Date of Last Discharge: _____

Number of Previous Admissions: _____

On last admission, was treatment: ☐ Completed ☐ Not completed

On last admission, the modality was:
☐ Detoxification ☐ Maintenance ☐ Drug free
☐ Other (specify): _____

On last admission, environment was:
☐ Residential _____
☐ Outpatient _____
☐ Prison ☐ Day care

EDUCATION

Schooling Since Last Admission: ☐ None ☐ Full-time school ☐ Part-time school

If any this period: ☐ Job training ☐ High school ☐ College ☐ Other (Specify): _____

Hours attending: _____

EMPLOYMENT

Employment Since Last Admission: ☐ No job this period ☐ Homemaker ☐ Homemaker and job

☐ Any job this period--Check A or B and 1 or 2:
☐ A = Full-time (over 35 hours/week) ☐ B = Part-time (under 35 hours/week)
☐ 1 = Any time during period ☐ 2 = Entire period

If Working--Satisfied with job? ☐ Yes ☐ No

How long on job (days, weeks, months): _____ Salary level: $_____

If Not Working--Actively seeking employment? ☐ Yes, within last 30 days ☐ No, not within last 30 days

Other Means of Support: ☐ None ☐ Welfare ☐ Unemployment insurance (weeks remaining: ____) ☐ Family and friends ☐ Other (Specify): _____

LEGAL

Does client have any current legal involvement? ☐ No ☐ Yes--Refer as soon as possible for Legal History interview

DRUG USAGE

Length of time continuously on drugs since last withdrawal: _____ Longest period drug free: _____

Drug Usage Since Last Withdrawal or Use, Including Current Use:

Substance	Amount Per Day	Cost Per Day	How Taken

Additional Notes

Date:	Signature of Interviewer:

EXHIBIT XXI

READMISSION MEDICAL HISTORY	Client Name:
	Record Number:

How would you rate your present state of health? ☐ Good ☐ Fair ☐ Poor

Are you presently receiving medical care? ☐ No ☐ Yes--Indicate:

Where: ☐ Private physician ☐ Clinic ☐ Hospital Date of last physical examination: _____

Name of provider: _____

Address: _____

Since your last admission, have you had any of the following: (Indicate when and where treated in the space provided)

☐ Hepatitis: _____
☐ Infected veins: _____
☐ Skin abscesses: _____
☐ Other infections: _____
☐ Overdose: _____
☐ Syphilis: _____
☐ Gonorrhea: _____
☐ Other medical or surgical problems (Specify): _____

_____

_____

LNMP: _____ Last bowel movement: _____ Any unusual color of stool or urine: _____

Comments:

Date:	Signature of Interviewer:

PHYSICIAN'S REVIEW

☐ Physical examination is necessary
☐ Physical examination is not necessary at this time

Comments:

Date:	Signature: M.D.

READMISSION PHYSICAL EXAMINATION	Client Name:
	Record Number:

Height:	Weight:	Temperature:	Pulse:	Respirations:	Blood Pressure:

General Appearance:

Skin: ☐ Fresh track marks Subcutaneous abscesses: ☐ Acute ☐ Healed

Eyes: EOM: _____ Fundi: _____

Pupils: ☐ Normal ☐ Myotic ☐ Mydriatic ☐ Reactive ☐ Nonreactive Sclera: ☐ Normal ☐ Icteric Nystagmus: ☐ Absent ☐ Present

Ear, Nose, and Throat: _____

Lymph Nodes: _____

Heart and Lungs: _____

Abdomen: _____

Liver: ☐ Palpable ☐ Nonpalpable ☐ Enlarged ☐ Tender ☐ Nontender Spleen: ☐ Palpable ☐ Nonpalpable Kidneys: ☐ Palpable ☐ Nonpalpable

Extremities: _____

Neurological: _____

Impression:	Recommendations:

Date:	Signature: M. D.

III. USING THE CLIENT RECORD IN CLINICAL AND PROGRAM MANAGEMENT

The preceding chapters have described the philosophy of the problem oriented client record system and have outlined the core components of the record system. In discussing the format of these records, their general use in direct delivery of treatment has already been introduced. This chapter concentrates on more specific uses of the record system in clinical case management and relates the client record system to various functions of program management.

A. CLINICAL MANAGEMENT

Clinical management refers to the continued monitoring and evaluation of treatment services. This activity takes place on many levels, ranging from the informal day-to-day activities routinely performed by the counselor to relatively formal and structured sessions involving personnel from the program's various disciplines. Clinical management coordinates available resources focused upon producing positive client growth. Comprehensive planning in developing and monitoring a treatment plan is the most effective way of coordinating and managing effective treatment. Client record systems provide a structured and sequential series of steps that facilitate treatment plan formulation and implementation. In the effort to provide quality services, the client record system is the basic source document for client management and staff assessment and training.

The following section discusses the use of client records in a variety of counselor/client supervision structures.

1. Counselor Evaluation Of Clients

The counselor's ongoing assessment of each client depends upon the existence of a complete, detailed data base, problem statement, treatment plan, and Progress Notes. Counselors cannot rely on memory alone to supply the relevant details of a client's background and experiences while in treatment. Occasionally, collection of new information illuminates earlier data and casts some background fact into greater prominence. The counselor's perceptions of the client's strengths and weaknesses will become refined through continual review and updating of the record. Moreover, the treatment process is intended to induce change in the client; this change will be accompanied by shifts in the priority of problems and by the emergence of new problem areas to be addressed.

The client record will be the only reliable means of communicating activities of other providers to the primary counselor. A quick glance through the record might tell the counselor that a client has had a dirty urine and has missed two consecutive appointments with the vocational education specialist--facts that would certainly impact on his/her immediate strategy in dealing with the client.

By carefully examining the records of all their clients, counselors may well discover trends or patterns of incidents that identify deficiencies in their counseling methods. The same examples used above--dirty urines and missed appointments--and other behavior indicating lack of progress in treatment, if documented for a significant number of clients, will be a clue for counselors that their clients are not progressing and that they must either substantially change strategies or seek assistance from their supervisors.

2. Supervisor's Review Of Individual Counselors

In a well-managed program, the counselor's treatment of clients is continually reviewed by senior clinical personnel. The purpose of such review is twofold: (1) to ensure that clients are being given treatment consonant with their individual needs and the program's overall philosophy and (2) to enhance and upgrade counselors' skills. The program will make its own decisions regarding scheduling and frequency of supervisor review, bearing in mind the Federal requirements for treatment plan review for each client. Many programs require that initial treatment plans be scrutinized by senior clinicians before treatment is under way. Also, a counselor is free to request a supervisory review at any time.

In conducting the review, the supervisor will probably have a limited opportunity to observe the counselor in action, perhaps by sitting in on a group counseling session. But, as with any level of clinical management, the review will have to be based largely on what has been documented in the client record. It may be, then, that one of the supervisor's first duties will be to see that documentation exists: to insist that counselors and other providers complete missing elements of the record and maintain current Progress Notes. Admittedly, the supervisor may not be primarily interested in evaluating the counselor's record-keeping habits, except to the extent that good record practice is itself a clinical skill deserving cultivation and, more important, is the primary base document to conduct review.

The supervisor will examine the current treatment plan against the data base to determine that problems were correctly identified and prioritized. Here it should be noted that generation of a problem list is not an easy task. Previous sections of the manual may have inadvertently given the impression that a problem list flows naturally and ineluctably from the data base. This is seldom the case; a number of intermediate analytical steps must be taken. This is an area where the supervisor, with greater experience and expertise, can be especially helpful.

Goals that the counselor and client have agreed to pursue will be examined by the supervisor and critiqued for their appropriateness and objectivity. The supervisor may wish to challenge the counselor's approach, or to refine steps in goal attainment, or to suggest a revision or reordering of the goals and action plans. The action plan should be carefully examined:

- To see whether actions are appropriate to identify client problems, background, presenting symptoms, and aspirations
- To determine whether target dates are realistic
- To ascertain that every problem is matched by a goal and an action plan
- To ensure that the action plan is consonant with program philosophy and objectives
- To judge whether action plans are feasible in light of the program's resources (including its referral network)

Finally, the supervisor will review Progress Notes with the following questions in mind:

- Is there a Progress Note for every problem identified in the Treatment Plan?

- Is there an evident relationship among client problems, goals, action plans, and progress?

- Do Progress Notes reflect the provision of appropriate supportive services? Are notes made by other providers?

- Is information on the Progress Notes transferred to an evolving Treatment Plan? In the case of a positive note, is the goal noted on the Treatment Plan checked off as "achieved"? If the Progress Note is negative, is this reflected in the Treatment Plan by redefinition of either goals or action plans?

Through both observation and careful review of client records, the supervisor can intervene successfully to redirect a number of poor or unsuccessful treatment practices. Examples are given below of frequent areas of supervisory review:

- Inadequate Provision of Service--A review by the supervisor reveals that a counselor has a group of clients who have significant reading deficiencies that impact negatively upon their job prospects. The supervisor reviewing the Treatment Plans notes that no on-site remedial education has been scheduled, nor referral made to a local educational institution, and works with the counselor and other staff to remedy the situation.

- Noncompliance with Program Objectives--In a methadone maintenance program, the supervisor, during a review of a particular counselor's caseload, notes that, although most clients display clean urines, little progress is being made in resolving problems identified in the client record. In discussing the matter with the counselor, it becomes apparent that the counselor believes that cessation of opiate abuse is the client's major and perhaps only concern, and the counselor has not seriously addressed efforts to resolve problems in other areas, e.g., employment, education, and personal growth. Because the program's objectives clearly stress broader rehabilitative efforts, the supervisor works with the counselor to ensure his/her understanding of program objectives and assists the counselor to broaden counseling efforts.

- Lack of Follow-Up--An intake physical examination indicated that a particular client displayed symptoms of hypertension. No Progress Notes indicate that this problem is being addressed. After discussion with the counselor and physician, the supervisor makes sure that medical follow-up occurs.

- Client/Counselor Match--In a review of a particular counselor case load, the supervisor may find that the counselor works particularly well with one category of client, e.g., older male clients with a long drug abuse history, and seems to have lesser impact on other categories of clients, e.g., younger, female clients. Depending upon the supervisor's assessment, he may provide instruction to the counselor on how to cope better with the group under question or he may decide to transfer some cases to other counselors.

It should be noted that the examples presented above are illustrative in nature rather than an attempt to be all-inclusive. It seems clear, however, that, in the supervision of counselors, fully documented client records are perhaps the single most important tool.

3. Peer Review

Peer review is simply an extension of the theory that "two heads are better than one." Counselors often look to their peers for guidance in dealing with a difficult case. For one thing, counselor assignments do change for various reasons, and the counselor currently responsible for the client may wish to consult a colleague who has dealt with the client in an earlier stage of treatment. Also, certain counselors may be generally recognized by their peers as the resident "experts" on one or more common problems. One counselor may be noted for success in family therapy techniques; another may be unusually effective with aggressive clients; still another may have cultivated a good technique for dealing with "splittees." These counselor characteristics are program resources that should not be overlooked, and counselors should have no hesitation about seeking the advice of their colleagues.

In some programs, peer review will be a recognized, scheduled activity; in other places, peer review will "just happen" as the need arises. Regardless of the particular mechanism, peer review will be enhanced by--and, indeed, would be severely impeded without--a complete client record.

Generally speaking, peer review might proceed along the same lines as supervisory review, with the same examination and cross-checking of documentation in the client record. One aspect of the process of peer review is the opportunity for counselors to meet informally with representatives of other program services. Occasionally, Progress Notes may show that a client whose response is satisfactory in most respects is not doing well in some other area. Perhaps the client has been taking remedial education courses but has unaccountably failed a number of tests. In this case, the primary counselor might wish to discuss the client with the education specialist and obtain another professional's opinion. It may be that the client, in coping with drug abuse and family problems, is doing all that can reasonably be expected of him for the time being and that educational services should be postponed.

4. Case Conferences

(1) Purpose

Case conferences are opportunities for representatives from each of the program's various disciplines to meet and discuss jointly a case or a group of cases. These conferences may be held for a variety of reasons, for example:

- To discuss a "problem" client, i.e., one who is not responding to any recognized treatment strategy or who has flagrantly violated a program rule
- To discuss a client or a group of clients whose characteristics or response to treatment afford a unique opportunity for counselor training
- To assess client(s) who are due to progress to another phase of treatment
- To give each counselor an opportunity to present one or more cases for review and to obtain the benefits of a multidisciplinary evaluation of some of his/her cases
- To fulfill the requirements of the Federal Funding Criteria for Treatment Plan review (every 30 days for residential clients; every 90 days for outpatient clients)

Often, the case conference is the only opportunity for the counseling, medical, support, and administrative staff to meet and exchange ideas in person. Cross-fertilization among varied staff discipline is of major importance, both to the client's welfare and to the continuing education of staff members. The client record is the distillation of the multidisciplinary approach to drug abuse treatment and the focus for the conferees' presentations, discussions, and conclusions.

(2) Membership

The Case Conference Committee should have one representative from each discipline within the program. The following list is a suggested membership:

- Director of the program (R)*
- Medical Director or consulting physician, psychologist, or Head Nurse (P)
- Clinical Supervisor (P)
- Nurse or other paramedical personnel (R)
- Counselors (R)
- Vocational Rehabilitation Specialist (R or I)
- Educational Specialist (R or I)
- Legal Counsel (R or I)

Composition of the group will be directed to some extent by the size and complexity of the program and the purpose of the particular case conference. Rotations can be arranged so that all staff members will have the opportunity to participate regularly. One person whose presence is a necessity is the primary counselor of the client(s) under discussion.

(3) Scheduling

Case conferences should be held at regularly scheduled intervals, preferably at least once every two weeks. In programs with a heavy caseload, these conferences might be held on a weekly basis so that the number of cases scheduled for review will remain manageable.

(4) Suggested Protocol for Presentation

The protocol for presentation may vary somewhat depending on the number of clients being presented and the specific reason for the conference. If only one client is on the agenda, the presentation will probably be made by the primary counselor; if several clients are to be discussed, the clinical supervisor may take the lead. In a case conference devoted to a medical aspect of treatment--e.g., detoxification regimens for barbiturate users, treatment of emergency cases, etc.--the presentation may be made by the program's medical director or consulting physician.

The oral presentation of a client should be organized in the following manner:

- Name and age of the client, relevant demographics, and time in treatment
- Complete problem list

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* P = permanent membership; R = rotating membership; I = participation by invitation

Data base on one or more of the problems

- Data acquired from the histories
- Data obtained from counseling sessions, medical examinations, laboratory reports, etc.

. Purpose of the presentation, i.e., the particular problem being focused on

. Interventions that have been attempted

. Call for questions on the presentation

. General discussion

. Summation

In some programs, the client is asked to attend part of the conference, particularly if a disciplinary measure or a discharge is being considered.

No effective presentation can take place without the complete and current client record, sections of which can be made available to the group at large through the use of an overhead projector.

(5) Case Conference Documentation

A Case Conference Committee should designate a secretary who will be responsible for recording the minutes of the meeting. These will include:

. Date, time, and duration of meeting
. Names of members present
. Cases presented (by number, not by name)
. Recommendations and relevant target dates for each case

A permanent file of these minutes should be kept by the Clinical Supervisor.

Because the end result of a case conference is often a change in a client's overall status or a change in the Treatment Plan, the case conference will also be documented in the client record in the following ways:

. If the client's progress was reviewed in detail, this may be documented in the record by a new Progress Note and possibly by a new or updated Treatment Plan. These documents should reference the case conference and the date.

. If the conferees determined that the client should be terminated or discharged, this should be documented in the Progress Note and discharge procedures then initiated.

. If the case was reviewed mainly as an aspect of continuing staff education and if no changes were made in the Treatment Plan, no further documentation of the client record is necessary.

5. Treatment Committee

(1) Purpose

A Treatment Committee, although it may have many of the same members, differs from the Case Conference Committee in purpose and orientation. Whereas the case conference is designed to focus on a client or a group of clients, the Treatment Committee has as its purpose the examination and evaluation of various program treatment practices and components. The Treatment Committee uses information in the client record as a baseline against which treatment practices can be evaluated, improved, or changed.

(2) Membership

The Treatment Committee is constituted largely of senior clinical personnel:

- Clinical Director (Chairman)
- Medical Director
- Counseling Supervisor
- Intake Coordinator
- Nursing Supervisor

(3) Roles and Activities

The Treatment Committee concerns itself with the following activities:

- Review and approval of all initial Treatment Plans
- Assurance that standards and practices are consistent throughout the program and consonant with overall program objectives
- Review of certain "case categories"; disciplinary cases, new admissions, dirty urines, "successful" discharges, candidates for termination
- Identification of training needs on the part of counseling staff

(4) Input to Program Management

One of the most important functions of the Treatment Committee is to formulate a clinician's perspective on matters that impact on program management. In this capacity, the Treatment Committee may advise program managers on:

- Hours of Operation--Are the present hours of operation creating difficulties for the clients? Are missed appointments a frequent problem?
- Addition of a Service--In reviewing client records, the Treatment Committee may discover that a significant number of clients have needs that are not presently met by the program or by agencies within its referral network. An example might be a family planning service or a vocational guidance service.
- Termination of a Service--Conversely, the Treatment Committee, in its review of case records, might discover gross underutilization of an existing service (e.g., remedial reading) and may recommend reduction or termination of this existing resource.

Restructuring of Counselor Assignments--After comprehensive review of both case records and counselor characteristics, a Treatment Committee might recommend a change in counselor assignments whereby the counselor, instead of guiding the same assigned clients from induction to discharge, would be assigned a group of inductees, or a group of intermediate-level clients, or a group nearing discharge. The Treatment Committee's recommendation would take into account the trade-offs between continuity of care and capitalizing on individual counselor strengths.

This section concludes the discussion on clinical uses of the client record system. The following describes a number of program management uses of the record system.

B. PROGRAM MANAGEMENT

Program management can be conceived as the expertise, strength, and determination to fuse the disparate elements of a program into a cohesive whole providing high quality care to clients. A wide variety of tasks are encompassed in program management, including:

- Coordinating diverse service elements
- Assessing needs on an ongoing basis and matching available resources to fluctuating demands
- Evaluating staff performance and training needs
- Creating linkages with resources available in the community

This section of the chapter suggests a number of program management areas that can be more capably managed through periodic scouting of information found in client records. In addition, appendix A discusses another program management application of the client record system--the use of the system in generating reports required both internally by managers and externally by funding, regulatory, and accrediting agencies.

1. Coordination Of Diverse Program Service Elements

In larger programs that provide a variety of services, problems often appear in delivering comprehensive services to clients. For example, in some programs, medical staff and counselors appear to work in a vacuum, with little or no contact or communication. In many programs, the client record file and the medical records are stored in different areas, and neither the counselor nor the physician has access to or interest in both sets of records. In some programs, counselors are not promptly informed of the results of urine screening and physicians are not cognizant of client progress or retrogression as perceived and documented by the counselor. This separation and accompanying bifurcation of effort is not in the best interest of the program or the client.

One recommended solution to a problem of this nature is to consolidate all client records into one file--as described in earlier chapters of this manual. If this solution is not feasible, mechanisms should be set up to ensure that appropriate communication among specific service providers exists. This can be done through the case conferences and treatment committees described earlier. In any event, it behooves program management to monitor carefully how specialized services are coordinated, e.g., medical services, counseling, remedial education, legal services, vocational rehabilitation, or other services.

The basic documentation attesting to coordination and follow-up efforts is located in each client file, and a quick perusal of the most current Treatment Plan and Progress Notes will establish whether coordination of diverse program services is occurring or not.

2. Limited Program Resources Versus Client Needs

As treatment programs mature, the available funding level usually remains static or decreases, whereas the demand from program services tends to increase. Consequently, most programs find themselves in a situation where resources are scarce and require careful allocation to areas of greatest client need. Programs, for example, at one stage of their development may invest in internal remedial education or vocational rehabilitation services. As the program matures and the client caseload per counselor increases, the program management may be faced with the painful choice of continuing in-house services at the cost of an overly high counselor/client caseload or dropping the in-house services and converting these resources into more counseling staff.

One major input into the decision-making process should come from a review of current client records in order to ascertain client need in terms of existing in-house services. If the In-Depth Interviews, Treatment Plans, and Progress Notes indicate an infrequent use of or limited need for specific in-house services, program management may identify an appropriate rationale for the reallocation of resources. Another major consideration, outside of the input from client records, is, of course, the availability and suitability of external resources such as a Board of Education or community job referral resources. Nevertheless, a careful scrutiny of client records may provide data sufficient for decision-making.

3. Changing Client Characteristics

Over time in many locales, treatment programs may be faced with the possibility that the characteristics of the target population are undergoing substantial changes and, thus, may require the program to make significant changes in the services provided and in the manner in which services are delivered. This change in client characteristics may also be presaged by changes occurring in the community.

For example, changes in a community may result in a major shift in the ethnic composition of the client population, with significant changes in job or housing availability, thereby requiring program management to seek resources to deal with endemic client problems and perhaps to attempt to recruit staff from the same ethnic group.

Another change in client characteristics may reflect that the average age of the client has been dramatically lowered or that the drug of choice on the street has shifted from heroin to some other substance.

It seems clear that a rapid response to changes of this nature is a prime management responsibility. This responsibility cannot be adequately discharged unless accurate and timely information is available. The Initial Interview form should provide information on client characteristics of current intakes, and a comparison between current and past intake interviews can quickly establish whether client characteristics are stable or in a condition of rapid change. This analysis, based upon client record forms, will enable program management to make important decisions in a timely fashion.

4. Staff Performance And Training Needs

Staff performance, especially in the clinical and counseling areas, is not an easy task for supervisors to assess. A host of ill-defined variables operate in a counselor/client relationship, and the identification of effective counseling techniques that lead directly to positive change on the part of clients is a difficult enterprise. Clinical supervisors, nevertheless, are required to monitor counselor performance, identify counselor strengths and weaknesses, and devise methods to upgrade staff performance and skills.

Because it is neither practical nor advisable for supervisors to observe every counselor/client encounter, or sit in on every counseling session, the basic source document for assessing counselor performance is the client record file. The development of a comprehensive client background, the identification of client strengths and weaknesses, the prioritization of client problems, the development of a Treatment Plan uniquely tailored to each client, and the application of interventions directly tied to the Treatment Plan as documented in the Progress Notes, can convey a true picture of counselor capability and performance. It would be reasonable to assert that, without a comprehensive client record system, clinical supervisors would find it extremely difficult, if not impossible, to assess staff performance.

Constant review of client records will provide the clinical supervisor with the capability to assess the strengths and weaknesses of the counseling staff as a group, as well as on an individual basis, and may lead to the development of a needs assessment as a precursor toward obtaining training to improve areas of weaknesses. A counseling supervisor, for example, upon reviewing client records, may discover that group counseling sessions are held with little frequency and are not particularly effective. Further inquiries may indicate that counselors are uneasy with the group process and lack fundamental knowledge and experience with the dynamics of a group setting.

With that information in hand, the counseling supervisor may seek appropriate training from the Regional Support Center, a nearby university, or other training resource.

Another example: upon review of client records, the counseling supervisor discovers that one counselor seems to have positive impact upon younger clients who have recently been enrolled in the program and seems to have less success with older clients with longer tenure in the program. A review of another counselor's caseload reveals the opposite, i.e., more success with older clients. The supervisor, upon identifying this situation, has several options. A training session can be held to strengthen each counselor's area of relative weakness, or the supervisor may decide to shift the client caseload in terms of existing counseling staff strengths and capabilities.

Frequent scrutiny of client records will enable supervisors to discover relative staff strengths and weaknesses and will enable them to take prudent and timely actions to improve client services.

5. Linkages With Community Resources

It is unlikely that any treatment program can provide all required client services on an in-house basis. Clients present a wide variety of needs in terms of general, specialized, or emergency health care; remedial reading, writing, and computation skills; career counseling, vocational training, and job development; funds or shelter; and a host of other immediate or long-range needs. The development of linkages and referrals to external sources will broaden the program's service range as well as develop its credibility, image, and outreach capability in its community.

Client records are a rich informational source that can determine current client needs, identify the quality of existing community resources that are currently being used, and identify client needs that are not being met. An assessment of this nature, based upon a review of client records, will provide program management with a clear picture of unmet needs. Subsequently, management may face the hard choice of whether to develop specific in-house resources with limited funds or seek to use outside community resources. Developing in-house resources such as remedial education or job development efforts is costly and usually duplicative of what may be frequently found in many communities. On the other hand, attempting to use existing resources may be difficult becuase the services may not be tailored specifically to client needs or the external agencies may be reluctant to provide services to drug treatment clients.

The first step in this process is to have clear and timely information on present client needs and the degree to which the program meets those needs. A comprehensive client record system will provide that critical information.

* * * *

In summary, effective program management prudently steers the program through difficult and dangerous times. Changing Federal and state requirements, limited resources, a fluctuating client census, changing client and community characteristics, uneven staff resources, complex interfaces with the community and supportive agencies--all require the continuous assessment of program operations.

Complete and comprehensive client records are a major asset in the formidable task of providing continuing high levels of quality care to the program's clients.

APPENDIX A

USING THE CLIENT RECORD SYSTEM FOR PROGRAM REPORTING

Managers are required to prepare periodic reports of program operations both to satisfy internal information needs and to meet the requirements of external funding, regulatory, and accrediting agencies. These reports may cover such areas as the current client census and client demographic characteristics, the amount of staff time spent in direct service delivery, the size of the program's waiting list, the time required for intake, the weekly urinalysis results, and current figures on new admissions and discharges. The client records are basic source documents for information of this type; they provide an audit trail for all of the program's intermediate reporting mechanisms.

The client record system presented in this manual has been deliberately devised to facilitate the collection of data useful to program managers. All forms in the client record are standardized so that the same kinds of information are collected for each client. This point may seem belabored, but among the various deficiencies noted in existing client record systems was the failure to collect standard information on clients' backgrounds and responses to treatment. Except for intake and discharge data, often no comparability existed among client records. Components of this system ensure that the same questions are asked of all clients and that responses are recorded in a standard fashion.

Examples of direct uses of the client record system in generating program management data are presented below. These examples are not exhaustive, and, no doubt, program managers will think of other ways the record system can be used for this purpose.

1. Counselor Activity Reporting

To ensure timely information on staff resources expended on specific program activities, most programs require that staff members complete periodic activity reports. The client record system will serve both the counselors, as a source of information for reporting direct services to clients, and the program managers, as a means of verifying reported activity.

Exhibit A-I shows an example of a counselor's semi-monthly activity report. On this form, the month has been divided into two reporting periods, and the counselor can simply draw a line through the period not being reported. The report is divided into two parts, A and B. Part A relates to direct services to clients, e.g., individual and group counseling, family therapy, and intake work-ups on applicants. The client record will serve as the means for verifying all time reported in Part A. Part B refers to all other activities that the counselor undertakes. This section includes time spent in staff meetings, case conferences, record keeping, outreach, public speaking, holiday, sick leave, etc.

A code is used for each activity, whether it is direct client service or another program activity. The list of counselor activities and corresponding codes can be found at the bottom of each report.

EXHIBIT A-1

SEMIMONTHLY ACTIVITY REPORT

Name (Please Print):

Reporting Period:
From: Month / Day / Year
To: Month / Day / Year

Name of Client	Date and Type of Service																Total Time
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
Subtotal A																	

Staff Activity	Date and Type of Activity																Total Time
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
Subtotal B																	
TOTAL TIME: A + B																	

Signature:

Date:

Code	Activity	Total Hours	Code	Activity	Total Hours
01	Individual Counseling		13	Staff Meetings	
02	Group Counseling		14	Case Conferences	
03	Family Therapy		15	Sick Leave	
04	Outreach		16	Holiday	
05	Intake		17	Compensatory Time	
06	Telephone Assistance and Information		18	Vacation	
07	Planning or Conducting Seminars		19	Leave Without Pay	
08	Consulting With Staff of Other Agencies		20	Other (Please Describe):	
09	Public Speaking				
10	Travel				
11	Client Record Keeping				
12	Other Administrative Functions				

The name of each client receiving services during the reporting period is recorded in Part A. The code denoting service received is entered in the box under the date service is provided and on the line congruent with each client's name. The recording space is divided by a horizontal slash (/) in each box. The service or activity code is written above the slash. Time, denoted by hours or fraction, is written below the slash. Sample entries are shown below:

SEMIMONTHLY ACTIVITY REPORT

Name (Please Print): John Q. Counselor

Reporting Period: From: 0,7 (Month) 1,6 (Day) 7,7 (Year) To: 0,7 (Month) 3,1 (Day) 7,7 (Year)

Part A

Name of Client	Date and Type of Service																Total Time
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
John Jones					01/1		03/1				01/1	X					3
Tom Brown										05/2				01/½			2½

The sample section of Part A shows the counselor's report for the period from July 16-31, 1977:

- John Jones received one hour of individual counseling on July 20 and another hour on July 26. On July 22, John Jones was in a group session for an hour. A total of three hours was spent by this counselor with John Jones during this reporting period.

- Tom Brown came in on July 25, and the counselor spent two hours doing an intake. On July 29, the applicant received half an hour of individual counseling.

This type of information can be easily abstracted from the client record, particularly the Progress Notes, which show time spent in service delivery.

The column labeled "Total Time" shows total number of hours of direct client services that the counselor provided. It is possible for a client's name to appear on more than one counselor's activity report. For example, if Counselor #1 does intake on an applicant and Counselor #2 is assigned as the primary counselor, the client's name would appear on each counselor's report.

CONTINUED

1 OF 2

Counselor activity reporting is an extremely valuable aid to managers in staff allocation, staff evaluation, and assessment of service utilization. It also is an important source document for billing clients (see Section 5, page A(8).

2. Client Status Reporting

Evaluation of clients' response to treatment may be carried out for many reasons:

- To support funding decisions made by external agencies
- To supply information needed internally for decisions on resource allocation or initiation or termination of some program service

Clients may be evaluated on a long-term basis after they have completed treatment or on an on-going basis while treatment is still in progress.

Whatever the scope of the evaluation or the reason for its taking place, certain classic measures of treatment success are commonly applied: reduction or cessation of drug abuse, employment, increased social stability, and clear arrest history or lack of legal involvement.

Exhibit A-II, Effectiveness Evaluation Data, shows how a single client can be evaluated on a monthly basis. This form can easily be filled out from Progress Note data. These forms can be aggregated for a given group of clients (e.g., all those admitted during the same month) to give program managers some idea of the overall effectiveness of treatment services in changing client behaviors.

Treatment evaluation is a complex subject and has been covered in detail in the first volume of the NIDA Treatment Program Monograph Series, Manual for Drug Abuse Treatment Program Self-Evaluation, L. Lynn Guess and Barry Tuchfeld, 1977. This publication discusses the methods of choosing a group for evaluation and the various objective measures of client success. It shows how to use client status information already collected for CODAP and gives examples of worksheets that may be used in aggregating client data.

3. CODAP Reporting

With few exceptions, all drug treatment programs receiving Federal funds must participate in the Client Oriented Data Acquisition Process (CODAP), a system developed and operated by the National Institute on Drug Abuse, which provides current information on clients and treatment provided. Approximately 1,600 clinics report to CODAP; these clinics account for some 40,000 client admissions and discharges each month. Forms and procedures required for CODAP reporting are described in Client Oriented Data Acquisition Process: Instruction Manual and Handbook (NIDA, January, 1977). CODAP participation requires three kinds of reports:

- Admission Report--To be completed for every client admitted to treatment and for readmitted clients and clients transferred to any clinic within the program
- Discharge Report--To be completed for every client discharged from treatment at the clinic, regardless of reason, and for routine transfer discharges.

EXHIBIT A-II

EFFECTIVENESS EVALUATION DATA (Optional)

Period From _____ To _____

Client Name:

Record Number:

DRUG ABUSE

Self-Administered Drugs of Abuse:	Self-Report: Amount	Self-Report: Frequency	Self-Report: Cost	Client Record No. Times Positive
None				
Heroin				
Barbiturates				
Amphetamines				
Cocaine				
Other				

Verification of Abuse

Fresh needle marks? ☐ Yes ☐ No

Counselor Opinion:

Present methadone dosage, if applicable:

Present Treatment Status: ☐ Drug free ☐ Being detoxified ☐ In stabilization ☐ Detoxified from methadone ☐ Methadone maintenance

MEDICAL

Problems? ☐ No ☐ Yes--Specify: Acute: _____

Chronic: _____

Last medical examination:

Physician's opinion of state of health: ☐ Good ☐ Fair ☐ Poor

PSYCHOSOCIAL

Clinic Behavior This Period: ☐ Satisfactory ☐ Marginal ☐ Disruptive

Is client satisfied with his/her family relationship? ☐ Yes ☐ No

Does client appear to be emotionally stable? ☐ Yes ☐ No

Lifestyle This Period: ☐ Lives alone ☐ With parents ☐ Other relatives ☐ With spouse and/or children ☐ Friends ☐ No permanent residence ☐ Other (Specify): _____

LEGAL

Does client have a case pending? ☐ Yes: ☐ Civil ☐ Criminal ☐ No: ☐ On parole ☐ On probation

Arrest history this period: Total days spent in jail this period:

EMPLOYMENT

Employment This Period: ☐ No ☐ Yes ☐ Homemaker ☐ Both homemaker and job

If any job this period, check A or B and 1 or 2:

☐ A--Full-time job ☐ B--Part-time job ☐ 1--Any time during period ☐ 2--Entire period

How long on this job: _____ (days, weeks, or months)

Salary level: $ _____

If working, satisfied with job? ☐ Yes ☐ No

Verification: _____

If not working, how many times has client received job counseling from program?

Other Means of Support: ☐ None ☐ Welfare ☐ Unemployment insurance (weeks remaining: _____) ☐ Family and friends ☐ Other (Specify): _____

Vocational Rehabilitation: ☐ Actively seeking employment ☐ Open case ☐ Verification: _____ ☐ Neither

EDUCATION

Schooling This Period: ☐ None ☐ Full-time school ☐ Part-time school

If any this period: ☐ Job training ☐ High school ☐ College ☐ Other (Specify): _____

Hours attending: _____ Grade average: _____

How many times has client received services for:

___ Mental health

___ Drugs ___ Educational

___ Legal ___ Vocational

___ Employment

___ Medical ___ Dental

Number of Hours:

Individual Counseling: _____

Group Counseling: _____

Total Hours This Period: _____

Counselor Comments:

Date:

Signature:

Admissions and discharges for the previous month are collected and submitted on a monthly basis to NIDA or to the Single State Agency (SSA).

Client Flow Summary--Is completed and submitted monthly and shows overall admission and discharge activity, census of NIDA-funded and other clients, current waiting list data, and funding information

The first two of these three reports--Admission and Discharge--may be easily prepared, by the program's record specialist or some other staff member designated as a CODAP liaison, from information collected on the Initial Interview, Discharge, and Readmission Interview forms (see Chapter II, exhibits III, XIII, and XIX). CODAP required information on these forms is marked by a large black dot and may be easily transferred to the CODAP report form as soon as the record source document is completed. Exhibit A-III shows a sample CODAP report form annotated with the sources of data from the Initial Interview. Training in filling out CODAP reports is available from most Single State Agencies. Admissions and discharges for the month being reported should be batched and all CODAP reports prepared at one time. Because CODAP information has to be coded numerically, it will be easier to do a group en masse.

The third report, Client Flow Summary, is useful not only to CODAP but also to the individual program manager. This report sums the two previous types of reports and requires information not available in client records (e.g., from waiting list, funding, and other sources).

A note of caution: some programs have erroneously assumed that the CODAP Admission Report can substitute for an Initial Interview. Although many data items are identical, the Initial Interview collects more information than the CODAP report. Furthermore, the Initial Interview has been designed and arranged as one of a series of integrated and sequential forms with a view toward providing treatment; it is the source document on which the initial Treatment Plan is based and suggests the necessity or priority for additional data base forms.

4. Third-Party Reimbursement

For the past several years, federally funded treatment centers have been urged to seek sources of third-party reimbursement for their clients. NIDA has provided substantial technical assistance in this area to programs through on-site consultation, regional seminars, and development of information such as the Reporting Series on Third Party Reimbursement, distributed by the National Clearinghouse for Drug Abuse Information. This manual cannot possibly hope to recapitulate all this information but, instead, focuses on the specific use of the client record in applying for and collecting reimbursements.

Program managers will recall the five factors involved in the interface between service delivery and payment programs:

Provider Requirements--Before billing for third-party reimbursements, a program must fulfill certain administrative requirements and meet any accreditation and licensure standards established or adopted by the third-party reimbursement program. In many cases, administrative requirements involve

EXHIBIT A-III

Client Record Manual

SAMPLE CODAP ADMISSION FORM SHOWING SOURCES OF DATA FROM INITIAL INTERVIEW

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE ON DRUG ABUSE

CLIENT ORIENTED DATA ACQUISITION PROCESS (CODAP) — ADMISSION REPORT (AR)

CARD 1

1. CLINIC IDENTIFIER — 11-18
2. DATE FORM COMPLETED (Month, Day, Year) — 19-24
3. CLIENT NUMBER (p1) — 25-34
4. DATE OF ADMISSION TO THIS CLINIC (p1) (Month, Day, Year) — 35-40
5. ADMISSION TYPE (p6) — 41
   1 = First Admission - To Any Clinic Within This Program
   2 = Readmission - To Any Clinic Within This Program
   3 = Transfer Asmission - From Another CODAP Reporting Clinic Within This Program
   4 = Transfer Admission - From A Non-CODAP Reporting Clinic Within This Program
6. MODALITY ADMITTED TO (p6) (See reverse side for codes) — 42
7. ENVIRONMENT ADMITTED TO (p6) (See reverse side for codes) — 43
8. MEDICATION PRESCRIBED (See reverse side for codes) Physician's Order Sheet. — 44-45
9. SEX 1 = Male 2 = Female (p1) — 46
10. DATE OF BIRTH (p1) (Month, Year) — 47-50
11. RACE/ETHNIC BACKGROUND (See reverse side for codes) (p1) — 51-52
12. SOURCE OF REFERRAL (See reverse side for codes) (p6) — 53-54
13. MARITAL STATUS (See reverse side for codes) (p1) — 55
14. LIVING ARRANGEMENT (See reverse side for codes) (p1) — 56
15. EMPLOYMENT STATUS (See reverse side for codes) (p5) — 57
16. CURRENTLY A HOMEMAKER (Maintains a household with one or more dependents) 1 = Yes 2 = No (p1) — 58
17. HIGHEST SCHOOL GRADE COMPLETED (00-20) (p1) — 59-60
18. CURRENTLY IN EDUCATIONAL OR SKILL DEVELOPMENT PROGRAM 1 = Yes 2 = No (p1) — 61
19. NUMBER OF TIMES ARRESTED WITHIN 24 MONTHS PRIOR TO THIS ADMISSION (00 for none) (p4) — 62-63
20. NUMBER OF PRIOR ADMISSIONS TO ANY DRUG TREATMENT PROGRAM (00 for none) (p3) — 64-65
21. MONTHS SINCE LAST DISCHARGE FROM ANY DRUG TREATMENT PROGRAM (00 = none 97 = not applicable) (p3) — 66-67
22. HEALTH INSURANCE TYPE (See reverse side for codes) (p5) — 68

Item 23 - DRUG TYPE(S) USED (p2)

Indicate in the following order:
- Drug problems for which the Client is being admitted for treatment
- Other drugs used during the month prior to admission

If 00 for None is entered, leave Items 24-28 blank.

00 = None
01 = Heroin
02 = Non-Rx Methadone
03 = Other Opiates And Synthetics
04 = Alcohol
05 = Barbiturates
06 = Other Sedatives Or Hypnotics
07 = Amphetamines
08 = Cocaine
09 = Marihuana/Hashish
10 = Hallucinogens
11 = Inhalants
12 = Over-The-Counter
13 = Tranquilizers
14 = Other

Item 24 - SEVERITY OF DRUG PROBLEM(S) AT TIME OF ADMISSION (p2)

0 = Not A Problem At Time Of Admission
1 = Primary
2 = Secondary
3 = Tertiary

Item 25 - FREQUENCY OF USE DURING MONTH PRIOR TO ADMISSION (p2)

0 = No Use During Month Prior To Admission
1 = Once Per Month
2 = Once Per Week
3 = Two To Three Times Per Week
4 = More Than Three Times Per Week
5 = Once Daily
6 = Two To Three Times Daily
7 = More Than Three Times Daily

Item 26 - MOST RECENT USUAL ROUTE OF ADMINISTRATION (p2)

1 = Oral
2 = Smoking
3 = Inhalation
4 = Intramuscular
5 = Intravenous

PATTERNS OF DRUG USE

CARD 2

23. DRUG TYPE(S) USED (Complete all blocks)	11	12	13	14	15	16	17	18
24. SEVERITY OF DRUG PROBLEM(S) AT TIME OF ADMISSION	19		20		21		22	
25. FREQUENCY OF USE DURING MONTH PRIOR TO ADMISSION	23		24		25		26	
26. MOST RECENT USUAL ROUTE OF ADMINISTRATION	27		28		29		30	
27. YEAR OF FIRST USE	31	32	33	34	35	36	37	38
	19		19		19		19	
28. YEAR FIRST USED ONCE PER WEEK OR MORE OFTEN (Enter 97 for not applicable if never used at this frequency)	39	40	41	42	43	44	45	46
	19		19		19		19	

CARD 2

29. CODED REMARKS — 47-77

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
47 48 53 58 67 73 77

This Report Is Required By P.L. 92-255. Failure To Report May Result In The Suspension Or Termination Of NIDA Treatment Grant Or Contract. The Information Entered On This Form Will Be Handled In The Strictest Confidence And Will Not Be Released To Unauthorized Personnel.

executing a purchase of service agreement, negotiating rates, obtaining an identifying vendor number, agreeing to meet reporting requirements, and assuring access to relevant patient and financial records.

- Client Eligibility--The service program can be reimbursed only when it serves clients meeting the eligibility criteria set by the third-party payment program. A large percentage of the clients of many drug abuse treatment programs may not be eligible under third-party programs, however, either because they do not meet eligibility criteria or because they have not had their eligibility determined by the payor.

- Service Coverage--The service program can be reimbursed only for services specifically designated as covered under a payment program. Many drug abuse treatment programs emphasize social as well as medical services and, thus, may offer services not included in traditional third-party payment programs.

- Rate Structure--Most payment programs are neither designed nor obligated to pay the full cost of covered services. Many also incorporate deductible and coinsurance features. Thus, the gap between the cost of providing a service and the reimbursement rate can be quite large.

- Billing Efficiency--Programs are reimbursed only when they submit claims accurately and promptly. Persistence may be required to follow up on claims that are returned unpaid or paid at less than the expected amount.

The Client Record System can be used to collect client and service information and provide documentation with respect to all of the five factors for any third-party reimbursement source.

(1) Provider Status

Each of the third-party programs has its own means of assuring that payments are made on behalf of clients receiving services from legitimate sources. These provider requirements generally involve licensure and/or accreditation standards, contracts, vendor agreements, etc. In almost all cases, these standards, contracts, or agreements include a requirement for a routinized system of collecting and retaining client-specific information. The Client Record System, properly completed and maintained, will meet the most stringent requirements for client records.

Payors often require specific staffing patterns in delivery of services. The record system can document staff expertise and utilization. To maintain provider status as well as receive monies earned, payors conduct audits of program operations. Client records are reviewed to determine if services billed were rendered according to the payor's requirements.

(2) Client Eligibility

In the past, programs have not collected as much money as possible from third-party payors because they have been unaware that clients within the program met third-party client eligibility criteria. The Initial Interview contains a section specifically designed to determine whether a client is currently eligible to receive benefits from a third-party payor(s). The fifth page of the Initial Interview asks for specific information on health insurance coverage.

Potential eligibility for some public welfare programs can be estimated by comparing the client's monthly individual and/or family income and family structure with the applicable Federal or state welfare program requirements. For example, a client may not be registered for Medicaid but may meet the income and family size criteria. By determining such potential eligibility, the program can refer clients to Medicaid, and, if the client's application is accepted, the client receives benefits and the program generates additional revenue. The family structure information is obtained during the In-Depth Psychosocial History, page one; the income information is included on page five of the Initial Interview.

(3) Service Coverage

Even if programs have met provider requirements and serve eligible clients, reimbursement from third-party payors will not occur unless the program provides a service included in the third-party payor's service coverage. For billing and auditing purposes, programs need to document delivery of the service and compliance with any limitations on the service. Such limitations may require that a physician provide or personally supervise the service, or that a service will be reimbursed only the first 12 times it is rendered. The following types of services may be covered:

- Medical--If the third-party reimbursement source covers only medical services, documentation of the physician's services may be found in the Physical Examination. The physician and other medical staff might also provide ongoing medical services to clients who would be reimbursed by a third-party payor. The documentation of the medical services could be found in the Medication Administration Sheet, the Physician's Order Sheet, or the Progress Note. Some third-party payors will reimburse programs for the cost of methadone maintenance, urinalysis, or both. The documentation for methadone maintenance and urinalysis would be presented on the Methadone Administration/Urinalysis Reports form. Finally, some payors reimburse laboratory services; documentation will be found on laboratory reports submitted to the program.

- Counseling--Properly documented and claimed, counseling may be reimbursed by some third-party payors. Again, each payor will have limitations on who can provide such counseling. The documentation of the physician providing or supervising counseling services, the staff providing counseling, and the time spent would be contained within the Progress Notes. Counseling services provided during the first 30 days of a client's involvement with the program would be documented on the Initial Interview and the In-Depth Interviews. Program administration must ensure that all services for which reimbursement is available are being properly recorded.

(4) Reimbursement Rate

In reimbursing treatment programs for services provided, third-party payors negotiate a reimbursement rate for each service covered calculated on the basis of the provider's hourly rate and the time spent delivering the service. Program staff need to be conscientious in noting all client contacts on the Progress Notes. This is important to establish the number of service units provided and the time expended in providing the service unit. These two pieces of data are critical in determining unit costs of service and negotiating reimbursement rates.

5. Billing System

Whether services are to be reimbursed by a third-party or by the client himself/herself, an efficient billing system is a must. Client records are an important source of billing information because they document providers, types of services rendered, and time spent in service delivery. Billing efficiency is based upon cooperation among and accuracy by the:

- Treatment staff, who must accurately and consistently record client contacts and services provided
- Record room staff, who must transmit client service information to the accounting department
- Accounting staff, who must prepare and submit bills to clients or to third-party payors for covered services provided to eligible clients

In small programs, staff may be responsible for several of the above functions. This pattern does not change the need for accuracy and consistency.

Setting up a system to identify reimbursable services provided to eligible clients is essential to the success of efforts to increase collections from third-party payors. The following procedures are suggested:

- The billing clerk prepares a set of standing instructions for the records clerk, identifying:
  - The payment program
  - Activities/services reimbursable by the payment program
  - Any restrictions on who provides services

  Exhibit A-IV, following this page, provides an illustration of suggested standing instructions for a program.

  The record clerk identifies a third-party payment source for a client from page 5 of the Initial Interview and clearly marks the outside front of the client's record:

  - A colored-bordered, gummed label clearly marked with the third-party payment source and eligibility date should be used.
  - Each major payment program should have its own colored border, e.g., red for Title XX, green for Medicaid, blue for Food Stamps, etc.

  The records clerk then scans all client records so marked to discover:

  - Has a reimbursable service been provided?
  - Has reimbursement for the service already been claimed?
  - Is sufficient information contained in the record?

  If the information is insufficient, the records clerk should return the client record to the staff member who provided the reimbursable service to complete the record notation.

EXHIBIT A-IV

THIRD-PARTY PAYMENT PROGRAM
STANDING INSTRUCTIONS COMPONENTS

Part of Record to Review	What to Look For	Frequency of Review	(Yes/No) Reimbursable
Physical Exam Sheet	Physician's services	First 30 days and annually	
Physician's Order Sheet	Physician's services, other services ordered (look for reports)	Upon return of file to record room	
Medication Sheet	Medication administered	Upon return	
Methadone Administration/ Urinalysis Report	Methadone administered	Upon return	
Lab Reports	. Completed lab tests . X-rays . Other diagnostic services	Upon return	
Treatment Plan/Progress Notes	. Physician's counseling services . Psychologist's counseling services . Other counseling services	Upon return	

- The records clerk sends an extrapolation of information on insurance coverage and services rendered to the billing clerk.

- The billing clerk prepares the claim from this information.

Once the reimbursement mechanism for each client (self or third-party payor) has been established, subsequent bills can easily be prepared from daily staff activity logs such as the one shown on exhibit A-V, following this page. This form is similar to the Semimonthly Activity Report (exhibit A-I); either form would be an acceptable source of billing information. At the end of the month (or however often a program sends out bills), the billing clerk would simply sum all reimbursable services by all providers for each client and prepare the bill accordingly. In this case, the client's record would serve as back-up documentation, showing that a claimed service had indeed been provided and documented on a given day.

If the program does not use any type of staff activity reporting, an alternative method of notifying the billing department that a reimbursable service has been rendered is through the use of an encounter form showing:

- Client's name and identification number
- Provider's name and position
  Service provided
- Time spent
- Date
- Provider's signature

6. Methadone Inventory Control

Methadone maintenance programs must account rigorously for receipt and dispensing of methadone. This accounting is done for internal control purposes to ensure that incorrect dosages or thefts do not occur and to satisfy various requirements of Federal and State agencies for reporting the use of controlled substances. In particular, the Drug Enforcement Administration (DEA) regularly audits methadone reports.

Methadone reporting is closely tied to client record systems, and some simple procedures have been worked out to facilitate preparation of reports.

- Establish and maintain a Methadone Dispensing Log that records the name and number of clients receiving methadone together with the dosage received. This information will be collected from individual client records. Exhibit A-VI, shows a sample page.

  - Prepare the Methadone Dispensing Log for the approaching month by entering the client's name from the current Roster of Active Clients.

  - After preparing the Methadone Dispensing Log, duplicate additional copies for use during the remaining days in the month.

  - At the time each methadone dosage is dispensed, the dispensing nurse sould enter the dosage and initial the Log. If there is any comment that should be recorded in the Client Record, the Head Nurse should place

EXHIBIT A-V

DAILY STAFF ACTIVITY LOG

Treatment Center: XYZ Drug Treatment Program Staff Member--Name: Jane Doe

Date: 10/3/77 Position: Senior Counselor

Client I.D. Number	Modality/Environment	Activity	Travel Spent (in Minutes)		
			Travel	Contact	Total
XXXXXXX	Outpatient Drug-Free	Group Counseling		15	15
XXXXXXX	"	"		15	15
XXXXXXX	"	"		15	15
XXXXXXX	"	"		15	15
XXXXXXX	"	Individual Counseling	20	60	80
	Central Administration	"		30	30
XXXXXXX	Outpatient Methadone	Family Counseling		50	50
XXXXXXX	"	Psychological Testing		60	60
XXXXXXX	"	Vocational Rehab. Counseling	30	30	60
	Central Administration	Client Record Keeping		40	40
	"	Compensation Time		100	100
		Total	50	430	480

EXHIBIT A-VI

METHADONE DISPENSING LOG

Date:	RN Signature:	Page ______ of ______

Client Name	Client Record Number	Dosage Dispensed	Lot Number	Comments
Total Dispensed				

an asterisk in the Comment column, indicating to the Record Clerk to hold that client's record aside until the Head Nurse has completed recording the comments in the client's Progress Notes.

- At the end of each dispensing session, the Head Nurse will give the Methadone Dispensing Log to the Record Clerk, who will transfer the dosage and, if applicable, log number information to the Methadone Administration/Urinalysis Report Flow Chart in each client's record.

- At the end of each day, the Head Nurse should total the dosages dispensed to determine the total amount of methadone dispensed that day. An adding machine with tape should be used to verify against the Log, ensuring that all dosages were entered into the machine correctly.

- The verified daily total should be posted to the Weekly Methadone Accountability Sheet, described in the next procedure.

- At the end of each week, file that week's Log in chronological order in front of previous logs in the locked cabinets that file the Client Record Folders. The logs should be held for periodic DEA audits.

Prepare Weekly Methadone Accountability Sheets that show the beginning methadone inventory, amount received from supplier, amount dispensed, and ending inventory for each day of the week. Exhibit A-VII, shows an example.

- The beginning inventory is equal to the preceding day's ending inventory.

- Amount received is taken from methadone supplier's invoices or delivery report.

- Amount dispensed is taken from the Methadone Dispensing Log.

- Ending inventory is derived from the formula: beginning inventory plus amount received less amount dispensed.

- The ending inventory balance should be verified against an actual physical count on a weekly basis.

- At the end of each week, file the sheet (in chronological order in front of previous sheets) in the locked cabinets that file the Client Record Folders. The sheets should be held for the DEA periodic audits.

7. Methadone Client Reporting

Another nationwide data collection effort that requires the participation of methadone programs is sponsored by the Food and Drug Administration of Department of Health, Education, and Welfare. This report (FD 2634) is submitted annually and covers the following kinds of information:

- General program data
- General patient (client) data
- Client treatment modalities and dynamics

WEEKLY METHADONE ACCOUNTABILITY SHEET

For the Week of _____ to _____, 19____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
1. Beginning Inventory								
2. Amount Received								
3. Amount Dispensed	( )	( )	( )	( )	( )	( )	( )	( )
4. Ending Inventory								

Notes By Line Number:

1. From preceding day's ending inventory.
2. From supplier's invoice or delivery report.
3. From Methadone Dispensing Log total.
4. Equals #1 + #2 — #3. A physical inventory should be taken weekly; the amount shown for the physical inventory should equal the amount shown as line #4, "ending inventory," at the moment the physical inventory is taken.

- Age and sex of clients in treatment
- Time in treatment
- Number of patients stabilized at end of year
- Urinalysis results
- Number of pregnant patients
- Number of adverse reactions
- Number of deaths (drug-related, crime-related, suicide, accident)
- Waiting list data
- Terminations by various categories
- Occupational status of clients at end of reporting year

Both the client record forms themselves and the filing system and subsidiary record systems will facilitate the preparation of this report. Most of the required information can be easily extrapolated from the Client Master Index Card File, which is fully described in appendix B, pages 5 - 7. This file, besides being much more easily handled than the record folders themselves, is generally maintained in an order that facilitates preparation of the FDA report (Pending Active Clients, Active, Temporary Inactive, etc.); and cards can be easily sorted and counted to provide such data as numbers of clients receiving methadone, numbers of terminations, and numbers and results of urinalysis tests.

* * * *

The foregoing examples have centered on the most frequent direct uses of client records for program reporting purposes. It should be noted that these examples are illustrative in nature and are not necessarily exhaustive or complete. Using these examples as models, managers will be able to discover other ways in which the client record system can be used to facilitate program reporting.

APPENDIX B

IMPLEMENTING AND MAINTAINING THE CLIENT RECORD SYSTEM

This appendix discusses various aspects of operationalizing and maintaining a client record system: the equipment, procedures, and training needed to implement and maintain a functioning system.

The procedures outlined in this appendix are essentially similar to any sound filing practice, except that they do highlight certain measures for protecting the confidentiality of client records. Much of this material will be of interest primarily to the program's record specialist, in contrast to the remainder of the manual, which explains the client record system from the perspective of counselors and program managers. However, all users of the client record system should review this appendix to understand how records are filed and controlled and to learn about certain filing mechanisms, subsidiary to the central record file itself, that can assist them in performance of their duties.

The appendix is organized into the following major sections:

I. Assembling Basic Equipment
II. Implementing the Record System in an Operational Environment
III. Maintaining the System
IV. Monitoring the System
V. Training Staff in the Operation and Use of the System

I. ASSEMBLING BASIC EQUIPMENT

A number of items should be obtained before implementing the system. This section briefly describes the nature and purpose of each item and the preliminary steps required.

1. Central File Room

If at all possible, client record files and related equipment should be kept in a room reserved for this purpose. The room should be located so that it is easily accessible by program staff and should have the following features:

- A door that can be securely locked. Ideally, the record room should have a dutch door with a 12" ledge surmounting the lower portion; both upper and lower portions should have locks.
- Adequate work space for the record clerk, including desk, table, shelves, and appropriate lighting and ventilation.
- Standing metal filing cabinets equipped with a locking mechanism. There should be drawer space sufficient to accommodate the five categories of records (Pending Active, Active, Pending Inactive, Temporary Inactive, and Permanent Inactive). (See definitions of these categories on page B(7).) If possible, each

category should be stored in a separate drawer or drawers. If space is limited, Permanent Inactive records can be stored elsewhere on the premises, so long as they are secure from unauthorized use. If the room is secure, open-shelf filing could be used as an alternative.

- Secure storage (locking cabinet or other secure area) for Charge-out Cards, Registration Log, Client Master Index Card File, and Tickler Files.

2. Registration Log Book

This log is maintained to ensure that client numbers are issued from a single source; therefore, a program, even though it may encompass more than one treatment facility, should keep only one Registration Log. The log consists of ruled pages showing client number, date of registration, name, sex, date of birth, Social Security number, and address. Exhibit B-I, following this page, shows a sample page. Print a number of pages sufficient to accommodate the program's intake for at least one year. These pages should be bound in a durable cover.

3. Client Record Forms

Appendix C contains a complete set of blank client record forms with accompanying summary specification sheets. These forms are suitable for reproduction but should first be reviewed by the Single State Agency official and the program's director, attorney, and records specialist to make sure that no relevant information requirements have been overlooked. Minor modifications or supplementary forms can be made as necessary. The fact that these forms are already in use in over 45 programs should relieve apprehension about their suitability for use in an operating environment.

When the necessary modifications have been made, the program should send the set of forms to be printed in a quantity sufficient to accommodate the program's expected intake for the next two years. Remember that some forms, e.g., Treatment Plan Review Forms and Progress Notes, will be used more than once for each client and, thus, will have to be ordered in greater quantity. Order a dozen complete sets of forms for each counselor, to be used in practice sessions.

4. Client Record Folders

Folders for client records should be 9 1/2" x 11 3/4" (letter size), of heavy manila stock, with full-cut (straight) tabs. They can be ordered prepunched, with two (2) prong fasteners. A client record folder is prepared immediately following registration; necessary steps are outlined below:

- Print the client registration number (which will also be the record number) on the top right edge.

- Stamp the front cover "CONFIDENTIAL"

- Prepare and affix to the front cover a chart assembly order form, showing the sequence of records in the folder. A sample is shown in exhibit B-II, following exhibit B-I. Note that, although a program may adopt whatever assembly method

EXHIBIT B-1

Client Record Manual

PAGE FROM REGISTRATION LOG BOOK

Client Number	Date Registered	Client Name (Last)	(First)	(MI)	Sex	Birthdate	Social Security Number	Street Address	City	State

ASSEMBLY ORDER OF CLIENT RECORD FOLDER

MUCHOS, Bessie May

CONFIDENTIAL FILE

CHART ORDER

Most Recent Entries on Top

Left Side

- Discharge Summary*
- Treatment Plan
- Periodic Review Sheet**
- Treatment Plan Review Sheet**
- Educational History
- Employment/Vocational History
- Legal History
- Psychosocial History
- Drug Use History
- Drug Use History Graph (Optional)
- Physical Examination
- Health Questionnaire
- Initial Interview
- Compliance and Authorization Forms
- Correspondence, if any

Right Side

- Latest Progress Notes
- Physician's Orders
- Methadone Reports
- Urinalysis Reports
- Medication Administration Sheet
- Other Lab or X-Ray Reports

Oldest Entries on Bottom

* Discharge Summary is added when client is discharged

** Periodic Review Sheets and Treatment Plan Review Sheets may be filed here or chronologically in the Progress Notes on the right side of the folder

is most convenient, the top sheet on the left should always be the current Treatment Plan and the top sheet on the right, the latest Progress Note. This assembly procedure will enable counselors and clinical supervisors to obtain information on the client's current status without fumbling through a number of documents.

5. Client Master Index Cards

Client Master Index Cards are the primary control mechanism of the record system. One card is made for each client and summarizes much of the information contained in the total record (date of admission, modality and environment, primary counselor, date of discharge). These cards should be printed on heavy, 5" x 8" stock, in a quantity sufficient to accommodate the program's new admissions over a two-year period. Exhibit B-III, following this page, shows a sample Client Master Index Card.

To store these cards, 5" x 8" file boxes will be needed. Separate boxes should be maintained for active and inactive clients. Divide the active file into two sections, labeled "Pending Active" and "Active," and use alphabetical file dividers for each section. Repeat the same procedure for the inactive file, using three sections: "Pending Inactive," "Temporary Inactive," and "Permanent Inactive." These file categories are explained on page B(7).

6. Charge-Out Cards

Charge-out cards should be made up in a quantity equal to the number of records in the active file. These cards are inserted into the file in the place of a record that has been removed and show the date removed, requestor, client name, and record number. Because they stand out among records, they serve as a useful reminder that a record is missing from the file and must eventually be retrieved. Charge-out cards should measure 11 3/4" x 10", slightly larger than a standard record holder, and, preferably, should be a different color so that they will be readily visible when filed among folders. Exhibit B-IV, following exhibit B-III, shows an example.

7. Loose Record File

Any material that belongs in a client record folder but has not yet been inserted is called "loose filing." Because all parts of a client record are confidential, this material should never be left lying about in desk drawers or on desk tops. Designate a small area of one filing cabinet for this material (a three-inch space in one drawer should be sufficient). Label this space "Loose Records," and divide into two compartments: "Alphabetical" and "Numerical."

8. Tickler Files

Tickler files are intended to remind staff when certain clients' records will be needed, e.g., for routine treatment plan review, case conferences, or counseling appointments. Necessary equipment will include 3" x 5" cards, file boxes, and sets of dividers numbered by months and by days of the month. Cards can be formatted according to purpose--appointment, treatment plan review, or case conference reminders.

EXHIBIT B-III

Client Record Manual

CLIENT MASTER INDEX CARD
(Actual Size: 5" x 8")

Name (Last, first, middle initial): _____ Client Number: _____

Address: _____

City: _____ State: _____ Telephone: _____ ☐ Male ☐ Female Race: _____ Birthdate: _____

MA/Insurance Number: _____

Date of Admission	Treated Other Program	Meth. Treat. (Use Code)	Admitted to: Modality / Environ.	Current: Modality / Environ.	Age on Admission	Counselor	CODAP	Date of Discharge	Disch. Status (Use Code)	Discharged from: Modality	Discharged from: Environment	CODAP
1	2	3	4	5	6	7	8	9	10	11	12	13

EXHIBIT B-IV

Client Record Manual

CHARGE-OUT CARD
(11 3/4" x 10")

CHARGE-OUT CARD

Date	Requestor	Name of Client	Record Number	Date	Requestor	Name of Client	Record Number

II. IMPLEMENTING THE RECORD SYSTEM IN AN OPERATIONAL ENVIRONMENT

By following the implementation schedule outlined below, programs will be able to phase in the new client record system without undue difficulty or confusion.

1. Pre-Implementation Period

While all materials and equipment are being assembled, set a definite date (approximately six to eight weeks hence) for the program to begin using the new client record system. During this period, program administrators and staff should meet to discuss potential difficulties in system implementation and methods of resolving them.

Program administrators (particularly clinical supervisors) should use this time to conduct training sessions with counselors to ensure that clinical staff are familiar with the use of the forms and the sequencing of obtaining client data, and especially with the use of the Treatment Plan and Progress Notes.

The training sessions should include practice in completing all aspects of the system, leaving adequate time to respond, in an individualized manner, to questions from all clinical staff. It should be noted that no attempt should be made to convert old client records to the new system.

2. Initiation Day

On the predetermined initiation day (and thereafter), all new clients should be interviewed, using the new forms and format. For clients enrolled in the program before the initiation of the new system, the new Progress Note form should be used. At the time that their treatment plan is scheduled for review, the new format should be employed. There should be no need to convert existing data base forms on currently enrolled clients to the new format.

III. MAINTAINING THE SYSTEM

A number of detailed procedures have been developed to ensure the smooth functioning of the overall client record system. These procedures are operating instructions and are focused in a fashion dissimilar to those procedures outlined in section I of this appendix that dealt with preparation of materials. This section covers operational procedures for maintaining:

- Registration Log Book
- Client Master Index Card File
- Control of Client Record Folders
- Tickler Files

1. Registration Log

The purpose and basic description of the Registration Log have been outlined earlier.

- Immediately after an applicant has completed the initial interview and a decision has been made to accept him/her for treatment, search the Client Master Index Card file (see below) to determine whether the applicant was ever previously enrolled in the program. Be sure to check female applicants under both maiden and married names.

- If no Client Master Index Card can be found for the applicant, assign a number from the Registration Log. These numbers will have been prerecorded either by hand or by a sequential numbering machine, and each client will be assigned the next unused number. Enter the client's date of registration, name, sex, date of birth, Social Security number, and address in the Registration Log, and record the registration number on the record folder, the Initial Interview, and any other completed parts of the record in the designated space. If changes in client's name or address occur while the client is in treatment, be sure to update information in the Registration Log.

- If a Client Master Index Card is found, showing that the client was a former patient, do not register the client again. Former clients will retain their original registration number.

2. Filing And Control Of Client Records

All client record folders are stored in metal filing cabinets equipped with a locking mechanism or on open shelves in a secure room. The preferred filing order is numerical (i. e., by Registration Number). This order will facilitate the filing of documents that have only the client's number to identify them. Also, confidentiality is better served if the client's name does not appear on the outside of the folder. Generally speaking, records will remain in better order and control can more easily be maintained if access to the central files is limited to the program's record specialist and perhaps an assistant. When a staff member requests a record for a counseling session, treatment plan review, or other activity, the record room personnel will remove the record from central files and replace it temporarily with a charge-out card showing the client's name and number, the requestor's name, and the date of removal.

When records are returned to central files, the following procedures should be observed:

- Check each record for completeness. Locate latest entry and make sure it is dated and signed properly. If information is missing, check the charge-out card to determine the most recent user; return the record to this individual for correction.

- Check the Loose Report File for material that needs to be added to the record.

- When the folder is complete, refile it in the appropriate place. Remove the charge-out card and draw a line through the last entry so the card can be reused.

- Ensure that all client record folders are returned to central files at the end of each day.

3. Client Master Index Card File

The Client Master Index Card (CMIC) File contains basic demographic data and captures information on the client's treatment modality and environment both at admission and at discharge. This file mechanism has been designed to serve as:

- A standard record control file
- A source of data for completing FDA methadone reports
- A control for CODAP and other reporting forms
- A source of general program statistics

Particular attention should be given to developing a good CMIC file. These cards are much easier to handle than the client record folders, and program statistics can easily be extrapolated from them if they have been properly filled out and maintained in a current status. Sources of data and instructions for filling out CMICs are provided below:

Upper Portion of Card

Data Element	Source
Name, address, etc.	First page of Initial Interview
Client Record Number	Registration Log (number is transcribed on CMIC immediately upon registration)

Lower Portion of Card

Col. No.	Data Element	Source/Procedure
1.	Date of Admission	Initial Interview, first page
2.	Treatment in Other Program	Initial Interview If client has been treated in any other drug treatment program, enter YES. If client has been treated only in this program or has never been treated, enter NO.
3.	Methadone Treatment	Initial Interview, Drug Treatment History Code as follows: 0 = Never treated with Methadone 1 = First time on this admission 2 = Any previous treatment with Methadone
4.	Modality and Environment Admitted To	Initial Interview, last page. Code as follows: Modality: DF = Drug Free; DETX = Detoxification; MM = Methadone Maintenance; X = Other Environment: P = Prison; OP = Outpatient; R = Residential; DC = Daycare; HOSP = Hospital Utilize same coding abbreviations when completing Columns 5, 11, and 12.
5.	Current Modality and Environment	Current Treatment Plan Note: This item must be updated when mode of treatment changes.
6.	Age on Admission	Initial Interview, first page
7.	Counselor	Initial Interview, last page, or Initial Treatment Plan

Col. No.	Data Element	Source/Procedure
8.	CODAP	Please check mark in this column when CODAP admission form has been completed
9.	Date of Discharge	Discharge Summary
10.	Status on Discharge	The following code should be utilized to facilitate sorting and compiling statistics used in the completion of FDA reports: T/PT Terminated, Patient decision T/PR Terminated, Program decision T/J Terminated, Jailed T/H Terminated, Hospitalized T/Exp Terminated, Died Trans. Transferred
11.	Modality Discharged From	Discharge Summary
12.	Environment Discharged From	Discharge Summary
13.	CODAP	Check this column when discharge CODAP form has been completed

In order to control the client record system effectively and to facilitate the annual procedure for sorting and compiling statistical data, Client Master Index Cards should be separated into five filing areas, which are distinguished according to the status of the client (Active or Inactive) and whether or not certain record room procedures have been completed:

. Pending	Cards of all clients admitted to the program; CODAP admission or other admission reporting forms not yet completed
. Active	Cards of clients admitted to the program; all admission forms completed
. Pending Inactive	Cards of all clients who have been discharged from the program; CODAP or other discharge forms not yet completed
. Temporary* Inactive	Cards of clients discharged within the reporting year (January 1 - December 31); all discharge reporting forms completed
. Permanent* Inactive	Cards of all clients discharged prior to current reporting year

All cards should be filed in alphabetical order beginning with the last name of client, then first name. Alphabetical file guides should be used in all files.

* The terms "Temporary" and "Permanent" are used to differentiate file categories. These terms do not refer to the discharge status of the client.

4. Tickler File For Treatment Plan Review

The client record clerk should maintain a Tickler File to assist in flagging records of clients with upcoming Treatment Plan Reviews. Procedures and equipment for setting up such a file have already been described in section I of this appendix.

Operational procedures are as follows:

- For each new client, note the dates of the first Treatment Plan Review; this information will be found on the original Treatment Plan.
- Prepare a standard 3" x 5" plain white index card with the client's name, record number, date of original Treatment Plan, and date of next review.
- File the card according to the date of the next review.
- Each day, check the Tickler File to ascertain which clients' reviews are due, pull the records of these clients, and notify the primary counselor that a Treatment Plan Review is due.
- Refile the card under the next review date.

A similar procedure can be followed for monitoring appointments or any other scheduled activities.

IV. MONITORING THE SYSTEM

Two basic operating procedures have been developed for monitoring a client record system. These include:

- Refiling checks
- Periodic quantitative checklist

Careful monitoring ensures ongoing evaluation of the system and its operational status. In addition, monitoring activities will:

- Identify staff members whose performance in record operation and use requires improvement
- Point out weak areas in the system (e.g., Treatment Plan development, coordination of Progress Notes and Treatment Plans), and thus identify areas for continuing staff education

1. Refiling Checks

Refiling checks will detect incomplete or missing forms, unsigned or undated entries, torn pages, and misfiled materials. Checks can be done when a client folder is returned to central files (e.g., after Treatment Plan review) and when a client has been discharged from the program. In the latter case, the following steps should be taken:

- Check that all forms are present and all new entries properly dated and signed.
- Repair torn sheets with transparent tape, if necessary; do not replace original forms.
- Rearrange pages of the record, if necessary, to maintain correct order (see exhibit B-II, following page B(2)) (for records of discharged clients only).
- Verify that the Discharge Summary sheet, including narrative summary, is completed, dated, and signed.
- Pull the Client Index Card and enter the discharge information.
- Refile Client Index Card.
- Pull client's card from all tickler files and destroy.
- File completed client record in the inactive section.

2. Periodic Quantitative Check And Checklist

Unlike refiling checks, which are done on an individual basis, the periodic quantitative check is performed on a sample of records pulled from the active files. Program administrators can decide the number of records that will constitute a representative sample. For each record pulled, an Individual Client Record Review Checklist should be filled out, as shown in exhibit B-V, following this page. If the check reveals incomplete records, these should be returned to the primary counselor or other appropriate staff member for completion. This routine should be conducted at least biannually. When all checklists are complete, they can be examined in toto to discover if there are general areas of record keeping that need improvement.

V. TRAINING STAFF IN THE OPERATION AND USE OF THE SYSTEM

All or most of the members of a program's staff are somehow involved in the creation and use of client records:

- Client Record Clerk controls the compilation, location, movement, and integrity of client records; this staff member is a key to the effectiveness of the overall system.
- Counselors are responsible for recording most of the information that appears in the client record and must use records constantly in their day-to-day contacts with clients.
- Clinical Supervisors review records mainly to assist in evaluating Treatment Plans, to monitor the performance of individual counselors, and to evaluate the program's overall attainment of treatment objectives.
- Medical Staff, including physicians, nurses, laboratory technicians, and paramedical personnel, complete a number of source documents in the record. Physician's orders are important in developing the Treatment Plan; and laboratory reports of urinalyses monitor the client's success or failure in adhering to the Treatment Plan.

INDIVIDUAL CLIENT RECORD REVIEW CHECKLIST

Client Number: _____ Date of Admission: _____ Date of Review: _____

Modality: ☐ Drug free ☐ Detoxification ☐ Maintenance ☐ Other

Environment: ☐ Prison ☐ Hospital ☐ Residential ☐ Day care ☐ Outpatient

Check Appropriate Block:	Yes	No	N/A or Comment
1. Primary Counselor assigned?	☐	☐	☐
2. Initial Interview complete?	☐	☐	☐
3. In-depth interviews complete:			
a. Health Questionnaire?	☐	☐	☐
b. Physical Examination--Laboratory results of:			
. Complete Blood Count and differential?	☐	☐	☐
. Serological test for syphilis?	☐	☐	☐
. Routine and microscopic urinalysis?	☐	☐	☐
. Urine screen for drugs (toxicology)?	☐	☐	☐
. Multiphasic chemistry profile?	☐	☐	☐
. Chest X-ray?	☐	☐	☐
c. Drug Use History?	☐	☐	☐
d. Legal History?	☐	☐	☐
e. Educational History?	☐	☐	☐
f. Employment/Vocational History?	☐	☐	☐
g. Psychosocial History?	☐	☐	☐
4. Treatment Plan:			
a. Latest Treatment Plan on top?	☐	☐	☐
b. Problems specified?	☐	☐	☐
c. Goals specified?	☐	☐	☐
d. Short or long term specified for goals?	☐	☐	☐
e. Treatment specifies type and frequency of counseling sessions?	☐	☐	☐
f. Supportive services identified?	☐	☐	☐
g. Evidence of participation by client in Treatment Plan?	☐	☐	☐
h. Length of time since last Treatment Plan review? _____	☐	☐	☐
i. Treatment Plan review documented in record?	☐	☐	☐
5. Urine Surveillance:			
a. How many urine surveillances are required for this client per month? _____ per week? _____			_____
b. How many were performed? _____ Recorded in chart?	☐	☐	☐
6. Progress Notes:			
a. Date of last Progress Note? _____			_____
b. Number of Progress Notes in last 30 days? _____			_____

- Statistical clerks use source documents in the client record for reports required by various external agencies and organizations. Accounting clerks use the records for billing purposes and to determine costs of treatment.

- Program Administrators use records, or information abstracted from records, in such tasks as monitoring the program's census, determining program costs, assigning caseloads, and as source material for management decisions.

Because the client record is the ultimate source document for practically all program activities and decisions, all members of the program's staff should be trained in the purpose and structure of the record, how to access or add to its information, and how to maintain the record in a usable condition.

This training can take many forms. For counselors, training should consist of practice sessions during which one counselor plays the part of a client and another conducts initial and in-depth interviews so as to become familiar with the content of the forms and gain expertise in obtaining important client data. Practice can extend to development of Treatment Plans and Progress Notes for the hypothetical client under supervision of clinical supervisors. Record clerks should be trained in the correct procedures for preparing a client record folder and assembling the various forms that make up the total record; their training will also include procedures for establishing and maintaining central files. Statistical personnel will learn how to extrapolate information from client records for CODAP and other reporting purposes.

APPENDIX C

CORE CLIENT RECORD FORMS AND SPECIFICATION SHEETS

DATA BASE FORMS

SECTION 1

INITIAL INTERVIEW FORM (Seven Pages)

SPECIFICATION SHEET:
INITIAL INTERVIEW FORMS

Purpose and Overall Description:

The Initial Interview Forms are designed to accomplish the following objectives:

- To obtain quickly the most pertinent information needed to determine whether to admit the applicant to the program
- To ascertain which modality and environment would be most appropriate for the client
- To formulate the initial Treatment Plan
- To determine from the responses obtained the order of priority for conducting the In-Depth Interviews
- To gather federally required data for the CODAP admission report

Basic data are gathered in the Initial Interview in each of the Data Base topics: Demographic, Drug Use and Treatment History, Health, Legal, Education, Employment and Vocational, and Psychosocial.

Used By:

- Counselor or any other service provider
- Person preparing CODAP reporting forms

Completed By:

- Counselor or Intake Interviewer

When Initiated:

- Initial Interview Forms are completed on the client's first day in the program

Source(s) of Data:

- Client responses
- Documents presented by client

Preparation Instructions:

- All federally required CODAP data are marked with a large black dot (●) and must be completed.
- Except for the above mandated information, any question that does not seem to apply to the applicant may be documented "N/A" (not applicable).
- It is recommended that all questions be answered, with either the above-mentioned "N/A" or the client's response.

INITIAL INTERVIEW

Name (Last, first, middle initial):

Client Number:

Address:

Street Apartment

City County State ZIP Code

	Month	Day	Year
Date of Interview:			
Date of Birth:			

Telephone Number:

Length of Time at Present Address:

Place of Birth:

Sex: ☐ Male ☐ Female

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Mother's Maiden Name (Last, first, middle initial):

Wife's Maiden Name (Last, first, middle initial):
or Husband's Name

In Case of Emergency, Notify:

Name (Last, first, middle initial):	Relationship:
Address:	Telephone Number:

If client is a minor, do we have permission to contact parents/guardian? ☐ Yes ☐ No--Why?

What other people can be contacted?

Race/Ethnic Background:
- ☐ White (Not Hispanic origin)
- ☐ Black (Not Hispanic origin)
- ☐ Hispanic--Puerto Rican
- ☐ Hispanic--Mexican
- ☐ Hispanic--Cuban
- ☐ Hispanic--Other
- ☐ American Indian
- ☐ Asian or Pacific-Islander
- ☐ Alaskan Native

Marital Status:
- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Living Arrangements:
- ☐ Alone
- ☐ With parents
- ☐ With spouse
- ☐ With others

Homemaker: Maintains a household with one or more dependents? ☐ Yes ☐ No

Number of dependents: ☐☐ Ages of dependents:

Creed:
- ☐ Catholic
- ☐ Islamic
- ☐ Jewish
- ☐ Protestant
- ☐ Other
- ☐ None

EDUCATION

Highest School Grade Completed:
- ☐ None
- ☐ Elementary through grade ____
- ☐ High school through grade ____
- ☐ College--number of years completed ____

Training Schools Attended:
- ☐ None
- ☐ Vocational
- ☐ Business
- ☐ Technical
- ☐ Other

☐ Presently Attending School

Type of program: ☐ Education ☐ Training

Date of enrollment:

Area of study:

☐ Not Attending School

HEALTH

Have you ever had psychiatric treatment? ☐ No ☐ Yes--Explain:

How would you rate your present state of health? ☐ Good ☐ Fair ☐ Poor

Do you have any of these communicable diseases? ☐ Tuberculosis ☐ Hepatitis ☐ Venereal disease ☐ None of these
☐ Other (specify):

Do you feel you have any other medical problem? ☐ No ☐ Yes--Indicate nature of problem:

Are you pregnant? ☐ No ☐ Yes ☐ Don't know

Additional Comments

Initial Interview--Page Two	Client Name:	Client Number:

DRUG USE HISTORY

Frequency:
0 - No use during past month
1 - Once per month
2 - Once per week
3 - Two to three times per week
4 - More than three times per week
5 - Once daily
6 - Two to three times daily
7 - More than three times daily

How Taken:
1 - Oral
2 - Smoking
3 - Inhalation
4 - Intramuscular
5 - Intravenous

Severity:
0 - Not a problem at time of admission
1 - Primary
2 - Secondary
3 - Tertiary

Types of Drugs Used	Past History: Year and Age of First Use (Year)	Past History: Year and Age of First Use (Age)	Past History: Year of First Regular Use	Past History: Maximum Use/Dose and Frequency	Current Use (During One Month Prior to Admission): Current Use (Yes or No)	Current Use: Frequency of Use (Use Code)	Current Use: Usual Dosage	Current Use: Usual Route of Administration (Use Code)	Current Use: Degree of Severity (Use Code)
Heroin									
Non-Rx Methadone									
Other Opiates or Synthetics									
Alcohol									
Barbiturates									
Other Sedatives, Hypnotics, Methaqualone									
Amphetamines									
Cocaine									
Marihuana/Hashish									
Hallucinogens (Specify, if Possible)									
Inhalants									
Over-the-Counter Drugs									
Tranquilizers									
Other(s) (Specify):									

Current Drugs of Preference: Primary: _____

Secondary: _____

Current Cost of Drugs Per Day: $_____

Initial Interview--Page Three	Client Name:	Client Number:

DRUG USE TREATMENT HISTORY

● Number of Prior Treatment Experiences: _____

Date of Admission	Voluntary	Involuntary	Name and Address of Treatment Facility	Type of Program Modality/ Environment	Discharge Date	Completed	Not Completed	Reason Not Completed (Use Code)

Longest Period Drug Free:
Length of Time Continuously on Drugs Since Last Withdrawal or Use:
● Number of Months Since Last Treatment Experience:

Type of Program Abbreviations:

Modality:
- Detoxification = Detox
- Methadone Maintenance = MM
- Drug Free = DF
- Other = Oth

Environment:
- Residential = Res
- Day Care = DC
- Hospitalized = In-Pt
- Prison = Pris
- Outpatient = OP

Reason for Leaving Codes:
1. = Completed Treatment--Goals fully achieved
2. = Completed Treatment--Goals partially achieved
3. = Left with facility advice
4. = Left against facility advice
5. = Noncompliance with facility rules
6. = Jailed
7. = Transferred
8. = Referred
9. = Other

Additional Comments

Initial Interview--Page Four	Client Name:	Client Number:

ALCOHOL USE AND TREATMENT HISTORY

Frequency of Alcohol Consumption: (In any amount or kind)

- ☐ Every day
- ☐ 2-3 times per week
- ☐ Weekends only
- ☐ 1-2 times per month
- ☐ Binges (Specify frequency): _____

Indicate Kind and Amount Consumed on Above Occasions:

- ☐ Wine: _____
- ☐ Liquor: _____
- ☐ Beer: _____
- ☐ Combination (Specify): _____

Usual Type of Drinking:

- ☐ Always with others
- ☐ Usually with others
- ☐ Sometimes with others
- ☐ With others and alone equally
- ☐ Sometimes alone
- ☐ Usually alone
- ☐ Always alone

Longest Dry Period During Last Three Months: _____

Hospitalized/Detoxified for Alcohol Use? ☐ No ☐ Yes--How many times? _____

Additional Notes

LEGAL

Have you ever been arrested? ☐ No ☐ Yes ● Arrests During Last 24 Months: ☐☐

Do you have any current legal involvement? ☐ No ☐ Yes ☐ Probation ☐ Parole

(If client has either current or past legal involvement, please complete full Legal History as part of Initial Interview.)

If Client Is a Minor:

Have you ever been officially declared a juvenile delinquent or in need of supervision from the juvenile court?

☐ No ☐ Yes--When: _____ Under what circumstances: _____

Have you ever been committed to an institution for juvenile delinquency or a place for supervision by a juvenile court?

☐ No ☐ Yes--How old were you at your first arrest? _____

Additional Notes

Initial Interview--Page Five	Client Name:	Client Number:

EMPLOYMENT

Current Status: ☐ Employed: ☐ Full-time (35 or more hours per week) ☐ Part-time (less than 35 hours per week)
☐ Unemployed: ☐ Looking--has sought employment in last 30 days ☐ Not Looking--has not sought employment in last 30 days
☐ Retired
☐ Leave of absence
☐ Other (specify): _____

Number of Months Employed in Last Two Years: _____

Usual Occupation When Employed:
☐ Professional, technical, managerial ☐ Craftsman ☐ Service worker ☐ No work experience
☐ Office, clerical, sales ☐ Entertainer, musician ☐ Laborer ☐ Student
☐ Operative ☐ Other ☐ Housewife

Source of Income: (Check all that apply and indicate amount)

	Client's Income	Spouse's Income	Family Income
☐ None			
☐ Monthly salary, if employed	$_____	$_____	$_____
☐ Unemployment Insurance--Number of weeks remaining: _____	_____	_____	_____
☐ Workmen's Compensation--Number of weeks remaining: _____	_____	_____	_____
☐ Veterans benefits	_____	_____	_____
☐ General assistance	_____	_____	_____
☐ Social Security Insurance	_____	_____	_____
☐ Social Security Disability	_____	_____	_____
☐ Supplemental Security Income	_____	_____	_____
☐ Family/friends	_____	_____	_____
☐ Illegal activities	_____	_____	_____
☐ Savings	_____	_____	_____
☐ Aid to Families with Dependent Children (AFDC)	_____	_____	_____
☐ Child support/alimony	_____	_____	_____
☐ Other (specify): _____	_____	_____	_____
Total Monthly Income	$_____	$_____	$_____

Do you have health insurance? ☐ None ☐ Medicaid: #_____ ☐ Medicare: #_____ ☐ CHAMPUS
☐ Blue Cross/Blue Shield #_____ ☐ Other private insurance, specify name of company: _____
Name of subscriber, if other than applicant: _____ Policy #_____ Name of subscriber, if other than applicant: _____
☐ Health Maintenance Organization or Prepaid Group Plan--Name: _____ Number: _____
☐ Other public funds for health care, specify: _____

Have you ever been declared eligible to receive benefits from:

	Yes	No	Receiving Benefits
☐ None			
General Relief	☐	☐	☐
Medicaid	☐	☐	☐
ADC	☐	☐	☐
SSI	☐	☐	☐
SSI-State Suppl.	☐	☐	☐
Food Stamps	☐	☐	☐
State Title XX	☐	☐	☐

Are you the surviving dependent (spouse or child) of a veteran who was killed during a war?
☐ No ☐ Yes--Deceased veteran's name: _____

MILITARY HISTORY

Were you ever a member of the armed forces? ☐ No ☐ Yes--Indicate: Rank/rating: _____
Length of service: _____ Date of discharge: _____ Type of discharge: _____
Duties performed: _____
Were you ever overseas? ☐ No ☐ Yes--Where? _____
Were you ever incarcerated while in the military? ☐ No ☐ Yes--Reasons: _____

Initial Interview--Page Six	Client Name:	Client Number:

SOURCE OF REFERRAL

- ☐ Self-referral
- ☐ General hospital
- ☐ Mental hospital
- ☐ Community Mental Health Center
- ☐ Social/community services agency
- ☐ Private physician or mental health professional
- ☐ C. I. U. or another drug treatment program
- ☐ Family or relative
- ☐ Friend
- ☐ Employer
- ☐ School
- ☐ NARA I
- ☐ NARA II
- ☐ TASC
- ☐ County/state probation
- ☐ County/state parole
- ☐ Federal probation
- ☐ Federal parole
- ☐ Police
- ☐ Other (Specify): _____

If accepted for treatment, do you have adequate transportation to this clinic? ☐ No ☐ Yes--What type? _____

Driver's License: ☐ None ☐ Revoked ☐ Currently valid ☐ Expired ☐ Suspended until _____ Why? (Explain): _____

DISPOSITION

☐ Accepted--Date of next appointment: _____

☐ Rejected--Reasons: _____

☐ Referred to: _____ Date of appointment: _____

☐ Refused treatment--Reasons: _____

Note: When an applicant is found to be ineligible or inappropriate for admission (i.e., rejected or referred), the reason and the course of action taken must be recorded.

Admission Type:
- ☐ First admission
- ☐ Readmission
- ☐ Transfer admission from: ☐ CODAP ☐ Non-CODAP

Modality Admitted to:
- ☐ Detoxification
- ☐ Methadone Maintenance
- ☐ Drug free
- ☐ Other

Environment Admitted to:
- ☐ Prison
- ☐ Residential
- ☐ Day care
- ☐ Outpatient
- ☐ Hospital

INITIAL ASSESSMENT

1. Truthfulness and Accuracy of Client's Responses During Interview:

2. Client Characteristics Requiring Consideration In Developing Treatment Plan:

Initial Interview--Page Seven	Client Name:	Client Number:

3. Apparent Areas of Client Strength:

4. Apparent Areas of Client Weakness:

5. Other Significant Observations: (Note: Must include any prior history of mental illness)

6. List Apparent Problems and Current Priority of Each: (Note--Use these problems to initiate Treatment Plan)

7. Staff Member Responsible for Monitoring Treatment (Primary Counselor):

Date:	Signature:
Date Reviewed:	Signature of Physician (Required for Methadone Program):

DATA BASE FORMS

SECTION 2

In-Depth Interviews

- DRUG USE HISTORY (One Page)
- LEGAL HISTORY (Three Pages)
- PSYCHOSOCIAL HISTORY (Four Pages)
- EDUCATIONAL HISTORY (Two Pages)
- EMPLOYMENT/VOCATIONAL HISTORY (One Page)

SPECIFICATION SHEET: IN-DEPTH INTERVIEWS — DRUG USE, LEGAL, EDUCATIONAL, EMPLOYMENT/ VOCATIONAL, AND PSYCHOSOCIAL

Purpose and Overall Description:

The In-Depth Interview Forms are designed to accomplish the following objectives:

- To complete the Data Base that was initiated in the Initial Interview process
- To gather detailed information useful in building a comprehensive Treatment Plan

The In-Depth Interview Forms cover the topics: Drug Use, Legal, Educational, Employment and Vocational, and Psychosocial. The remaining Data Base topic, Health, is completed in the Medical History (Health Questionnaire) and Physical Examination.

Used By:

- Counselor
- All other service providers

Completed By:

- Primary Counselor
- Other counselors specializing in the various fields, i.e., Legal, Educational, Employment and Vocational, and Psychosocial

When Initiated:

In-Depth Interviews should be completed within the first 30 days of treatment. It is recognized, however, that the Psychosocial Interview may take a longer time. Short-term detoxification programs may not need to maintain a complete set of In-Depth Interview forms, but should concentrate on those portions germane to the client's immediate problems.

Source(s) of Data:

- Client responses
- Documentary evidence presented by client or other agencies with whom communication has been properly authorized by the client

Preparation Instructions:

In-Depth Interviews should be conducted in the order of priority indicated by the client's responses to related questions contained in the Initial Interview. The questions and the forms should not interfere with the counselor's usual technique; i.e., counselor need not follow the printed order of the questions but should tailor them to his or her counseling style. Additionally, as an entire counseling session could conceivable emanate from a single question, the completion time for the entire set should remain somewhat elastic. Again, it is recommended that all questions be asked, if appropriate, and responses be documented, leaving no blanks. If the client's response is too long to be contained in the space provided, it is recommended that the reply be contained in a Progress Note, with a reference to that Progress Note and date in the response space.

DRUG USE HISTORY	Client Name:	Client Number:

Please refer to Initial Interview, pages two, three, and four, for Drug and Alcohol History obtained at that time.

Which drug causes you the most problems in the following areas:

Social: Family _____ Job _____
Friends _____ Education _____
Legal _____ Financial _____

Physical: _____

Mental: _____

Which drug causes you the most overall harm? _____

What is the main reason for your starting to use drugs? ☐ Friends' influence ☐ Kicks ☐ Medical

☐ Other (Specify): _____

Do you have any feelings about why you continue to use drugs? _____

_____

Have you ever lost consciousness while using drugs? ☐ No ☐ Yes--How many times? _____

Have you used alcohol to the point of intoxification? ☐ Constantly ☐ Frequently ☐ Sometimes ☐ Seldom ☐ Never
Have you been drunk continuously for several days?

Does any member of your family have a drug problem? ☐ No ☐ Yes--Indicate:

Name(s): _____ Relationship: _____

_____ _____

_____ _____

How many of your present friends are drug users? ☐ All ☐ Most ☐ Some ☐ Few ☐ None
How many of your present friends are alcohol users?

When using drugs or alcohol are you generally: ☐ Alone ☐ With one or two others ☐ In a group

How many times have you stopped using drugs "on your own" in the street? _____

What was your motivation? _____

Why did you return to drugs? _____

Why have you enrolled in treatment at this time? (Check all that apply)

☐ Want to get off drugs
☐ Want to avoid arrest
☐ Want to improve mental health
☐ Want to be self-supporting and not depend on family for support
☐ Forced by the courts
☐ Couldn't support habit
☐ Getting disgusted with lifestyle
☐ Want to avoid criminal activity
☐ Want to improve physical health
☐ Want to get Public Assistance
☐ Pressured by family or friends
☐ Shortage of drugs on the street
☐ Other (Specify): _____

If you stopped using drugs, do you believe your life would be: ☐ Substantially improved ☐ Somewhat improved ☐ Unchanged ☐ Worsened

What expectations do you have of the program? _____

_____

_____

ASSESSMENT OF DRUG USE HISTORY

Include truthfulness of client responses; attitude toward drug use and proposed treatment. List all problems on Treatment Plan.

_____

_____

_____

_____

_____

_____

Date:	Signature:

LEGAL HISTORY Page One	Client Name:	Client Number:

Please refer to Initial Interview, page five, for information obtained at that time.

True Name (Last, first, middle): ______
Alias #1: ______ Alias #2: ______

Presently on probation? ☐ No ☐ Yes--Complete as many of the following sections as are necessary for each probation.

☐ Federal Name of Judge/Court: ______
☐ State Probation Officer: *
☐ Local Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

Length of probation: ______ How much of that time has been served? ______
Has probation been extended for any reason? ☐ No ☐ Yes--Why? ______

Is probation in danger of being revoked? ☐ No ☐ Yes--Why? ______

☐ Federal Name of Judge/Court: ______
☐ State Probation Officer: *
☐ Local Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

Length of probation: ______ How much of that time has been served? ______
Has probation been extended for any reason? ☐ No ☐ Yes--Why? ______

Is probation in danger of being revoked? ☐ No ☐ Yes--Why? ______

☐ Federal Name of Judge/Court: ______
☐ State Probation Officer: *
☐ Local Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

Length of probation: ______ How much of that time has been served? ______
Has probation been extended for any reason? ☐ No ☐ Yes--Why? ______

Is probation in danger of being revoked? ☐ No ☐ Yes--Why? ______

Presently on parole? ☐ No ☐ Yes--Where: ______
☐ Federal Length of parole: ______ How much of that time has been served? ______
☐ State Has parole been extended for any reason? ☐ No ☐ Yes--Why? ______
☐ Local

Is parole in danger of being revoked? ☐ No ☐ Yes--Why? ______

Parole Officer:*
Name: ______ Telephone Number: ______
Address: ______ City: ______ State: ______

* Note: An authorization form must be completed and signed by the client prior to release of any information.

Legal History--Page Two	Client Name:	Client Number:

Does client have any outstanding fines? ☐ No ☐ Yes--Indicate:

Amount	Charges	Amount Paid	Amount Owed	Location of Court	Name of Judge

Does client have any outstanding traffic violations? ☐ No ☐ Yes--Indicate:

Violation	Date	Location	Hearing Date	Court	Judge

Does client have any outstanding warrants? ☐ No ☐ Yes--Reason for warrant: _____

Where: _____ Would client like to clear up these warrants? ☐ No ☐ Yes--When: _____

Any pending cases? ☐ No ☐ Yes

Date of Incident	Cited	Arrested	Charge(s)	Trial Phase (See Below)	Has client entered plea? No	Guilty	Not Guilty	Next Court Date	Where

Trial phases, enter one: 1 = Arraignment; 2 = Preliminary; 3 = Pretrial; 4 = Trial; 5 = Sentencing

Incarcerated? ☐ No ☐ Yes--How long in jail: _____

Is client out on bail? ☐ No ☐ Yes--How much was bail: $_____ City: _____

Does client have an attorney? ☐ No ☐ Yes: ☐ Public defender ☐ Private attorney

Does client need an attorney? ☐ No ☐ Yes

Name of Attorney: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone: _____

An authorization form must be completed and signed by client and attorney prior to release of any information to attorney.

Has client ever been in a court-referred drug rehabilitation or detox program? ☐ No ☐ Yes--Indicate:

☐ Inpatient ☐ Outpatient Where: _____

How long: _____ Date of completion: _____ Did client complete treatment? ☐ Yes ☐ No:

If program not completed, is court aware that client left? ☐ Yes ☐ No

Is client seeking entrance to residential drug facility? ☐ No ☐ Yes--Will residence in such facility be induced through:

☐ Court ☐ Parole ☐ Probation ☐ Client's commitment ☐ Family ☐ Other: _____

Legal History--Page Three	Client Name:	Client Number:

Official Adult Record:

☐ No Adult Convictions

☐ Adult Convictions (Prior Only)(Not Arrests)--List below, most recent first:

Date of Conviction	Type of Offense	Check Disposition: Fine	Check Disposition: Suspended Sentence	Check Disposition: Probation	Time Served	Name of Institution	Parole	Where	How Long

Have you ever spent any time in jail, even if not convicted? ☐ No ☐ Yes--About how much time altogether during your life (estimate)? _____

ASSESSMENT OF LEGAL HISTORY

Include truthfulness and accuracy of client's responses, client's attitude toward any apparent problems, and the priority of any proposed course of action. List all problems on Treatment Plan.

Date:	Signature of Interviewer:

PSYCHOSOCIAL HISTORY Page One	Client Name:	Client Number:

Relationships:

1. Childhood Family Structure:

2. Present Family Structure:

3. Significant Others:

Name/Relationship	Your Relationship with Them			Aware of Your Habit		Drug User	
	Good	Fair	Poor	Yes	No	Yes	No

4. At present, which of the individuals designated in questions 1, 2, and 3 do you consider to be most significant in your life, and why? _____

5. What are your reasons for designating "good" relationships in answer to 1,2, and 3? _____

6. What are your reasons for designating "poor" relationships in answer to 1,2, and 3? _____

7. How do the people listed in 1, 2, and 3 perceive your problem? _____

8. Are any of the people listed aware that you are receiving treatment? ☐ No ☐ Yes--What are their expectations?

9. Are any of the people listed willing to become involved in your treatment? ☐ No ☐ Yes--Specify: _____

10. How do you perceive problems that are presently faced by family members in areas such as education, employment, legal involvement, health, drug usage, etc. ? _____

(Note to Counselor: Can these be verified? ☐ Yes ☐ No)

Psychosocial History--Page Two	Client Name:	Client Number:

11. How would you rate your relationships with the following: Males: Good Fair Poor Females: Good Fair Poor
Friends/peers ☐ ☐ ☐ ☐ ☐ ☐
Authority figures ☐ ☐ ☐ ☐ ☐ ☐

12. What are your reasons for designating "good" relationships in question 11? _____

13. What are your reasons for designating "poor" relationships in question 11? _____

14. Past Living Arrangements (Including Childhood)
(1) How many places did you live? _____
(2) If you lived in more than one place, what were the reasons for moving? _____
(3) What was the longest period that you lived in any one place? _____
(4) With whom did you live during this longest period? _____
(5) If at any time you did not live with your natural family, with whom did you live? _____

15. Living Arrangements--During the 12-month period prior to entering this treatment program:
(1) How many places did you live? _____
(2) What was the longest period that you lived at any one place? _____
(3) With whom did you live during this longest period? _____
(4) With whom are you living now? _____

16. Sexual Orientation
(1) What were your impressions of sex during your early life? _____
(2) From whom did you learn about sex? _____
(3) Have your impressions about sex changed? _____ In what way? _____ Why? _____
(4) How would you classify yourself sexually? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other
(5) How would you rate your degree of satisfaction with your sex life? ☐ Satisfied ☐ Dissatisfied
(6) Do you believe that drugs interfere with your sexual activity? ☐ No ☐ Yes--Explain: _____

17. Money Management
(1) How do you generally handle money when you have it? Specify: _____
(2) Do you presently owe money? ☐ No ☐ Yes--To whom? _____ How much: _____

18. Recreational Activities:

(1) In the past year have you engaged in any of the following activities? (Check all that apply)

	Frequency		
	Daily	Weekly	Less than Weekly
Parties	☐	☐	☐
Dancing	☐	☐	☐
Watching television	☐	☐	☐
Writing	☐	☐	☐
Painting or sculpting	☐	☐	☐
Theatre	☐	☐	☐
Listening to music	☐	☐	☐
Playing musical instrument	☐	☐	☐
Movies	☐	☐	☐
Reading	☐	☐	☐
Museums or art galleries	☐	☐	☐
Spectator sports events	☐	☐	☐
Sports activities--Specify: _____	☐	☐	☐
Camping	☐	☐	☐
Physical conditioning	☐	☐	☐
Hobbies--Specify: _____	☐	☐	☐
Other--Specify: _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

(2) How do you currently spend your leisure time? _____

19. Abuse History:

(1) Were you an abused child? ☐No ☐Yes--How: ☐Mentally ☐Physically ☐Emotionally ☐Sexually
By whom? _____

(2) Have you been abused since you have been an adult? ☐No ☐Yes--How: ☐Mentally ☐Physically ☐Emotionally ☐Sexually By whom? _____

(3) Do you think you have the potential for abusing others? ☐No ☐Yes--Explain: _____

20. Interest in Recovery:

(1) Do you believe you have any serious problems? ☐No ☐Yes ☐Maybe
If Yes or Maybe, specify: _____

If Yes or Maybe, do you believe that you need help for these problems? ☐No ☐Yes ☐Maybe

(2) Do you believe that other people (family, parole officer, etc.) feel that you have any serious problems?
☐No ☐Yes Maybe
If Yes or Maybe, specify: _____

(3) Do you believe that other people feel that you need help for these problems? ☐No ☐Yes ☐Maybe

(4) In the past, have you received treatment for psychological problems somewhere other than a drug program?
☐No ☐Yes--Indicate:
Where: _____
By whom: _____
Dates of attendance--From _____ to _____ Nature of problem: _____

(5) Are you presently receiving treatment for psychological problems somewhere other than a drug program?
☐No ☐Yes--Indicate:
Where: _____
By whom: _____
Dates of attendance--From _____ to _____ Nature of problem: _____

21. Is there anything about which we haven't asked you that you think we should know? _____

Psychosocial History--Page Four	Client Name:	Client Number:

22. Note to Counselor: Review responses to questions regarding client's military history (Initial Interview, page five) for psychosocial follow-up.

PSYCHOSOCIAL ASSESSMENT

Include client's strengths and weaknesses. Evaluate current status and priorities. List all problems in Treatment Plan.

	Signature of Interviewer:

EDUCATIONAL HISTORY Page One	Client Name:	Client Number:

Please refer to Initial Interview, page one, for Educational History obtained at that time.

IF PRESENTLY ENROLLED IN SCHOOL, Indicate:

Degree of Interest: ☐ High interest ☐ Average interest ☐ Little interest

Progress: ☐ Above average ☐ Satisfactory ☐ Unsatisfactory

IF NOT PRESENTLY ENROLLED IN SCHOOL, Indicate:

Name of last school attended: _____ Last grade attended: _____

Note: Complete the following sections as appropriate:

Elementary School:

How well did you do in elementary school? ☐ Good ☐ Fair ☐ Poor

What were the best and worst things about it (school, teachers, other students, curriculum, etc.)? _____

Did client: ☐ Graduate ☐ Drop out--Why? _____

High School:

How well did you do in junior high? ☐ Good ☐ Fair ☐ Poor; How well did you do in senior high? ☐ Good ☐ Fair ☐ Poor

What were the best and worst things about it (school, teachers, other students, curriculum, etc.)? _____

Did client receive diploma? ☐ Yes ☐ No--Why not? _____

G.E.D.:

Have you completed the G.E.D. courses? ☐ Yes ☐ No

Have you taken the tests? ☐ No ☐ Yes--Are the scores available? ☐ No ☐ Yes--Where? _____

Did you receive a certificate? ☐ No ☐ Yes

Additional Notes

Educational History--Page Two	Client Name:	Client Number:

College:

How well did you do in college? ☐Good ☐Fair ☐Poor

Name of Institution — Courses or Name of Major/Minor

If client received degree, specify: _____

Vocational School/Special Training:

Name of Institution	Course of Study/Training	Year	Check One: Formal School	Check One: OJT
			☐	☐
			☐	☐
			☐	☐

What qualifications or licenses does client have? _____

If client is untrained or unskilled:

Have you ever taken any vocational skills or interest tests? ☐No ☐Yes--When: _____

What did they show? _____

General Background Information:

Did you change schools often? ☐No ☐Yes--Why? _____

How often did you miss school? _____ Why? _____

Were you hyperactive during school years? ☐No ☐Yes--Did you receive medication for it? ☐No ☐Yes

Have you ever had a learning disability? ☐No ☐Yes--Explain: _____

Are you interested in more schooling? ☐No ☐Yes--What would you like to study? _____

Do you plan to enroll in the near future? ☐No ☐Yes--Indicate:

If Applicable:

- Name of institution: _____
- Type of program: _____
- Projected date of enrollment: _____ Have you been accepted? ☐Yes ☐No
- Will you need financial assistance or tutoring? ☐Yes ☐No
- Have you used your GI educational benefits? ☐Yes ☐No--Are you still eligible? ☐No ☐Yes

ASSESSMENT OF EDUCATIONAL HISTORY

Include client's needs, capabilities, and interests. Outline realistic goals. Indicate priority of problems. List all problems on Treatment Plan.

Date:	Signature of Interviewer:

EMPLOYMENT/VOCATIONAL HISTORY	Client Name:
	Client Number:

Please refer to Initial Interview, page five, for Employment Information obtained at that time.

IF PRESENTLY EMPLOYED, Indicate:

Degree of Satisfaction: ☐ Highly satisfied ☐ Satisfied ☐ Dissatisfied

Reason for above opinion: _____

_____

If dissatisfied, are you looking for other employment? ☐ No ☐ Yes--What kind of work? _____

_____

Relationship to employer: ☐ Good ☐ Fair ☐ Poor
Relationship to other employees: ☐ ☐ ☐

How many days have you missed in the last month? _____

Does your employer know you have a drug problem? ☐ No ☐ Yes--Is your job in jeopardy? ☐ No ☐ Yes

PAST HISTORY:

What was the longest period that you held a job? _____ What type of job was it? _____

_____

What was the approximate weekly salary for the job? _____

Was this salary about average for most jobs you have had? ☐ Yes ☐ No

Why did you leave the job? _____

Resigned: ☐ Didn't like the work ☐ Couldn't take the pressure ☐ No opportunity for advancement
☐ To change job ☐ Drug use interfered with job ☐ Job interfered with drug use
☐ Other (Specify): _____

Fired: ☐ Poor performance of duties ☐ Couldn't get along with co-workers ☐ Use of drugs
☐ Couldn't get along with boss
☐ Other (Specify): _____

Approximately how many other jobs have you had? _____ What kinds of jobs have they been? _____

_____

What has been the average length of stay on these jobs? _____ Why did you usually leave these jobs?

_____

When unemployed, did you: Look for work? ☐ Yes ☐ No Enter training program? ☐ Yes ☐ No

If No to both of these, how did you spend your time? _____

_____

How many of your present friends are employed? ☐ All ☐ Most ☐ Some ☐ Few ☐ None

Have you ever been bonded? ☐ Yes ☐ No

Do you know if you can be bonded? ☐ No ☐ Yes--How much: _____

Do you have any past military skills? ☐ No ☐ Yes--What are they: _____

_____

ASSESSMENT OF EMPLOYMENT/VOCATIONAL STATUS

Evaluate client's capabilities, interests, and handicaps, if any. Indicate priority of problems. List all problems on Treatment Plan.

Date:	Signature:

DATA BASE FORM

SECTION 3

Health-Related Forms

- HEALTH QUESTIONNAIRE (Three Pages)
- PHYSICAL EXAMINATION (Three Pages)

SPECIFICATION SHEET: HEALTH QUESTIONNAIRE AND PHYSICAL EXAMINATION FORMS

Purpose and Overall Description:

A Health Questionnaire and Physical Examination are completed to minimize the risk of individuals entering treatment with undetected serious illnesses, conditions, or contagious diseases. In addition, these forms collect information which may clarify the present problem or affect the Treatment Plan. Accordingly, it is a requirement of the Federal Funding Criteria, as well as the JCAH, that a complete Health Questionnaire and Physical Examination be obtained for every client admitted to the program.

The Health Questionnaire addresses such areas as family history, personal history, review of organic systems, and current medical status. During the Physical Examination, special attention is given to: pulmonary, hepatic, and cardiac abnormalities; the presence of infectious disease; the dermatologic sequelae of addiction; and the existence of concurrent surgical problems. In methadone programs, there must be documented physiological evidence of addiction.

Used By:

- Physician to detect medical problems that may affect the client or other clients in the program
- Primary Counselor in developing Treatment Plan

Completed By:

- Health Questionnaire may be completed by paramedical personnel, the Counselor, or in some cases, by the client
- Physical Examination is performed by a physician

When Initiated and Modified:

- Health Questionnaire is completed prior to the Physical Examination
- In all treatment modalities, except methadone, the Physical Examination must be completed within 21 days; in methadone programs, the examination should be performed prior to the administration of any medication

Source(s) of Data:

- Client
- Existing medical records from other institutions

Preparation Instructions:

- Forms are self-explanatory

HEALTH QUESTIONNAIRE	Client Name:	Client Number:

How would you rate your present state of health? ☐ Good ☐ Fair ☐ Poor

Do you have any of these communicable diseases? ☐ Tuberculosis ☐ Hepatitis ☐ Venereal Disease ☐ None

☐ Other (Specify): _____

Do you feel you have any other medical problem? ☐ No ☐ Yes--Indicate nature of problem: _____

_____

Are you presently receiving medical care? ☐ No ☐ Yes--Indicate:

Where: ☐ Private physician ☐ Clinic ☐ Hospital

Name of provider: _____

Address: _____

How long: ☐ In past month ☐ In past 6 months ☐ In past 12 months ☐ Over 12 months

If medical treatment involves use of drug(s) of any kind, indicate: Substance(s): _____

_____ How long used: _____

FAMILY HISTORY

Provide as much data as possible:

	Alive	Deceased	Cause of Death If Known
Father			
Mother			
Brothers or Sisters			

	Alive	Deceased	Cause of Death If Known
Husband			
Wife			
Child(ren)			

Which, if any, blood relative has ever had:

Cancer	Stroke
Tuberculosis	Epilepsy, fits, or convulsions
Diabetes	Sickle Cell trait/Disease
Heart trouble	Alcoholism
High blood pressure	Other drug problems

PAST HISTORY

Instructions: Place a checkmark (✓) in the boxes where applicable, and enter date of occurrence in space provided.

Immunization History:
☐ Tetanus immunization (Date: _____)
☐ Childhood immunizations completed: _____
☐ Other (Specify): _____

Weight: Maximum weight: _____ (Date: _____) Minimum weight: _____ (Date: _____)
Recent weight loss: ☐ No ☐ Yes--How much: _____

Injuries: ☐ Broken bones _____ ☐ Lacerations _____ ☐ Head injuries _____

Allergies: ☐ Hay fever or asthma _____ ☐ Hives _____ ☐ Eczema _____

Are you allergic to:

Penicillin	☐ Yes	☐ No	Any foods: _____	☐ Yes ☐ No
Sulfonamides	☐	☐	_____	
Aspirin	☐	☐	Other: _____	☐ ☐
Other antibiotics	☐	☐	_____	

Surgery: ☐ T&A _____ ☐ Appendectomy _____ ☐ Blood transfusions _____ Age
☐ Other (Specify): _____ _____
_____ _____
_____ _____

Previous Hospitalizations, Including Psychiatric: _____
_____

Health Questionnaire--Page 2 | Client Name: | Client Number:

Habits: Do you use any of the following:

Substance	Age First Used	Frequency/Amount of Present Use
Coffee		
Tea		
Cola drinks		
Nicotine		
Sleeping medication (Specify):		
Medication for pain or headaches (Specify):		
Herbal preparations		
Other over-the-counter drugs (Specify):		

Give food intake for the past 24 hours:

Breakfast: _____

Lunch: _____

Dinner: _____

Other snacks: _____

Do you sleep well? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you crave any food or substance? _____

HISTORY OF ILLNESS OR SYMPTOMS

Instructions: Place a checkmark (✓) beside any applicable area and indicate the age of occurrence in the space provided.

Illnesses:

☐ Measles ____
☐ German measles ____
☐ Chicken pox ____
☐ Diphtheria ____
☐ Typhoid fever ____
☐ Mumps ____
☐ Whooping cough ____
☐ Scarlet fever ____
☐ Rheumatic fever ____
☐ Anemia ____
☐ Sickle Cell anemia ____
☐ Jaundice ____
☐ Gall bladder disease ____
☐ Thyroid disease ____
☐ Cancer ____
☐ Bright's Disease or kidney infection ____
☐ Infected veins ____
☐ Bleeding tendency ____
☐ High or low blood pressure ____
☐ Polio ____
☐ Ulcers ____
☐ Bedsonia or nonspecific urethritis ____

☐ Diabetes ____; Insulin type and dosage: _____; Diet: _____
☐ Epilepsy ____; Medications taken: _____
☐ Hepatitis ____; Where treated: _____ Positive HAA? _____
☐ Malaria ____; Where treated: _____
☐ Syphilis ____; Where treated: _____
☐ Gonorrhea ____; Where treated: _____
☐ Tuberculosis ____; Date of last TB test: _____; Date of last chest x-ray: _____
☐ Overdose ____; Number of times: _____; Where treated: _____

Instructions: Place a checkmark (✓) beside the problems you now have or have had in the past.

SKIN:
☐ Infections/abscesses
☐ Ringworm

EYES:
☐ Wear glasses
☐ Double vision
☐ Loss of vision
☐ Eye injury

EAR, NOSE, AND THROAT:
☐ Bleeding gums
☐ Hoarseness
☐ Infections
☐ Dizziness
☐ Deafness
☐ Buzzing or ringing in ears
☐ Severe nosebleeds
☐ Difficulty in swallowing
☐ Sinus trouble
☐ Do you sniff drugs?

HEART AND CHEST:
☐ Pain in chest
☐ Shortness of breath
☐ Rapid heart rate, strongly felt
☐ Inability to sleep without several pillows
☐ Spitting up phlegm or mucus
☐ Frequent colds or sore throat
☐ Bronchitis
☐ Pneumonia
☐ Cough, fever
☐ Spitting up of blood
☐ Night sweating

(Symptom table continues, next page)

Health Questionnaire--Page 3	Client Name:	Client Number:

STOMACH:

- ☐ Poor appetite
- ☐ Nausea, vomiting
- ☐ Vomiting blood
- ☐ Pain, gas
- ☐ Bowel habits: ☐ Constipation ☐ Diarrhea
- ☐ Take laxatives--How often: _____
- ☐ Hemorrhoids
- ☐ Tarry, light gray, or white stools
- ☐ Jaundice--Yellowing of skin and whites of eyes

URINARY:

- ☐ Pain on urination
- ☐ Difficulty in urinating or retention
- ☐ Need to get up to urinate at night
- ☐ Blood in urine
- ☐ Infections, gonorrhea, or syphilis
- ☐ Stones

MUSCLE, BONE, EXTREMITIES:

- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness
- ☐ Deformities
- ☐ Bone pain in spine
- ☐ Muscle pain along spine
- ☐ Cramps in legs
- ☐ Swelling of ankles and hands
- ☐ Blueness of lips and nails
- ☐ Numbness or tingling

OTHER:

- ☐ Slurred speech
- ☐ Anxiety
- ☐ Fatigue
- ☐ Depression
- ☐ Sleeplessness
- ☐ Feeling tired after sleeping

Usual hours of sleep: _____

- ☐ Headaches
- ☐ Convulsions
- ☐ Paralysis
- ☐ Tremors
- ☐ Staggering gait
- ☐ Difficulty in remembering places and events

QUESTIONS FOR WOMEN

BREASTS: ☐ Lumps ☐ Pain or tenderness

OB/GYN:

LNMP (Last normal menstrual period): _____

Duration--How many days: _____

Interval: _____

☐ Clots ☐ Discharge ☐ Heavy flow
☐ Spotting ☐ Pain

Birth control method: _____

Last Gyn exam: _____

Pregnancies: _____

- ☐ Miscarriages: _____
- ☐ Stillbirths: _____
- ☐ Abortions: _____

Any born with congenital defects?

☐ Yes ☐ No

Additional Notes

Date:	Signature of Interviewer:
Date of Review:	Signature of Physician (Required for Methadone Program):

PHYSICAL EXAMINATION	Client Name:	Client Number:

Height:	Weight:	Temperature:	Pulse:	Respirations:	Blood Pressure:

General Appearance:

Physiology	Normal	Abnormal	Description of Abnormal Findings
Skin, General Appearance			
Scalp and hair distribution			

Check, if present, and describe:

- ☐ Tattoos
- ☐ Track marks ☐ New ☐ Old
- ☐ Thrombosed veins
- ☐ Brawny edema
- ☐ Subcutaneous abscesses: ☐ Acute ☐ Healed
- ☐ Puffy hand sign

Eyes			
EOM			
Fundi			

Check findings:

Sclera: ☐ Normal ☐ Icteric

Pupil size: ☐ Normal ☐ Myotic ☐ Mydriatic ☐ Reactive ☐ Nonreactive

Nystagmus: ☐ Absent ☐ Present

Ears--Canal and drums			
Nose			
Mouth and throat			
Teeth			
Neck, including thyroid			
Lymph Nodes:			
Cervical			
Axillary			
Epitrochlear			
Inguinal			
Heart			
Peripheral pulses			
Lungs			
Breasts			
Abdomen			

Check findings:

Liver: ☐ Palpable ☐ Not palpable ☐ Enlarged ☐ Tender ☐ Non-tender

(continues next page)

Physical Exam--Page 2	Client Name:	Client Number:

Physiology	Normal	Abnormal	Description of Abnormal Findings
Abdominal findings (continued) Spleen: ☐ Palpable ☐ Not palpable Kidneys: ☐ Palpable ☐ Not palpable			
Herniations			
Spine			
Extremities			
Joints			
Edema			
Varicosities, thrombophlebitis			
Neurological (DTR's, Babinski, Romberg)			
Cranial Nerves			
Gait			
Balance			
Coordination			
Motor strength			
Check findings: Mental status: ☐ Alert ☐ Somnolent ☐ Noticeably high Speech: ☐ Clear ☐ Slurred			
Anus and rectum (including prostate)			
Male genitalia			
Pelvic exam			

Summary Documentation of Current Physiological Addiction

Addictive Drug Used:

Heroin/Other Narcotics:

Urine results: _____

Daily heroin consumption: _____

_____

Time last used heroin: _____

_____

Toxic State:

- ☐ New tracks
- ☐ Contracted pupils
- ☐ Constipation

Withdrawal State: (Check if present)

- ☐ Dilated pupils
- ☐ Rhinorrhea
- ☐ Lacrimation
- ☐ "Gooseflesh"
- ☐ Anorexia, nausea, vomiting
- ☐ Diarrhea
- ☐ Fever
- ☐ Diaphoresis
- ☐ Other (Specify): _____

_____

Barbiturates/Sedatives:

Toxic State:

- ☐ Slurred speech
- ☐ Nystagmus
- ☐ Staggering gait
- ☐ Positive Romberg

Withdrawal State:

- ☐ Anxiety
- ☐ Tremulousness
- ☐ Insomnia
- ☐ Orthostatic hypotension
- ☐ Delerium
- ☐ Convulsions
- ☐ Fever
- ☐ Other (Specify): _____

_____

Physical Exam--Page 3	Client Name:	Client Number:

Impression:

Laboratory Tests Ordered:

- ☐ CBC and differential
- ☐ STS
- Urinalysis: ☐ Routine and microscopic ☐ Toxicology (drugs)
- ☐ SMA 12
- ☐ Chest X-ray

As appropriate:

- ☐ HAA
- ☐ Sickle cell
- ☐ Pap smear
- ☐ GC culture
- ☐ EKG
- ☐ Biological test for pregnancy
- ☐ Tuberculin skin test
- ☐ Hematocrit only

For Program Use Only

Results Received

Recommendations:

Date:	Physician's Signature: M. D.

Required for Methadone Program:

I have reviewed all the documented evidence on this client to verify a two-year history of addiction and current physiologic dependence. In my judgement, the client fulfills the requirements for admission to a methadone maintenance program.

Date:	Physician's Signature: M. D.

TREATMENT PLAN
and
TREATMENT PLAN REVIEW

SPECIFICATION SHEET:
TREATMENT PLAN

Purpose and Overall Description:

The Treatment Plan is the focal point in the documentation of the treatment of the client. It provides summary statements of the client's problems, appropriate realistic goals, and strategies for achieving these goals. A written Treatment Plan is required by Federal Funding Criteria and JCAH standards. This document facilitates the formulation of the plan from the definition of problems to the setting of goals. The Treatment Plan can also serve as a written "contract" between client and counselor.

The form is designed to follow problems arising in any of the Data Base topics: Legal, Educational, Drug and Alcohol Use, Employment and Vocational, Psychosocial, and Health. Each page is structured to provide for both a concise statement of the problem, referenced by the Index Number shown on the form, and the formulation of a treatment strategy that includes specific short- and long-term goals.

Used By:

- Counselor and client in assessing progress and revising treatment plans
- Clinic Coordinator in evaluating thoroughness and logic of counselor's work
- Other program service providers, particularly in case conferences
- NIDA and State auditors in reviewing cases

Completed By:

- Primary Counselor

When Initiated and Modified:

Initially prepared as soon as any problem is identified. A tentative plan, therefore, may be completed on the first day and a permanent plan within 30 days. It may be updated at any time. The Treatment Plan must be reviewed every 30 days in a residential environment, and every 90 days in outpatient clinics.

Source(s) of Data:

- Initial and In-Depth Interview Forms
- Direct discussions with client, during which the counselor and client should reach agreement on stating problems and setting goals
- Progress Notes
- Treatment Plan Review Form

Preparation Instructions:

- For the Index Number, use the number of the Data Base topic under which problem falls (see left margin)
- Enter all problems as soon as identified
- State problems briefly (details of the problem should be in the Initial Interview, In-Depth Interview, or Progress Note of that date)
- State goal briefly, after consultation and agreement between counselor and client
- State Treatment Plan briefly, including type and frequency of services or activities and providers who will participate
- Update Treatment Plan from ongoing Progress Notes as new problems emerge, old problems are clarified and resolved, and/or treatment approaches changes
- Note the attainment of goals on current Treatment Plan sheet
- Compare Progress Notes with the statements of goals on Treatment Plans

TREATMENT PLAN REVIEW

TREATMENT PLAN REVIEW	Client Name:	Client Number:

Date of Last Review: Date of this Review:

1 = Drug Use; 2 = Medical; 3 = Legal; 4 = Psychosocial; 5 = Educational; 6 = Employment/Vocational

1. Review each unresolved problem/goal/plan on the current Treatment Plan.
2. Use appropriate Index Number for each area reviewed.
3. Using DAP format, document the review. Include all pertinent details which lead to the modification, if any, of each problem/goal/plan, and technique.

Index No.	

TREATMENT PLAN

Client Name:

Client Number:

Client Currently:
- ☐ Outpatient
- ☐ Residential
- ☐ Aftercare

Date of Review:
Next Scheduled Review:

Review previous Treatment Plan and Progress Notes, if any. Carry forward all unresolved problems. Use original date on old problems. Use Index Number for each problem/goal/plan. 1 = Drug Use; 2 = Medical; 3 = Legal; 4 = Psychosocial; 5 = Educational; 6 = Employment/Vocational

Date Identified	Index No.	Statement of Problem	Statement of Goal	Short-Term	Long-Term	Action Plan/Responsible Staff Member	Target Date	Date Solved

Signature of Primary Counselor: Date:

Signature of Client: Date:

Signature of Physician: Date:

SPECIFICATION SHEET:
TREATMENT PLAN REVIEW SHEET

Purpose and Overall Description:

The Treatment Plan Review Sheet is designed to provide documentary evidence that the Treatment Plan has been reviewed in compliance with Federal Funding Criteria.

Used By:

- Primary Counselor
- All service providers
- Case Conference Committee
- External review teams (NIDA, SSA, and JCAH)

Completed By:

- Primary Counselor

When Initiated:

- As preparation for a 30- or 90-day mandatory Treatment Plan Review
- As indicated for a complex or difficult case review

Source(s) of Data:

- Current Treatment Plan
- Progress Notes written since last review

Preparation Instructions:

Identify each unresolved problem on the Treatment Plan and review it, using the Index Number, by tracing it through all the Progress Notes and Data Base questions completed since the preceding Treatment Plan Review to determine, in the following sequence:

- Whether the original statement of the problem is valid or should be restated
- Whether the goals should remain the same or be redefined
- Whether the Treatment Plan strategies should remain the same or be reformulated utilizing different techniques

Purpose and Overall Description:

Progress Notes are required to provide documentary evidence of person-to-person services provided to the client. They are also used in conjunction with the Treatment Plan to assess progress made in pursuing that plan and to modify it if necessary. The form itself is straightforward, providing space for notes, for dating those notes, and for referencing notes to the Treatment Plan by use of the appropriate Index Number.

Used By:

. Anyone who provides service to the client and has access to the Client Records

Completed By:

. Anyone who provides service to the client

When Initiated and Modified:

. Immediately after provision of any service to the client

Source(s) of Data:

. Personal observations made by provider of service to the client

Preparation Instructions:

. Progress Notes should be written in a problem-oriented fashion that relates to the problems, goals, and treatment plans of the Treatment Plan Form

. Progress Notes should be written to include three elements described by the mnemonic, DAP:

D: Data may be subjective or objective. Subjective data are usually recordings of the client's statements, noted in quotation marks. Subjective data are usually placed first to ensure that the client's point of view will be taken into consideration at the outset. Objective data are factual observations, often about the client's behavior and appearance. For example, "The client did not make eye contact during the interview. Broke into tears."

A: Assessment, or the interpretive section of the Progress Notes. It includes the counselor's analysis of and conclusion about the current situation and is based upon the subjective and objective findings, modified by the counselor's review of previous Progress Notes on the same subject, and the current Treatment Plan.

P: Plan, or recommended changes to the Treatment Plan. If the assessment of the counselor is that the original Treatment Plan for a problem should continue, he should so state and no modification will be required on the Treatment Plan. However, if the counselor amends the goal or the therapy in any way, this change should be noted immediately on the Treatment Plan sheet, with the date of the change. If a new problem arises, this should be added to the Treatment Plan, dated, with statements of the goal and the proposed therapy.

Organization of the Progress Notes in the "DAP" manner will aid the treatment staff to think systematically. Progress Notes must be concise, cogent, and complete--not diffuse and out of context. The review and necessary updating of the Treatment Plan assures follow-up on every problem and facilitates the federally mandated 30- or 90-day Treatment Plan Review.

Preparation Instructions (Continued):

- Progress Notes must be written in a form that relates them unmistakably to the problem. Each note should be preceded by the Index Number of the appropriate problem. If a new problem is being discussed, it should be added to the current Treatment Plan immediately, dated, and numbered accordingly. Progress Notes should take into account previously written notes on the same problem (these notes are easily identified when numbered and titled).

- Progress Notes should be titled to reflect the type of counseling encounter, e.g., Group, Individual, Family, etc. When auditing the Client Record, these titles will account for the number of counseling hours.

PROGRESS NOTES	Client Name:	Client Number:

1. Index-number each Progress Note to correspond with most recent problem/goal/treatment plan:
   (1) Drug Use (4) Psychosocial
   (2) Medical (5) Educational
   (3) Legal (6) Employment/Vocational
2. Write Progress Notes in problem-oriented format:
   D = Data
   A = Assessment
   P = Plan
3. New problems, goals, and plans should be index-numbered and added to the most recent Treatment Plan, including date identified.
4. Date and time all Progress Notes. Signature must be present and should include discipline.
5. Progress Note should reflect type of service, e.g., individual, group, telephone, case review, consultation, etc.

Date	Time Spent	Index No.	Notes

DISCHARGE SUMMARY
(One Page)

SPECIFICATION SHEET:
DISCHARGE SUMMARY

Purpose and Overall Description:

The Discharge Summary is a straightforward, one-page form that captures information required by federal regulations and the JCAH standards. The form documents the specific information required in the CODAP Discharge Form, except data that do not change and were recorded on Initial Interview.

In addition, the form provides for a narrative summary of the discharge, required specifically by JCAH.

Used By:

- Counselor, if client reenters program
- Any other provider in later follow-up
- Clerical personnel in preparing the CODAP Discharge Form
- Another program to which the client may be transferring (no information can be released without the client's explicit written consent)

Completed By:

- Primary Counselor

When Initiated or Modified:

- Within a week of discharge

Source(s) of Data:

- Client Record, particularly the Treatment Plan and Progress Notes

Preparation Instructions:

The Discharge Summary should be structured utilizing the problem-oriented format of the Treatment Plan and Progress Notes. Problems or treatments mentioned should be referenced precisely by Index Number to those mentioned in the Treatment Plan and/or Progress Notes.

The narrative Discharge Summary should be as brief and concise as possible without sacrificing any of the important details of the client's treatment. The summary should not reiterate the entire record but should incorporate the following five requirements: (1) reason for admission, to include diagnosis; (2) brief summary of treatment and client's response; (3) reason for discharge; (4) rehabilitative status or condition upon discharge; and (5) instructions given to client and follow-up plans.

DISCHARGE SUMMARY
(With CODAP Information)

Client Name:

Client Number:

Date of Admission:

Date of Discharge:

Reason for Discharge:
- ☐ Completed treatment--no drug use
- ☐ Completed treatment--some drug use
- ☐ Transferred to other CODAP clinic within program
- ☐ Transferred to non-CODAP clinic within program
- ☐ Referred to outside program
- ☐ Client discharged for noncompliance to program rules
- ☐ Client left without completing treatment
- ☐ Incarcerated ☐ Death

Current Employment Status:
- ☐ Full-time (35 or more hours per week)
- ☐ Part-time (less than 35 hours per week)
- ☐ Retired
- ☐ Unemployed--has sought employment in last 30 days
- ☐ Unemployed--has not sought employment in last 30 days
- ☐ Leave of absence

Number of Months Employed Since Admission: ☐☐

Number of times arrested during treatment: ☐☐

Drug Use at Time of Discharge:

(See codes on page three of Data Base)

	Use at Discharge	Severity at Discharge	Frequency Last 30 Days	Usual Route of Administration
None				
Heroin				
Non-Rx Methadone				
Other opiates or synthetics				
Alcohol				
Barbiturates				
Other sedatives, hypnotics				
Amphetamines				
Cocaine				
Marihuana/hashish				
Hallucinogens				
Inhalants				
Over-the-counter				
Tranquilizers				
Other				
Drug unknown				

Educational Status at Time of Discharge:

Last formal year completed: ☐☐

Currently in educational or skill development program ☐Yes ☐No

Training program completed during treatment ☐Yes ☐No

Marital Status:
- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Living Arrangements:
- ☐ Alone
- ☐ With parents
- ☐ With spouse
- ☐ Other (Specify): _____

Maintaining household with one or more dependents? ☐Yes ☐No

Public Assistance:
- ☐ None
- ☐ General Relief
- ☐ Medicaid
- ☐ ADC
- ☐ SSI
- ☐ Food Stamps
- ☐ SSI-State Supplement
- ☐ State Title XX

Current Gross Weekly Legal Income:

Personal: $_____ Family: $_____

Alcohol Use at Time of Discharge:

Drinks Per Occation: Wine: ☐☐ Drinks or ☐☐ Bottles
Liquor: ☐☐ Drinks or ☐☐ Pints
Beer: ☐☐ Cans

For the alcoholic beverage used most frequently, how often does the client drink: (use code below)
- ☐ As many as 5 drinks or more
- ☐ As many as 3 to 4 drinks
- ☐ As many as 1 to 2 drinks

1 = Nearly every time
2 = More than half the time
3 = Less than half the time
4 = Once in a while
5 = Never

Modality at Discharge:
- ☐ Detoxification
- ☐ Maintenance
- ☐ Drug free
- ☐ Other

Environment at Discharge:
- ☐ Prison
- ☐ Day care
- ☐ Residential
- ☐ Outpatient

Date:

Signature of Interviewer:

SPECIAL FORMS

- URINALYSIS RESULTS (Drug Free Modality)
- METHADONE ADMINISTRATION/URINALYSIS REPORTS
- PHYSICIAN'S ORDER SHEET
- MEDICATION ADMINISTRATION SHEET
- READMISSION INTERVIEW
- READMISSION MEDICAL HISTORY
- READMISSION PHYSICAL EXAMINATION

URINALYSIS RESULTS
Drug Free Modality

Client Name:

Client Number:

Date of Sample																																
Results Positive for:																																
Morphine																																
Methadone																																
Cocaine																																
Dilaudid																																
Codeine																																
Amphetamine																																
Barbiturate																																
Quinine																																
Other																																
Negative																																
Comments or Remarks (For Extensive Notes, Use Progress Note Form)																																

METHADONE ADMINISTRATION/URINALYSIS REPORTS

Client Name:

Record Number:

Prescribed Dosage (Enter amount from Physician's Order Sheet):

Year: Month:

Day	Dosage	Admin. By	Comment	Urinalysis--Enter Results of All Urinalysis Reports												
					Clean	Methadone	Opiates	Quinine	Cocaine	Barbiturates	Amphetamines	Benzodiazepines				Other
1																
2																
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PHYSICIAN'S ORDER SHEET	Client Name:
	Record Number:

Note: Physician's orders must be dated, including time, and signed legibly; telephoned orders should be later countersigned.

For RN Use Only
T = Transferred to Administration Sheet

Date	Time	Physician's Orders and Signature	T ✓	Signature of RN

MEDICATION ADMINISTRATION SHEET (Do Not Use for Methadone Administration)	Client Name:	Client Number:

Date / Time	Name of Medication (Record Exact Dosage, Quantity, Strength, Etc.)*	Signature	Comments
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* Note: Any change in medication must be signed or countersigned by the program physician.

READMISSION INTERVIEW

Name (Last, first, middle initial):

Address:

Street Apt.

City State ZIP Code

Birthdate: Month Day Year Sex: ☐ Male ☐ Female

MA/Ins. Nos.:

Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

TO BE OBTAINED FROM PREVIOUS RECORD

Record Number: _____

Date of Last Admission: _____ Date of Last Discharge: _____

Number of Previous Admissions: _____

On last admission, was treatment: ☐ Completed ☐ Not completed

On last admission, the modality was:
☐ Detoxification ☐ Maintenance ☐ Drug free
☐ Other (specify): _____

On last admission, environment was:
☐ Residential _____
☐ Outpatient _____
☐ Prison ☐ Day care

EDUCATION

Schooling Since Last Admission: ☐ None ☐ Full-time school ☐ Part-time school

If any this period: ☐ Job training ☐ High school ☐ College
☐ Other (Specify): _____
Hours attending: _____

EMPLOYMENT

Employment Since Last Admission: ☐ No job this period ☐ Homemaker ☐ Homemaker and job

☐ Any job this period--Check A or B and 1 or 2:
☐ A = Full-time (over 35 hours/week) ☐ B = Part-time (under 35 hours/week)
☐ 1 = Any time during period ☐ 2 = Entire period

If Working--Satisfied with job? ☐ Yes ☐ No
How long on job (days, weeks, months): _____ Salary level: $_____

If Not Working--Actively seeking employment? ☐ Yes, within last 30 days ☐ No, not within last 30 days

Other Means of Support: ☐ None ☐ Welfare ☐ Unemployment insurance (weeks remaining: ____) ☐ Family and friends ☐ Other (Specify): _____

LEGAL

Does client have any current legal involvement? ☐ No ☐ Yes--Refer as soon as possible for Legal History interview

DRUG USAGE

Length of time continuously on drugs since last withdrawal: _____ Longest period drug free: _____

Drug Usage Since Last Withdrawal or Use, Including Current Use:

Substance	Amount Per Day	Cost Per Day	How Taken

Additional Notes

Date: Signature of Interviewer:

READMISSION MEDICAL HISTORY	Client Name:
	Record Number:

How would you rate your present state of health? ☐ Good ☐ Fair ☐ Poor

Are you presently receiving medical care? ☐ No ☐ Yes--Indicate:

Where: ☐ Private physician ☐ Clinic ☐ Hospital Date of last physical examination: _____

Name of provider: _____

Address: _____

Since your last admission, have you had any of the following: (Indicate when and where treated in the space provided)

☐ Hepatitis: _____
☐ Infected veins: _____
☐ Skin abscesses: _____
☐ Other infections: _____
☐ Overdose: _____
☐ Syphilis: _____
☐ Gonorrhea: _____
☐ Other medical or surgical problems (Specify): _____

LNMP: _____ Last bowel movement: _____ Any unusual color of stool or urine: _____

Comments:

Date:	Signature of Interviewer:

PHYSICIAN'S REVIEW

☐ Physical examination is necessary
☐ Physical examination is not necessary at this time

Comments:

Date:	Signature: M.D.

READMISSION PHYSICAL EXAMINATION

Client Name:

Record Number:

Height:	Weight:	Temperature:	Pulse:	Respirations:	Blood Pressure:

General Appearance:

Skin: ☐ Fresh track marks Subcutaneous abscesses: ☐ Acute ☐ Healed

Eyes: EOM: _____ Fundi: _____

Pupils: ☐ Normal ☐ Myotic ☐ Mydriatic ☐ Reactive ☐ Nonreactive Sclera: ☐ Normal ☐ Icteric Nystagmus: ☐ Absent ☐ Present

Ear, Nose, and Throat: _____

Lymph Nodes: _____

Heart and Lungs: _____

Abdomen: _____

Liver: ☐ Palpable ☐ Nonpalpable ☐ Enlarged ☐ Tender ☐ Nontender Spleen: ☐ Palpable ☐ Nonpalpable Kidneys: ☐ Palpable ☐ Nonpalpable

Extremities: _____

Neurological: _____

Impression:

Recommendations:

Date:

Signature:

M. D.

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END