

Pierce County Alliance
DRUG COURT PROGRAM SCREEN

Name: _____ Gender: M F Race: _____ Date of Birth: _____

Address: _____ Phone: _____ SSN: ____/____/____
Number Street Apt City State Zip

Are you currently Pregnant: Y N Do you have medical insurance: Y N Private: Provider (Dr.): _____ Apple:

Name of person you live with: _____ Relationship: _____ Number in Household: _____

Employed: Yes No Name of Employer: _____ Days & Hours Worked: _____

Other Source of Income: SSI ____ AFDC ____ GAU ____ TANF ____ Retirement ____

Marital Status: Never Married Married/Committed Relationship Divorced Widowed Separated

ARREST HISTORY

Current Charges: _____

All Drugs used: _____ Date of Last Use: _____

Frequency: _____ Have you EVER used any of the following:

Amount of Drug Use: _____ KRATOM Y N WHEN: _____

Have you ever received MAT for Opiates or Alcohol? Y N PCP Y N WHEN: _____

Are you currently interested in receiving MAT? Y N SPICE Y N WHEN: _____

Are you aware of the benefits of MAT? Y N BATH SALTS Y N WHEN: _____

Do you have a medical marijuana card: YES NO When? _____ FENTYNOL Y N WHEN: _____

KETAMINE Y N WHEN: _____

Currently on Supervision: Y N DOC# _____ CCO Name: _____ CCO Phone: _____

Have you ever been enrolled in ANY Drug Court Program previously? Y N

ARE YOU WILLING TO PARTICIPATE AND COMPLY WITH THE DRUG COURT PROGRAM RULES? Y N

ARE YOU AN ADDICT? Y N Have you ever participated in AA/NA meetings? Y N

Have you ever served in the military? Y N If Yes, Period of Service: _____

Type of Discharge: _____ Date of Discharge: _____

Have you ever attempted Suicide? Y N When _____ How _____

Do you hold any type of professional license with the State of Washington? Y N

MEDICAL STAUTS

PHYSICAL DISABILITIES: _____ MENTAL HEALTH ISSUES: (Depression, Anxiety, Bi-Polar, etc)

List all prescribed medications your are PRESENTLY taking: _____

TREATMENT HISTORY

List all Chemical Dependency or MICA Treatment: Inpatient and Outpatient

Name of Agency In/Out Patient Length of Stay Completed Treatment After Care Length of abstinence

FOR COUNSELOR USE ONLY

Defendant is: Selected ____ Not Selected ____ Offender Score ____ pts Sentencing Range ____ mo

Arrest Date ____ Screening Date: ____ Admit Date: ____ Cause Number ____

Counselor Initials: ____ Counselor Code: ____ Date: ____

Outside Provide: Y N Restitution Yes ____ No ____ \$ ____

Database Entry Confirmation Date: ____ Initials: ____

NOTES: _____

ACES
(Adverse Childhood Experience Screening)

NAME: _____ AGE: _____ DATE: _____

PYHSICAL ABUSE BY A PARENT	YES	NO
PHYSICAL NEGLECT	YES	NO
EMOTIONAL ABUSE BY A PARENT	YES	NO
EMOTIONAL NEGLECT	YES	NO
SEXUAL ABUSE BY ANYONE	YES	NO
DOMESTIC VIOLENCE	YES	NO
LIVING WITH A FAMILY MEMBER EXPERIENCING MENTAL HEALTH	YES	NO
EXPERIENCING THE INCARCERATION OF A HOUSEHOLD MEMBER	YES	NO
LOSS OF A PARENT	YES	NO
GROWING UP WITH ALCOHOL AND/ OR DRUG ABUSER IN THE HOME	YES	NO

Any information contained herein pertaining to an alcohol or drug abuse patient is protected by state (RCW 70.02) and federal confidentiality rules (42 CFR Part 2) to include the Health Insurance Portability and Accountability Act (HIPAA) of 1996, (45 CFR Parts 160 & 164). These rules prohibit any further disclosure unless EXPRESSLY permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. These rules also restrict the use of such information to criminally investigate or prosecute any alcohol or drug abuse patient. If you received this correspondence in error, please notify the originator and delete or destroy it without printing, copying or forwarding it.

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION:
CRIMINAL JUSTICE SYSTEM REFERRAL**

I, _____, AUTHORIZE Pierce County Alliance (PCA) to exchange the information specified below with the following:

Pierce County Superior Court; Pierce County Prosecutor's Office, Department of Assigned Counsel and other Defense Counsel: and Washington State Department of Corrections (assigned CCO).

(Individual must date and initial all applicable items, below)

DATE	INITIAL	TYPE OF INFORMATION TO BE RELEASED
		Substance abuse assessment, evaluation, diagnosis, treatment recommendations, urinalysis and other drug and alcohol testing results, prognosis and general progress report information
		Current and historical legal, medical, social and treatment records
		HIV/AIDS and TB related information
DATE	INITIAL	PURPOSE FOR WHICH INFORMATION IS TO BE RELEASED
		Assist Criminal Justice and Treatment Systems by providing treatment related information
DATE	INITIAL	MEANS OF TRANSMISSION
		Voice (telephone or face to face)
		Facsimile (fax or computer data transfer)
		Hand delivery or mail
		E-mail
		Other:

_____ I understand, as a condition of the program the agency provides a chemical dependency evaluation, UA/BA results, periodic treatment progress reports, and related information to the Court, which are included in the Court record. These items then become part of the public record and are therefor subject to public access.

_____ I also understand this consent will remain in effect and cannot be revoked by me unless there is a formal and effective termination or revocation of my conditional release or other proceeding under which I was ordered into a program of the Pierce County Alliance.

_____ If I am not under any Criminal Justice System order or obligation, I may revoke this consent in writing, except to the extent the program has already taken action upon it. Otherwise, this consent will expire not later than sixty (60) days after my discharge from the program.

_____ I agree to keep confidential the identity and any information about other Individuals both during and after my program participation. I also understand any disclosure made is bound by Federal Confidentiality Regulation (Part 2 of Title 42) and those recipients of this information may re-disclose it only in connection with their official duties.

Individual Signature

Date

Counselor/Witness Signature

Date

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
 In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	