[Insert organisation name/logo]

# CLIENT ASSESSMENT FORM

**Note\***

This template is a guide on how to complete a comprehensive assessment and has been adapted from the [NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment, May 2020](https://www.health.nsw.gov.au/aod/Publications/clinical-care-standards-AOD.pdf).

It is the organisation’s responsibility to adapt and implement the template as needed.

\*Please delete note before finalising this template.

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## Section 1. Substance Use

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.1 Substance use history**  [Detail name of specific substances used] | **Route of use [oral, inject, etc.]** | **Age at first use** | **When last used** | **No. days used in the last month** | **Average amount used daily** | **Frequency/duration used/**  **pattern** | **Effect sought** | **Dependency (see below)** |
| **Tobacco products/vapes** |  |  |  |  |  |  |  |  |
| **Alcoholic beverages** |  |  |  |  |  |  |  |  |
| **Cannabis** [marijuana, pot, grass, hash, etc.]  **Prescribed:**  **Yes  No** |  |  |  |  |  |  |  |  |
| **Amphetamine type stimulants**  [speed, meth, ice, ecstasy] |  |  |  |  |  |  |  |  |
| **Inhalants**  (Nitrous, glue, petrol, paint thinner, etc.) |  |  |  |  |  |  |  |  |
| **Sedatives or Sleeping pills**  [benzodiazepines, xanax, valium, rohypnol, etc.]  **Prescribed:**  **Yes  No** |  |  |  |  |  |  |  |  |
| **Hallucinogens**  (LSD, acid, mushrooms, PCP, Special K, etc.) |  |  |  |  |  |  |  |  |

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| **Opioids**  [Heroin, codeine, methadone, oxycodone, morphine, etc.]  **Prescribed:**  **Yes  No** |  |  |  |  |  |  |  |  |
| **Emerging Psychoactive Substances** (kronic, bath salts, etc) |  |  |  |  |  |  |  |  |
| **Other**  [cocaine, GHB, etc] |  |  |  |  |  |  |  |  |

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| --- |
| **1.2 Current drug use state** [signs of intoxication, withdrawal, BAC] |
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| --- | --- |
| **1.3 AOD use history and behaviours** | |
| **Tick as many boxes as relevant to**  **indicate when experienced** | **Notes** |
| **1.3.1 Periods of abstinence**  Current (within the last four weeks) Past Never |  |
| **1.3.2 Treatment / interventions**  Current (within the last four weeks) Past Never |  |
| **1.3.3 Hospitalisations/ED presentations related to AOD use**  Current (within the last four weeks) Past Never |  |
| **1.3.4 Overdoses**  Current (within the last four weeks) Past Never |  |
| **1.3.5 Withdrawal and related complications (seizures, delirium, hallucinations, etc.)**  Current (within the last four weeks) Past Never |  |
| **1.3.6 Risky injecting practices (shares equipment, etc.)**  Current (within the last four weeks) Past Never |  |
| **1.3.7 Have you or someone else (e.g. children, family significant others, friends etc.) been hurt (mentally or physically) due to your alcohol or other drug use?**  Current (within the last four weeks) Past Never |  |

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| **1.4 Notes/actions/patterns of use:** |
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## Section 2. Medical History

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| --- | --- | --- | --- |
| **2.1 Problem/condition/experience** [tick appropriate] | | | |
| **Allergies** | **Cardiac or respiratory**  **problems**  (e.g. asthma, emphysema, high blood pressure, heart attack/ angina) | **Gastrointestinal/**  **hepatic problems**  (e.g. liver disease, pancreatitis, gastric ulcer, reflux) | **Skeletal injuries or**  **problems**  (e.g. back injury, limb fracture or injury] |
| **Endocrine**  **problems**  (e.g. diabetes) | **Neurological problems**  (e.g. fits, seizures, epilepsy, migraines) | **Head injuries** | **Dental problems** |
| **Chronic pain**  **condition** | **Pregnancy** | **Other:** | |

**2.2 Would the client like to be tested for blood borne viruses?  Yes  No**

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| --- |
| **2.3 History of conditions, investigations and treatments where appropriate:** |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2.4 Current prescribed medications** (including methadone, medicinal cannabis, psychotropic medication, over-the-counter-drugs, and complementary medicines) | | | | |
| **Medication** | **Reason for prescription** | **Prescribed dose and duration of treatment** | **Taken as prescribed (if no, reason?)** | **Prescriber/**  **pharmacy and pick-up arrangements** |
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| **2.5 Notes and actions:** |
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## Section 3. Mental Health

**Note\***

Organisations are encouraged to identify and implement a mental health screener tool to suit their individual organisational requirements. The below section is a guide (3.3) and is based on the Mental State Examination (MSE). It is not a replacement for your current Mental Health screener tool, for example K10 (Kessler Psychological Distress Scale).

\*Please delete note before finalising this template.

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| --- | --- | --- | --- |
| **3.1 Current diagnosed conditions** [tick appropriate] | | | |
| **Depression** | **Anxiety** | **Psychosis** | **PTSD** |
| **Bipolar disorder** | **Other:**  (Please specify) | | |

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| **3.2 History, treatments and outcomes (current diagnosis, community treatment order, past diagnosis, history of trauma, hospitalisations):** |
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| **3.3 Mental state** | |
| **Appearance**  Grooming, clothing choice, cleanliness& hygiene, posture & gait |  |
| **Behaviour**  Attitude, gestures, mannerisms, eye contact, body language, facial expressions, abnormal movements |  |
| **Speech**  Rate, volume (loud, quiet, whispered), quantity (poverty of speech, monotonous, mutism), fluency (stuttering, slurring, normal), tone |  |
| **Mood/affect**  Client (self) rated mood on a scale of 1-10. Staff observed affect; Anxious, elevated, blunted, labile (uncontrollably/excessively sad, happy, angry), incongruent, range and intensity |  |
| **Thoughts: form**  Ask the client what has been on their mind - amount and speed of thought, poverty of ideas. Flight of ideas, perseveration, loosening of associations, continuity of ideas, disturbances in language (incoherence) |  |
| **Thoughts: content**  Delusions, suicidal thought, obsession and phobias |  |
| **Perceptions**  Ask if the person ever sees, hears, smell, taste or feels things that are not present - Hallucinations (auditory, visual taste, touch, smell), depersonalisation, derealisation, illusions, distortion of senses, misinterpretation of true sensation |  |
| **Cognition**  Level of consciousness & alertness, memory (recent and past), orientation to time, place, person |  |
| **Insight/judgement**  Client’s knowledge of problem and need for treatment. Reasoned, poor or impaired judgement |  |

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| **3.4 Notes** (How does the person see AOD use impacting on their mental health, social activity etc.) |
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## Section 4. Suicide Prevention, Self-Harm and risk to others

**Note\***

The following Suicide Risk Screener is part of the Suicide Assessment Kit (SAK) from the National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia. Refer to the Suicide Risk Screener Instructions in the SAK, accessible [here](https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Suicide%20Assessment%20Kit%20updated.pdf).

If your organisation is using a different tool, please insert the tool/screener below and delete the SAK template attached below. Please note that all the information and templates in the NADA Policy Toolkit is just a guide, and not a replacement for your current self-harm and suicide risk screener.

For more information on Suicide and self-harm Prevention refer to the Suicide and self-harm Prevention policy in the [NADA Policy Toolkit](https://nada.org.au/resources/policy-toolkit/).

\*Delete this note before finalising this document.

|  |  |  |
| --- | --- | --- |
| **Screen completed by** |  | |
| **Date** |  | **Time: .am/pm** |

**Yes\*** = Indicates high risk answer

**I need to ask you a few questions on how you have been feeling, is that ok?**

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| **1. In the past 4 weeks did you feel so sad that nothing could cheer you up?**  All of the time  Some of the time  Most of the time    A little of the time  None of the time |
| **2. In the past 4 weeks, how often did you feel no hope for the future?**  All of the time  Some of the time  Most of the time    A little of the time  None of the time |
| **3. In the past 4 weeks, how often did you feel intense shame or guilt?**    All of the time  Some of the time  Most of the time    A little of the time  None of the time |

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| **4. In the past 4 weeks, how often did you feel worthless?**  All of the time  Some of the time  Most of the time    A little of the time  None of the time |
| **5. Have you ever tried to kill yourself?**   |  |  | | --- | --- | | **Yes\*** | **No** |   **If Yes,**   1. How many times have you tried to kill yourself?  Once  Twice  3 + 2. How long ago was the last attempt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Please mark  In the last 2 months  2-6 months ago  6-12 months ago  1-2 years ago  More than 2 years ago   1. Have things changed since? |
| **6. Have you gone through any upsetting events recently?**  **(tick all that apply**)   |  |  | | --- | --- | | **Yes\*** | **No** |   Family breakdown  Relationship problem  Impending legal  prosecution  Trauma  Chronic pain/illness  Loss of loved one  Child custody issues  Conflict relating to sexual identity  Other (specify below) |
| |  |  | | --- | --- | | **Yes\*** | **No** |   **7. Have things been so bad lately that you have thought about killing yourself?**  **If No, skip to question number 10.**  **If Yes, please complete below**  a. How often do you have thoughts of suicide? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  b. How long have you been having these thoughts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  c. How intense are these thoughts when they are most severe?  Very intense  Intense  Somewhat intense  Not at all intense  d. How intense are these thoughts in the last week?  Very intense  Intense  Somewhat intense  Not at all intense |
| |  |  | | --- | --- | | **Yes\*** | **No** | | **Yes\*** | **No** | | **Yes\*** | **No** |   **8. Do you have a current plan for how you would attempt suicide?**  **If Yes, please complete below**  a. What method would you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Access to means?)  b. Where would this occur?\_\_\_\_\_\_\_\_\_(Have all necessary preparations been made?)  c. How likely are you to act on this plan in the near future?  Very likely  Likely  Unlikely  Very unlikely |
| **9. What has stopped you acting on these suicidal thoughts?** |
| |  |  | | --- | --- | | **Yes\*** | **No** |   **10. Do you have any friends/family members you can confide in if you have a serious problem?**   1. Who is/are this/these person/people? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. How often are you in contact with this/these person/people? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Daily  A few days a week  Weekly  Monthly  Less than once a month |
| **11. What has helped you through difficult times in the past?** |

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| **Client presentation/statements (tick all that apply)**  Agitated  Disorientated/confused  Delusional/ hallucinating  Intoxicated  Self-harm  Other: \_\_\_\_\_\_\_\_\_  **NOTE**: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically HIGH |

**Yes\*** = Indicates high risk answer

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| --- | --- | --- | --- |
| **Workers rated risk level** | **Low** | **Moderate** | **High** |

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| --- | --- |
| **Level of risk** | **Suggested response** |
| **Low**   * No plans or intent * No prior attempt/s * Few risk factors * Identifiable ‘protective’ factors | * Monitor and review risk frequently * Identify potential supports/contacts and provide contact details * Consult with a colleague or supervisor for guidance and support * Refer client to safety plan and keep safe strategies should they start to feel suicidal. |
| **Moderate**   * Suicidal thoughts of limited frequency, intensity and duration * No plans or intent * Some risk factors present * Some ‘protective’ factors | * Request permission to organise a specialist mental health service assessment as soon as possible * Refer client to safety plan and keep safe strategies as above * Consult with a colleague or supervisor for guidance and support * Remove means where possible * Review daily |
| **High\*:**   * Frequent, intense, enduring suicidal thoughts * Clear intent, specific/well thought out plans * Prior attempt/s * Many risk factors * Few/no ‘protective’ factors * Or highly changeable | * If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone * Remove means where possible * Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available * Consult with a colleague or supervisor for guidance and support |

## Section 5. Psychosocial

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| **5.1 Resources and Supports** |
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| **5.2 Genogram / Ecomap** |
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| **5.3 Family, Children and Social relationships** (child care responsibilities and impact of substance use on these, child protection involvement |
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| --- |
| **5.4 Housing** |
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| **5.5 Finances, employment and training** |
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| **5.6 Current legal status** [tick appropriate] |
| No criminal justice involvement  Parole  Bail/charged  Community correction order  Court order  Bond  Combined custody and treatment order  Compulsory treatment (Drug and Alcohol Treatment Act 2007 No 7)  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Charges pending and convictions** |
|  |

## Section 6. Assessment summary

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| --- |
| **Assessment outcome:** |
| **Priority  Waiting list  [Insert group program name/s]**  **Referral to another agency**  **Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **6.1 Client allergies** |
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| **6.2 Goals and reasons for presentation** (including client demographics e.g. gender, age & presenting issues) |
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| --- | --- |
| **6.3 Substances used** | |
| **Main substance used** | **Other substances used** |
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|  |  |
|  |  |
| **Problematic use** | |
| **Mild dependence  Moderate dependence  Severe dependence** | |

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| --- | --- | --- |
| **6.4 Medical** | | |
|  | | |
| **6.5 Mental health** | | |
|  | | |
| **6.6 Suicide prevention, self-harm and risk to others** | | |
| Suicide screener attached | Yes  No | |
| Suicide risk formulation template attached | Yes  No | |
| If no, please explain the reasons | | |
|  | | |
|  | | |
|  | | |
| Suicide prevention | Self-harm | Risk to other |
| Low  Moderate  High\*  \*High risk levels require immediate action. For more information refer to the Suicide and self-harm prevention policy in the [NADA Policy Toolkit](https://nada.org.au/resources/policy-toolkit/). | Low  Moderate  High\* | Low  Moderate  High\* |
| Comments | | |
|  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **6.7 Psychosocial** | | | | | |
|  | | | | | |
| **6.8 Brief Case formulation** | | | | | |
|  | | | | | |
| **6.9 Treatment type(s) required** | | | | | |
|  | | | | | |
| **6.10 [Insert organisation name] actions** | | | | | |
| **Date** | | **Action** | | | |
|  | |  | | | |
|  | |  | | | |
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|  | |  | | | |
| **6.11 Referrals** | | | | | |
| **Date** | **Agency name** | | | **Contact details** | **Referral form completed** |
|  |  | | |  | Yes  No |
|  |  | | |  | Yes  No |
|  |  | | |  | Yes  No |
| **6.12 Your agency’s detailed care/treatment plan complete:** | | | | | |
| **No** | | | **[insert date]** | | |
| **Yes** | | | **[Insert date]** | | |
| **Review date** | | | **[insert review date]** | | |

## Section 7. Client Assessment Checklist

|  |  |
| --- | --- |
| **Section details** | **Complete** |
| **Section 1. Substance Use** | **Yes  No** |
| **Section 2. Medical History** | **Yes  No** |
| **Section 3. Mental Health** | **Yes  No** |
| **Section 4. Suicide Prevention, Self-Harm and risk to others** | **Yes  No** |
| **Section 5. Psychosocial** | **Yes  No** |
| **Section 6: Assessment summary** | **Yes  No** |
| **Section 7: Client assessment checklist** | **Yes  No** |