ADULT ASI QUESTIONNAIRE

Client’s Name: First _________________________________________

Middle________________________________________

Last _________________________________________

Social Security #: ____________ - ____________ - ____________

Date of Birth: ____________ / ____________ / ____________

Gender (M/F): □

Client ID: ____________________________

INSTRUCTIONS
1. Leave no blanks. Where appropriate code items:
   Y-Yes
   N-No
   X-Question not applicable
   Z-Question not answered
   Use only one character per item.

2. Space is provided after sections for additional comments.

SEVERITY RATINGS
The severity ratings are interview estimates of the patient’s need for additional treatment in each area.
The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situations). Each rating is based upon the patient’s history of problem symptoms, present condition and subjective assessment of the patient’s treatment needs in a given area.

Orion Healthcare Technology is the U.S. leader in providing automated practice management solutions to the behavioral health and substance abuse fields. Our products include adult, adolescent, criminal justice and co-occurring assessments; treatment plans, patient placement, progress notes, discharge summaries, outcome research software, MIS, office scheduling and billing applications. If you would like information about the automated version of this questionnaire or others, please feel free to call our toll-free number 800-324-7966 or visit www.MyAccuCare.com. Orion allows the photocopying of this questionnaire for clinical use, but reserves the software rights for this product.
**ADULT ASI QUESTIONNAIRE**

**GENERAL INFORMATION**

G1. Client ID: ____________________________________________

G2. Social Security #: ______ - ______ - ______

G3. Provider #: _________________________________________

G4. Date of Admission: ______ / ______ / ______

G5. Date of Interview: ______ / ______ / ______

G6. Time Begun: ______ : ______

G51. Who referred you for an evaluation?
   1-Attorney
   2-Probation/Parole Officer
   3-Presentence Investigator
   4-Self
   5-Judge or Court
   6-Other

G52. Referral source's name ________________________________

   Address _____________________________________________

   Address _____________________________________________

   City, State, Zip ________________________________________

   Phone #: (______) ______ - ______

G53. By when do you need this assessment? ______ / ______ / ______

G54. Why are you receiving this assessment (1-6)?
   1-OWI or DWI
   2-Court ordered
   3-Attorney recommended
   4-Other criminal arrest
   5-Self interest
   6-Other

G55. BAC: _____________________________________________

G56. By whom was it ordered (1-4)?
   1-Judge
   2-Probation
   3-Presentence
   4-Parole

   Specify other __________________________________________

G57. Interviewer's initials: _________________________________

G10. Gender
   M-Male
   F-Female

G12. Special:
   1-Terminated
   2-Refused
   3-Unable to respond
   X-Not applicable

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**COMMENTS FOR GENERAL AREA:**

_________________________________________________________

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Client's:
First name ____________________________
Middle name __________________________
Last name ____________________________

Address

Address

City ____________________________ State ______ Zip

Phone number: ______ - ______ - ______

G14. How long have you lived at this address? Years ______

G15. Is this address owned by you or your family (Y/N)?

G16. Date of birth: ______ / ______ / ______

G17. Of what race do you consider yourself?
   1-White
   2-Black
   3-American Indian
   4-Alaskan Native
   5-Asian or Pacific Islander
   6-Hispanic-Mexican
   7-Hispanic-Puerto Rican
   8-Hispanic-Cuban
   9-Other Hispanic

G18. Religious preference:
   1-Protestant
   2-Catholic
   3-Jewish
   4-Islamic
   5-Other
   6-None

G19. Have you been in a controlled environment in the past 30 days?
   1-No
   2-Jail
   3-Alcohol or drug treatment
   4-Medical treatment
   5-Psychiatric treatment
   6-Other

   Specify Other: __________________________________________

G20. How many days? ______

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**Adults ASI Questionnaire**

**Page 1 of 13**

**Client Name: ________________________________**
MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? (Include ODs, DTs, exclude detox) ☐ ☐

M2. How long ago was your last hospitalization for medical problems?

Years ☐ ☐ Months ☐ ☐

M51. What was it for? __________________________________________

M3. Do you have any chronic medical problems which continue to interfere with your life (Y/N)? ☐ ☐

Specify: _________________________________________________

M4. Are you taking any prescribed medication on a regular basis for a physical problem (Y/N)? ☐ ☐

M52. What is it? _____________________________________________

M53. What is it for? ___________________________________________

M5. Do you receive financial compensation (pension, disability, etc.) for a physical disability (Y/N)? ☐ ☐

Specify: _______________________________________________

M6. How many days have you experienced medical problems in the past 30 days? ☐ ☐

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 1-SLIGHTLY 2-MODERATELY 3-CONSIDERABLY 4-EXTREMELY

M7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐ ☐

M8. How important to you now is treatment for these medical problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient’s need for medical treatment (0-9)? ☐ ☐

CONFIDENCE RATINGS

Is the Medical Status information significantly distorted by:

M10. Patient’s misrepresentation (Y/N)? ☐ ☐

M11. Patient’s inability to understand (Y/N)? ☐ ☐

COMMENTS FOR MEDICAL AREA: __________________________________________

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### EMPLOYMENT/SUPPORT STATUS

**E1.** Education completed (GED = 12 years):

<table>
<thead>
<tr>
<th>Years</th>
<th>Months</th>
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</table>

**E2.** Training or technical education completed:

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<tr>
<th>Months</th>
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</thead>
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</tbody>
</table>

**E3.** Do you have a profession, trade or skill (Y/N)?

Specify: ________________________________________________

**E4.** Do you have a valid driver's license (Y/N)?

**E5.** Do you have an automobile available (Y/N)?

*(Answer “no” if no valid driver’s license)*

**E6.** How long was your longest full-time job?

<table>
<thead>
<tr>
<th>Years</th>
<th>Months</th>
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<tbody>
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</table>

**E7.** Usual (or last) occupation:

1a. Higher Executives  
1b. Large Proprietor (Value over $180,000)  
1c. Major Professionals  
2a. Business Managers  
2b. Proprietors of Medium-Sized Businesses  
3a. Administrative Personnel  
3b. Proprietors of Small Businesses (<$55,000)  
3c. Minor Professionals  
3d. Farmers (owners $41,000-$60,000)  
4a. Clerical and Sales Workers  
4b. Technicians  
4c. Proprietors of Little Businesses (<$10,000)  
4d. Farmers (Owners $21,000-$40,000)  
5a. Skilled Manual Employees and Small Farmers  
5b. Small Farmers (owners <$20,000)  
6a. Machine Operators and Semi-Skilled Employees  
6b. Small Farm Tenants  
7. Unskilled Employees

Specify: ________________________________________________

**E8.** Does someone contribute to your support in any way (Y/N)?

Specify: ________________________________________________

**E9.** Does this constitute the majority of your support (Y/N)?

**E10.** Employment status:

|                           | 5-Service  
|---------------------------|------------|
| 1-Full-time (35+ hrs/wk)  | 6-Retired/Disability  
| 2-Part-time (reg. hrs.)  | 7-Unemployed  
| 3-Part-time (irreg., daywork) | 8-In controlled environment  

**E11.** How many days were you paid for working in the past 30?

<table>
<thead>
<tr>
<th>How much money did you receive from the following sources in the past 30 days??</th>
</tr>
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<tbody>
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</tbody>
</table>

**E12.** Employment (net income):

**E13.** Unemployment compensation:

**E14.** Welfare:

**E15.** Pension, benefits or social security:

**E16.** Mate, family or friends:

**E17.** Illegal:

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**E51.** What was our gross income last year?

**E18.** How many people depend on you for the majority of their food, shelter, etc.?

**E19.** How many days have you experienced employment problems in the past 30?

**E20.** How troubled or bothered have you been by these employment problems in the past 30 days?

**E21.** How important to you now is counseling for these employment problems?

---

**INTERVIEWER SEVERITY RATING**

**E22.** How would you rate the patient’s need for employment counseling (0-9)?

**CONFIDENCE RATINGS**

Is the Employment/Support Status information significantly distorted by:

**E23.** Patient’s misrepresentation (Y/N)?

**E24.** Patient’s inability to understand (Y/N)?

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COMMENTS FOR EMPLOYMENT AREA: __________________________________________________________

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**DRUG/ALCOHOL USE**

D51. What age did you first try alcohol or drugs?  

D52. What was it? ________________________________________________

<table>
<thead>
<tr>
<th></th>
<th># Days Past 30</th>
<th>Lifetime</th>
<th>Route of Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1. Alcohol (any use at all)</td>
<td></td>
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<tr>
<td>D2. Alcohol (to intoxication)</td>
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<tr>
<td>D3. Heroin</td>
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<td></td>
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<tr>
<td>D4. Methadone</td>
<td></td>
<td></td>
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<tr>
<td>D5. Other opiates/analgesics</td>
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<td></td>
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<tr>
<td>D6. Barbiturates</td>
<td></td>
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<td>D7. Other sedatives/hypnotics/tranquilizers</td>
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<tr>
<td>D8. Cocaine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>D9. Amphetamines</td>
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<td></td>
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<tr>
<td>D10. Cannabis</td>
<td></td>
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<tr>
<td>D11. Hallucinogens</td>
<td></td>
<td></td>
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<tr>
<td>D12. Inhalants</td>
<td></td>
<td></td>
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<tr>
<td>D13. More than 1 substance per day (including alcohol)</td>
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</tbody>
</table>

**Route of Administration**

1-Oral  4-Non-IV injection  5-IV injection  3-Smoking  2-Nasal

D53. Have you ever used a needle to administer any of these drugs (Y/N)?  

D54. Are you an I.V. drug user (Y/N)?  

D14. According to the interviewer, which substance(s) are the major problem?  

- 00-No problem  
- 01-Alcohol  
- 02-Alcohol to intox.  
- 03-Heroin  
- 04-Methadone  
- 05-Opiates/analgesics  
- 06-Barbiturates  
- 07-Other sed/hyp/tranq  
- 08-Cocaine  
- 09-Amphetamines  
- 10-Cannabis  
- 11-Hallucinogens  
- 12-Inhalants  
- 15-Alcohol & one or more drugs  
- 16-More than one drug

D15. How long was your last period of voluntary abstinence from this major substance (substance identified in D-17)? (00-never abstinent) Months  

D16. How many months ago did this abstinence end? (00-never abstinent)
How many times have you:

D17. Had alcohol DTs?  
D18. Overdosed on drugs?

How many times have you been treated for:

D19. Alcohol abuse?  
D20. Drug abuse?

How many of these were for detox only:

D21. Alcohol?  
D22. Drug?

D55. How long ago were you last in treatment?  
Years  
Months

D56. Name of Center __________________________________________
D57. Address ________________________________________________
D58. Type of treatment: 
1-Inpatient  2-Outpatient
D59. How long did it last?  
Days
D60. Did you complete it successfully (Y/N)?
D61. Have you been evaluated for alcohol or drugs before 
today (Y/N)?
D62. Where: _________________________________________________

When:                                                                   /        /       /        /

How much money would you say you spent during the past 30 days 
on:

D23. Alcohol?  $  
D24. Drugs?  $

D25. How many days have you been treated in an outpatient setting for 
alcohol or drugs in the past 30 days (include AA & NA)?

How many days have you experienced:

D26. Alcohol problems?  
D27. Drug problems?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT 
TWO QUESTIONS:

0-NOT AT ALL  
1-SLIGHLY  
2-MODERATELY  
3-CONSIDERABLY  
4-EXTREMELY

How troubled or bothered have you been in the past 30 days by 
these:

D28. Alcohol problems?  
D29. Drug problems?

How important to you now is treatment for these:

D30. Alcohol problems?  
D31. Drug problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE 
INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

How would you rate the patient’s need for treatment for (0-9):

D32. Alcohol Problems?  
D33. Drug Problems?

CONFIDENCE RATINGS

Is the Drug/Alcohol Status information significantly distorted by:

D34. Patient’s misrepresentation (Y/N)?
D35. Patient’s inability to understand (Y/N)?

ADDITIONAL COMMENTS FOR DRUG/ALCOHOL AREA:

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**LEGAL STATUS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Under the influence at the time?</th>
</tr>
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<tbody>
<tr>
<td>L1. Was this admission prompted or suggested by the criminal Justice system (judge, probation/parole officer, etc.) (Y/N)?</td>
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<tr>
<td>L2. Are you on probation or parole?</td>
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<tr>
<td>0-Neither</td>
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<tr>
<td>1-Probation</td>
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<tr>
<td>2-Parole</td>
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<tr>
<td>How many times in your life have you been arrested and charged with following?</td>
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<td>L3. Shoplifting/vandalism/theft?</td>
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<tr>
<td>L4. Parole/probation violations?</td>
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<td>L5. Drug charges?</td>
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<td>L6. Forgery?</td>
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<td>L7. Weapons offense?</td>
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<td>L8. Burglary/larceny/B&amp;E?</td>
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<td>L9. Robbery?</td>
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<td>L10. Assault?</td>
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<td>L11. Arson?</td>
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<tr>
<td>L12. Rape/sex-related crimes?</td>
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<tr>
<td>L13. Homicide/manslaughter?</td>
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<td>L14. Prostitution?</td>
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<td>L15. Contempt of court?</td>
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<td>L16. Other?</td>
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<tr>
<td>L17. How many of these charges resulted in convictions?</td>
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<tr>
<td>How many times in your life have you been charged with:</td>
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<td>L18. Disorderly conduct?</td>
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<td>Vagrancy?</td>
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<td>Public intoxication?</td>
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<td>L19. Driving while intoxicated?</td>
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<tr>
<td>L20. Major driving violations?</td>
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<td>L51. MIP (minor in possession)?</td>
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<tr>
<td>L21. How many month(s) were you incarcerated in your life?</td>
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<td>L22. How long was your last incarceration?</td>
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<td>Months</td>
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<tr>
<td>L23. What was it for?</td>
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**COMMENTS FOR LEGAL AREA:**

<table>
<thead>
<tr>
<th>Comment</th>
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</table>
L24. Are you presently awaiting charges, trial or sentencing (Y/N)?

L25. For what?

L26. How many days in the past 30 were you detained or incarcerated??

L27. How many days in the past 30 have you engaged in illegal activities for profit?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 3-CONSIDERABLY
1-SLIGHTLY 4-EXTREMELY
2-MODERATELY

L28. How serious do you feel your present legal problems are? (exclude civil problems)

L29. How important to you now is counseling or referral for these legal problems?

THE QUESTIONS BELOW ARE BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient’s need for legal services or Counseling (0-9)?

CONFIDENCE RATINGS

Is the Legal Status information significantly distorted by:

L31. Patient’s misrepresentation (Y/N)?

L32. Patient’s inability to understand (Y/N)?
**FAMILY HISTORY**

Have any of your relatives had what you would call a significant drinking, drug use or psychological problem – one that did or should have led to treatment?

<table>
<thead>
<tr>
<th>Y-Yes</th>
<th>N-No</th>
<th>X-Not applicable</th>
<th>Z-Not answered</th>
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</table>

**Mother’s Side**

- H1. Grandmother
- H2. Grandfather
- H3. Mother
- H4. Aunt
- H5. Uncle

**Father’s Side**

- H6. Grandmother
- H7. Grandfather
- H8. Father
- H9. Aunt
- H10. Uncle

How many siblings do you have?

- H53. Brothers: [ ] [ ]
- H54. Sisters: [ ]

Have any of your siblings had what you would call a significant drinking, drug use or psychological problem – one that did or should have led to treatment?

<table>
<thead>
<tr>
<th>Y-Yes</th>
<th>N-No</th>
<th>X-Not applicable</th>
<th>Z-Not answered</th>
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**Siblings**

- H11. Brother #1
- H51. Brother #2
- H12. Sister #1
- H52. Sister #2

**COMMENTS FOR FAMILY HISTORY AREA:**

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## FAMILY/SOCIAL RELATIONSHIPS

**F1. Marital status:**
- 1-Married
- 2-Remarried
- 3-Widowed
- 4-Separated
- 5-Divorced
- 6-Never Married

**F2. How long have you been in this marital status?**
- Years
- Months

**F3. Are you satisfied with this situation (0-2)?**
- 0-No
- 1-Indifferent
- 2-Yes

**F4. Usual living arrangements for the past three years:**
- 1-With sexual partner and children
- 2-With sexual partner alone
- 3-With children alone
- 4-With parents
- 5-With family
- 6-With friends
- 7-Alone
- 8-Controlled environment
- 9-No stable arrangements

**F5. How long have you lived in these arrangements?**
- Years
- Months

**F6. Are you satisfied with these arrangements?**
- 0-No
- 1-Indifferent
- 2-Yes

Do you live with anyone who:

**F7. Has a current alcohol problem (Y/N)?**

**F8. Uses non-prescribed drugs (Y/N)?**

**F9. With whom do you spend most of your free time?**
- 1-Family
- 2-Friends
- 3-Alone

**F10. Are you satisfied spending your free time this way?**
- 0-No
- 1-Indifferent
- 2-Yes

**F11. How many close friends do you have?**

Would you say you have had close, reciprocal relationships with any of the following people in your life?

- Y-Yes
- N-No
- X-Not applicable
- Z-Not answered

- **F12. Mother**
- **F13. Father**
- **F14. Brothers/Sisters**
- **F15. Sexual Partner/Spouse**
- **F16. Children**
- **F17. Friends**
Have you had significant periods in which you have experienced serious problems getting along with:

<table>
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<th>Y-Yes</th>
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<th>X-Not applicable</th>
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F18. Mother
F19. Father
F20. Brothers/Sisters
F21. Sexual partner/Spouse
F22. Children
F23. *Other significant family
F24. Close friends
F25. Neighbors
F26. Co-workers

F27. Emotionally (make you feel bad through harsh words)?

F28. Physically (cause you physical harm)?

F29. Sexually (force sexual advances or sexual acts)?

F30. With your family?
F31. With other people (excluding family)?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL  3-CONSIDERABLY
1-SLIGHTLY    4-EXTREMELY
2-MODERATELY

How troubled or bothered have you been in the past 30 days by these:

F32. Family problems?
F33. Social problems?

How important to you now is treatment or counseling for these:

F34. Family problems?
F35. Social problems?
PSYCHIATRIC STATUS

P1. How many times have you been treated for any psychological or emotional problems:
   - In a hospital or inpatient setting? 
   - As an outpatient or private patient?

P2. Do you receive financial compensation for a psychiatric or emotional disability (include pension, SSI, SSDI, etc.) (Y/N)?
   Have you had a significant period (that was not a direct result of drug or alcohol use) in which you have:
   - Y-Yes   N-No   X-Not applicable   Z-Not answered
   - Past 30 Days   Lifetime

P3. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily functioning?

P4. Experienced serious anxiety/tension - uptight, unreasonably worried, inability to feel relaxed?

P5. Experienced hallucinations - saw things or heard voices that others did not see or hear?

P6. Experienced trouble understanding, concentrating or remembering?

P7. Experienced trouble controlling violent behavior including episodes of rage or violence?

P8. Experienced serious thoughts of suicide?

P9. Attempted suicide?

P10. Been prescribed medication for any psychological/emotional problems?

NOTE: For questions 7-9, include incidents that occurred when the person was under the influence of substances.

P11. How many days in the past 30 have you experienced these psychological or emotional problems?

ASK THE INMATE TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL   3-CONSIDERABLY
1-SLIGHTLY   4-EXTREMELY
2-MODERATELY

P12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

P13. How important to you now is treatment for these psychological or emotional problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

At the time of the interview, is the patient (Y/N)?

P14. Obviously depressed/withdrawn?

P15. Obviously hostile?

P16. Obviously anxious/nervous?

P17. Having trouble with reality testing, thought disorders, paranoid thinking?

P18. Having trouble comprehending, concentrating, remembering?

P19. Having suicidal thoughts?

INTERVIEWER SEVERITY RATING

P20. How would you rate the patient’s need for psychiatric/psychological treatment (0-9)?

CONFIDENCE RATINGS

Is the Psychiatric Status information significantly distorted by:

P21. Patient’s misrepresentation (Y/N)?

P22. Patient’s inability to understand (Y/N)?

Time Begun: ____________________

Time End: ____________________

COMMENTS FOR PSYCHIATRIC AREA: ___________________________

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### DIAGNOSTIC IMPRESSION

**SASSI-3:**

- RAP?  
- FVA?  
- FVOD?  
- SYM?  
- OAT?  
- SAT?  
- DEF?  
- SAM?  
- FAM?  
- COR?
RECOMMENDATION FOR TREATMENT


LEVEL OF CARE RECOMMENDATION

(Check one):

1. Not applicable
2. Level I – (Outpatient treatment)
3. Level II – (Intensive outpatient/partial hospitalization)
4. Level III – (Medically monitored intensive inpatient)
5. Level IV – (Medically managed intensive inpatient)