ARC-ip - 2019 INTAKE/ SCREENING SUMMARY FORM – DATA ENTRY

Name:____________________________SITE________HRS______ M OR F BD__________AGE_______RACE______

Court: ______________ Release: Y/N **Attorney:**____________________ Release: Y/ N Luggage Searched Yes/ No

LEGAL HX -PAST OFFENSE TYPE	DATE OF OFFENSE(S) WITH PENALTY	COURT	DIP/ TX	SEVERITY

Presenting Problem: **OVI/ RO/ PC**	**Pulled over for:**___________________________ Normal or Unusual Day? Why?______________________		
BAC: ______ **OR** **DRUGS:**_ ______	What were you using night of arrest- how much over what period?		
Alcohol Use (Past/Present):	**Past?**	**Present?**	
Drug Use (Past/Present):	**Past?**	**Present?**	
Tx Hx: **Drug/Alc.** -- -- -- -- -- -- -- -- -- -- **Mental Health**	- - - - - - -- - - - - - - -		
Medical Problem then Pertinent Medications	**Problem:**____________________**Med(s):**____________________ USE BACK (INTAKE) IF NEED MORE SPACE		
Audit Score	**0-7** No Problem /**8-15** Mild Prob. /**16-19** Moderate/ **20<** Severe Prob		
MAST 1 -2 -3 – 4	Blackouts – Work Problems – Problems with Spouse – Psychiatric Help – Emotional Regret – Lost a Job or Friends – Fights – Neglected Responsibility – Hospitalized – Detox/ Withdrawal - Family Concern Problems w/ Spouse – Gone for Help – Before Noon Drinking		
DAST 1 -2 -3 – 4	Abused Prescriptions – Used Illegal Drugs – Used More Than One Drug At Once - Blackouts – Work Problems – Problems w/ Spouse – Psychiatric Help – Emotional Regret – Lost a Job or Friends – Fights – Neglected Responsibility – Hospitalized – Detox/ Withdrawal - Family Concern /Problems w/ Spouse – Gone for Help		
WPI Probability Med___% Vy High___ %	Regularity of Drinking/ Preference of Drinking/ Loss of Controlled Drinking/ Rationalization of Drinking/ Emotional Sensitivity		
Personality Med___% Very High___ %	Anxiety, Depressive Fluctuations, Resentfulness, Sense of Incompleteness, Sense of Aloneness, Problems with Relationships		

RECOMMENDATIONS: NO ASSESS OR TX		FURTHER ASSESSNEBT OR ARC ASSESS? Why? (RISK FACTORS)	CONT. W/ TX Where?	COMP. DRIVERS
		Where?	When started?	List Meds:

NEED COMPREHENSIVE?	What Medication/ Medical Problem & Why it affects driving?

CLIENT PARTICIPATION: QUIET ATTENTIVE INTERACTIVE GUARDED **ATTITUDE**: POSITIVE NEUTRAL NEGATIVE DISRUPTIVE

CLIENT PARTICIPATION: ____

OVI STORY - GROUP NOTE:____
THIS IS NOT HOW THEY ARE PARTICIPATING, THIS IS WHAT THEY SAID IN GROUP THAT IS SIGNIFICANT

COUNSELOR SIGN:__________________________DATE__________SERV.SUPER______________________

I HAVE BEEN INFORMED OF THE RECOMMENDATIONS BEING MADE: W. L. THOMAS PSYD, LICDC-CS, ICRC

CLIENT SIGN____________________________DATE___________INTERVIEW TIMES_______________

INTAKE

This information should be filled out by DIP staff to guarantee DIP standards are being met.

Client Name/ID #_______________________________________ID# _______________

(ID # is DOB yearmodayInitials ex:19610425wlt

Date intake completed:____

Is the client currently taking any prescription drugs? If **yes,** list type of medication and amount brought to the program.	**Type of medication**	**Amount**	☐ **Yes**	☐ **No**
Is the client currently taking any over-the-counter medications? If **yes,** list type of medication and amount brought to the program.	**Type of medication**	**Amount**	☐ **Yes**	☐ **No**
Does the client have any special dietary requirements? If yes, list:________________________			☐ **Yes**	☐ **No**
Does the client have any known allergies to medications? If yes, list medicine and reactions:________________________			☐ **Yes**	☐ **No**
Does the client have any food reactions? If yes, list food and reactions:________________________			☐ **Yes**	☐ **No**
Is the client currently pregnant?		☐ **n/a** for males	☐ **Yes**	☐ **No**
Does the client have any special needs? If yes, list needs:________________________ **Luggage Search** **YES OR NO (CIRCLE ONE & Initial)**			☐ **Yes**	☐ **No**

Name/address and **telephone number** who we can contact in case of an emergency:

Name:______________________________Phone # including area code________________

Street Address:__________________________City______________State________ Zip _____

Telephone # including area code:____

Relationship to DIP Participant:____

Client Signature____**Date**____________

Staff Signature____**Date**____________