# Recovery Services of Northwest Ohio, Inc.

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## Driver Intervention Program
## Intake/Screening Interview

Name _____Social Security No._____

Address _____ _____
Street City

_____ _____ _____
State Zip County

Date _____Phone _____DOB _____Age_____

Place of Birth _____ Driver's License Number _____

Referred by _____ BAC Level _____

Race (Circle One): **W** = White **B** = Black
**A** = Asian/Oriental **N** = Native American/American Indian
**M** = Alaskan Native **O** = Other

Ethnicity (Circle One): **A** = Puerto Rican **C** = Cuban
**B** = Mexican **D** = Hispanic
**E** = Not of Hispanic Origin

### Education

What is the highest grade you completed in school, including college (Circle One)

| Code | Level | Code | Level |
|---|---|---|---|
| 00 | =Less than Grade 1 | 16 | = 4 yrs. College/Undergrad. Degree |
| 01-11 | = Grade 1-11 _____ | 17 | = Graduate Courses |
| 12 | = HS Diploma/GED | 18 | = Graduate Degree |
| 13 | = Trade or Technical School | 19 | = Post Graduate |
| 14 | = Some College | 20 | = Further Specialized Studies |
| 15 | = 2 yrs. College/Associate | | |

Are you currently enrolled in school/college? Yes or No. If yes, please explain:_____
_____

**Presenting problem/precipitating factors leading to the need for screening (Why are you attending the DIP Program)**: _____

### Religion

Any specific religious affiliation? _____

### Work History

Are you currently employed? _____Yes _____No If not employed are you Disabled? ____Yes ____No. If yes, please explain_____

Are you currently on **OHIO MEDICAID** ____Yes ____NO (Need copy of Card)

Name of your employer: _____

Number of years employed there: _____

What is your usual occupation? _____

Have you ever lost a job due to drinking/using? _____Yes _____No
If yes explain: _____

## Legal History

Do you have any **arrests, OVI's or other alcohol/drug related matters pending**?
_____Yes _____ No
If yes explain,_____

How many times have you been arrested for DUI/DWI/OVI or reduced charges in the past six (6) years? _____ How many times have you been arrested for a DUI/DWI/OVI or reduced charge in your lifetime_____

Any previous alcohol/drug arrest record in your lifetime? _____Yes _____No
Type and date(s): _____

Any previous arrest record not alcohol/drug related in your lifetime? _____Yes _____No
Type and date(s): _____

Have you been in jail in the **past six (6) months**? _____ Yes _____ No

Have you ever been arrested for an offense not related to driving which was alcohol related, such as public intoxication, open container, assault, etc., in the past 12 months? _____Yes _____No

While driving during the past five (5) years, have you ever been stopped by the police and ticketed for a driving-related offense but not arrested for OVI when you had been drinking or under the influence of drugs? _____ Yes _____ No

Are your currently on probation? ____ Yes or ____No. If yes, with whom and why_____
_____

## Marital Status

Present Marital Status: _____Single, Never Married _____Married _____Separated
_____Common-Law Marriage _____Divorced _____Widowed

Are you experiencing problems in your relationships? _____Yes _____No If yes, explain:
_____

Do you have children? _____Yes _____No How many?___ Ages_____

## Military History

Have you ever served in the Military? _____Yes _____No
Branch of Military_____Military Classification_____
Years of services_____Type of discharge_____

## Personal Interests

What interests, hobbies, or recreations do you enjoy? _____
_____

How do you spend most of your free time? _____
_____

## Medical History

When did you last have a complete physical? _____
Do you believe you need one? _____Yes _____No

Have you ever been advised by a Physician that alcohol/drug use was harming your health?
_____Yes _____No

Do you smoke cigarettes or use other forms of tobacco? _____Yes _____No

Have you ever experienced problems in your eating habits? _____Yes _____No
If yes, explain_____

Have you ever been told that you have a weight problem? _____Yes _____No

Do you have problems sleeping? _____Yes _____No If yes, explain_____
_____

Do you take any prescription drugs? _____Yes _____No If yes explain (List the type and amount used)_____
_____

Do you take any over-the-counter drugs regularly? _____Yes _____No If yes, explain (List type and the amount used)_____
_____

Do you have any allergies (To include medications, food or in general) _____Yes _____No
If yes, explain_____
_____

Do you have any special dietary requirements? _____Yes _____No If yes, explain__
_____

Do you have any other special needs? _____Yes _____No If yes, explain_____
_____

Do you have any medical problems? _____Yes _____No If yes, explain_____
_____

Pregnant status of female clients_____

**Alcohol/Drug Use History** (Indicate lifetime usage and/or experience Patient admits with each of the following chemicals)

| | | | | | |
|---|---|---|---|---|---|
| Alcohol | Yes | No | Pain Pills (Prescription) | Yes | No |
| Tranquilizers | Yes | No | Stimulants (Meth) | Yes | No |
| Cocaine | Yes | No | Narcotics | Yes | No |
| Barbiturates | Yes | No | Marijuana, Hashish | Yes | No |
| Sleeping Pills | Yes | No | Nicotine | Yes | No |
| Caffeine | Yes | No | Other (Inhalants, etc.) | Yes | No |

For each of the drugs/chemicals used, indicate the frequency of usage, amount typically used on a giving occasions, age of first usage, date of last does and route of administration.
**(See chart on Page 4)**

| CHEMICAL | FREQUENCY OF USAGE (Start with first use and work to present, giving a detailed using history) | AMOUNT USED PER EPISODE | AGE OF FIRST USE | DATE OF LAST USE | ROUTE OF ADMINISTRATION (Oral/Smoked/Snorted/Injected) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Comments:**

How many years have you been drinking and/or using drugs?_____

How would you describe your drinking/drug behavior?
_____No problem _____Slight problem _____Moderate Problem ____Severe Problem

How many times have you received alcohol or drug treatment from other than Self-Help Groups during the past six (6) years?_____ In your lifetime (this includes assessments, past 72 Hour DIP programs, education and counseling)? Explain_____
_____

Previous mental health or alcohol/drug treatment (Include social service agencies and self-help groups):

| | **Past** | **Present** |
|---|---|---|
| None | _____ | _____ |
| Self, without help | _____ | _____ |
| AA | _____ | _____ |
| Al-Alon | _____ | _____ |
| Other counseling | _____ | _____ |
| Psychiatric | _____ | _____ |
| Chemical dependency | _____ | _____ |

Have you ever experienced feelings of depression or suicide? _____Yes _____No

Have you ever attempted suicide _____Yes _____No How many times?_____

By what method?_____If yes, were you hospitalized and when?
_____

Name, address and telephone number of a person to be contacted in case of emergency: **MUST HAVE**
_____
_____
_____
_____

**(Office Use)**

Type and amount of any medications brought to the 72 Hour Driver Intervention Program.
**TO BE COMPLETED AT BEGINNING OF DIP PROGRAM FOR THOSE CLIENT'S WHO HAVE MEDICATIONS.**

**Screening Instruments Administered**

First screening instrument used and results: **MAST-**_____

Second screening instrument used and results: **MORTIMER-**_____

## Recommendations for referral:

_____An Assessment

_____No Assessment needed

_____ _____
DIP Instructor's Signature/Credentials Date

**Individual Note (INTAKE/SCREENING):**_____

_____

_____ _____ _____
Counselor Signature/Credentials Date Time

## TO BE COMPLETED AT BEGINNING OF DIP PROGRAM

Baggage and materials brought to the DIP searched _____Yes _____No

Items taken from DIP participant during search_____

Items secured in locked box _____Yes _____No

Signature of staff who completed search_____Date_____

Baggage and materials brought to DIP searched upon discharge _____Yes _____No

Items taken from DIP participant during search_____

Signature of staff who completed search_____Date_____