Synthesis of Questions for the Four Main Substance Abuse Domains Based on CTP and HCP Intake Forms

Domain	Sub-domain	Data Concept	Synthesis of Question	List of values or follow-on question	List of values or follow-on question (1)	List of values or follow-on question (2)	List of values or follow-on question (3)	List of values or follow-on question (4)
Core Demographics - *not included in this spreadsheet*								
Extended Demographics - *not included in this spreadsheet*								
Addiction History & Status	Substances Abused	Abused substances	What substance(s) are you seeking treatment for? *Select all that apply* *NB. Some CTPs collect "drug of choice", but this is considered duplicative of the above question.*	multiple substances (based on Gateway CTP): Alcohol, Marijuana (Cannabis), Crack/cocaine, Hallucinogens (LSD), Ecstasy (MDMA), Ketamine ("Special K"), Mushrooms, Heroin, Meth/Amphetamines, Inhalants, PCP ("Angel Dust"), Roypnol ("Roofies"), GHB (Ga. Homeboy, G), Rx medication, Benzodiazepines, Tobacco/Nicotine (specify types - Cigarettes, Cigars, Pipe, Chewing Tobacco, Other), Oxycontin, Methadone/Other Opiates, Other Possible revisions or additions to terminology from other CTPs: Suboxone/Subutex, Non-prescription Methadone, Opiates and Synthetics, Sedative or Hypnotics, Stimulants, Tranquilizers, PCP, Over the Counter (OTC) medications, Inappropriate use of prescription medications, Caffeine				
			What substances have you ever used in your life? *Select all that apply* *NB. include alcohol, tobacco and drugs*	SEE multiple substances above				
		Age of first use	*Answer for each substance ever used.* What were your ages when you first used these substances?	SEE multiple substances above	age in years			
		When last used	*Answer for each substance ever used.* When did you last use these substances?	SEE multiple substances above	month and year OR last 3 months, last 6 months, last 1 year, last 2 years, last 5 years, more than 5 years ago			
		For adolescents or children only	*Question to be asked of parent/legal guardian* Do you feel the adolescent is currently using alcohol or drugs? OR Do you feel the child or his/her friends are currenly using alcohol or drugs?	Yes/No	If Yes, explain			
	Frequency & Route	Frequency of use	*Answer for each substance used in past 6 months.* In the past 6 months, what substances have you used and how frequently have they been used? *NB. Some CTPs limit this and following questions to the past 30 days*	SEE multiple substances above	Frequency: Less than once a month 1-3 days per month 1-2 days per week 4-6 days per week Daily			

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			What is the longest consecutive period of voluntary abstinence/sobriety in the past 12 months from using any mood altering drugs or alcohol? How did you maintain your voluntary abstinence/sobriety? *NB. exclude tobacco/nicotine*	Period: number of days, weeks or months, no abstinence/sobriety, or not applicable	Describe how abstinence/sobriety was maintained.			
		Route of use	*Answer for each substance used in past 6 months.* Of the substances used in the past 6 months, how were these taken?	SEE multiple substances above	Route: Drank/Swallowed Smoked, Chewed Injected (IV) Inhaled/Snorted *(Include other routes?)*			
			If any substance was injected in the past 6 months, did you share needles?	Yes/No				
		Pattern of use	*Answer for each substance used in past 6 months.* Of the substances used in the past 6 months, what best describes your pattern of use?	SEE multiple substances above	Pattern: Morning use Night use Weekend use Binge use *(Include other patterns?)*			
			What events are associated with your cravings and use? (e.g., holidays, anniversary of family deaths)	Events: major holidays anniversaries of family deaths birthdays other dates significant to you; explain___ *(Include other events?)*				
		Amount used (i.e., dose)	Of the substances used in the past 6 months, what is the typical amount you used at any one time?	multiple substances from LOV	Amount used: *(How should amount/dose be coded?)*			
	Addiction Severity	Dependence/Withdrawal/ Tolerance	Of the substances used in the past 6 months, what happens when you reduce or stop using?	SEE multiple substances above *(Is a breakdown by substances necessary?)*	Withdrawal symptoms: *(What typical symptoms should be included?)* *Suggestions: Seizures, Sweating, Racing heart, Palpitations, Muscle tension, Tightness of chest, Difficulty breathing, Tremor, Nausea/vomiting/diarrhea, Anxiety, Restlessness, Irritability, Insomnia, Headaches, Poor concentration, Depression, Social isolation* *Select all that apply*			

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			Which of the following describes your situation concerning substance use in the last 12 months?	Based on DSM-IV diagnostic criteria for dependence: >I experience loss of control >My efforts to reduce or control substance abuse have been unsuccessful >I spend significant time obtaining and/or using substance(s) or recovering from the effects >Important social, educational, occupational or recreational activties are given up or reduced due to substance use >I continue to use substance(s) despite recurrent psychological or physical problems caused or worsened by use	*NB. Some overlap with domain Family and Social Support*			
		Substance Abuse Consequences	Which of the following describes the consequences of your substance use in the last 12 months? *Select all that apply*	Based on DSM-IV diagnostic criteria for substance abuse: >Recurrent substance use has resulted in failure to fulfill major role obligations at work, school or home >Recurrent substance use has occurred in situations in which it is physically hazardous (e.g., DUI or operating machinery while impaired) >Recurrent substance-related legal problems have occurred (e.g., arrests for possesion, DUI, or substance-related disorderly conduct) >Continued to use substance(s) despite having persistent or recurrent interpersonal problems caused or worsened by the effects of the substance(s) (e.g., arguments with spouse about consequences of intoxication, physical fights)	*NB. Some overlap with domain Family and Social Support and domain Legal/Criminal Justice Status*			
		Concerns	Which best describes your concerns regarding alcohol or drug use? *Select one*	>I have no concerns, but others have concerns (i.e., spouse, significant other or family member) >I am not sure if I have concerns >I have some concerns and I need options about what to do >I have many concerns and I need help now >I have concerns and have already begun to take actions >I need more information				
		Recognition of problem	At any time in your life, past or present, have you ever thought you might have a problem with alcohol or drugs?	Yes/No	If Yes, explain			
			Has your substance use had a negative consequence on your life?	Yes/No	If Yes, explain			
			Has your substance use resulted in emotional or behavioral concerns?	Yes/No	If Yes, explain			

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		Family history	Is there any family or household history of substance abuse or dependence? *NB. include alcohol, tobacco and drugs*	Yes/No	If Yes, explain			
		Multi-question index - consider complete instrument	SEE Addiction Severity Index (Lite)					
		Multi-question screen - consider complete instrument	SEE Modified Mini Screen (MMS Rev.6/05)					
		Gambling	During the past 6 months have you made repeated, unsuccessful attempts to stop gambling?	Yes/No	If Yes, explain	*NB. Some overlap with domain Legal/Criminal Justice Status*		
			Have you felt depressed or suicidal because of your gambling losses?	Yes/No	If Yes, explain			
			Have you lost an important relationship or vocational/educational opportunity because of your gambling?					
			During the past 6 months how often have you gambled?	*Develop code list?* *Suggestions:* *1-3 times per month* *1-3 times per week* *4 or more times per week*				
			How old were you when gambling became a problem?	Age in years				
			Have you ever received treatment for gambling and when?	Yes/No	If Yes, explain and provide month and year			
Addiction Treatment History & Status	Addiction Treatment Hx	Previous treatments	Have you ever had previous treatment, education or diversion for substance abuse?	Yes/No □	Specify which: treatment, education, diversion. *Select all that apply*	Specify substances: alcohol, tobacco or drugs. *Select all that apply*		
			How many times and when have you had detox/rehab treatment?	number of times	for each time, provide length of stay/treatment	for each time, provide start month and year		
			How many times and when have you had MMTP/BUP treatment programs?	number of times	for each time, provide length of stay/treatment	for each time, provide start month and year		
			How many times and when have you had outpatient treatment?	number of times	for each time, provide length of stay/treatment	for each time, provide start month and year		
			How many times and when have you had residential/inpatient treatment?	number of times	for each time, provide length of stay/treatment	for each time, provide start month and year		
			What was helpful and not helpful about your previous treatment experience?	Explain *Develop code list?*				
			Have you ever participated in Alcoholic Anonymous (AA) or Narcotics Anonymous (NA)? How many times did you attend per week and when was the last time?	Yes/No.	Number of times per week	Last time: month, year		
			What did you like and not like about your AA/NA participation?	Explain *Develop code list?*				
		Quitting or Reducing Use	Have you attempted to quit, cut down or stop substance use?	Yes/No □	If Yes, who helped support this attempt? Who helped: family, friends, support group, on my own	If yes, how long have you been attempting to quit, cut down or stop substance use? Years: less than 1, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or more		
			Have you ever been treated for withdrawal?	Yes/No □				

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	Current Treatment Status	Why do you use subtances	Why do you use drugs or alcohol? *Select all that apply*	Reason: To make friends easier, To feel accepted by others, To feel more confident or in control, To defly my parents, To feel comfortable with sex, To deal with anger, To relieve depression, To relax or unwind, To be less critical of self, To help me sleep, To feel happy, To avoid things, To feel more alert, To feel more tolerant of others, Other	If Other, specify reason			
		Why use restarted	Why did you restart drug or alcohol use? *Select all that apply*	Reason: Depression, Anxiety, Stress, Boredom, Thought I could control it, Cravings, Friends, Missed the effects, Stopped going to treatment, Stopped going to groups, Stopped taking medication, Probation done, Don't know, Other	If Other, specify reason			
		Stress contributors	What stress in your life may contribute to the potential for relapse?	Stress: Environmental, Situational Crisis, Life Style Changes, Lack of Support System, Emotional Bond Disruption, Domestic Violence, Death, Traumatic Injury, Biological Changes, Interpersonal Difficulty, Physiological, Academic, Pain, Fear, Divorce, Relocation, Grief/Loss, Other	If Other, specify			
		Ability to control	Do you think you could quit, cut down or stop use for awhile?	Yes/No	Explain			
			Does patient see a need to address these concerns in treatment?	Yes/No	Explain, including the patient's attitudes			
	Recovery Goal or Vision	Hope	Do you have a sense of hope for the future?	Yes/No	Explain			
		Reason seeking treatment	What is your main reason for seeking treatment? *Select one*	Main Reason: Work related problem, School related problem, DUI/DWI, Other legal problems, Life out of control, Marital/Family problem, Want to quit, Medical problems, Other	If Other, specify reason			
		Expectations/Readiness	What does patient desire as an outcome therapy?	Explain. *Develop code list?*				
			What does patient desire to change?	Explain. *Develop code list?*				
			What is patient's reasons given for this change?	Explain. *Develop code list?*				
			What does patient state needs to change?	Explain. *Develop code list?*				
			What is patient willing to address in treatment?	Explain. *Develop code list?*				
		Improvement indicators	Has the patient shown improvement since the last evaluation and by what indicators?	Yes/No	If Yes, select all indicators where there was improvement: Reduced use of prescription opiates, Reduced illegal use of non-prescription opiates, Reduced illegal use of durgs other than opiates, Reduced criminal behavior, Reduced risk of spreading infectious diseases, Reduced abuse of alcohol, Improved schooling or training, Improved employment, Improved family relationships, Other	If Other, specify		

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	Current Treatment Plan	Self-help	Are you currently attending a self-help group?	Yes/No	If Yes, select self-help group. *Develop code list for self-help groups?*			
		Recent non use	If applicable, why did you not use substances in the 30 days prior to admission?	Reasons: Recovery with risk of relapse, Patient reports no problem, Self-initiating detoxification, Incarcerated/Institutionalized, Inpatient treatment program, SWI/DUI/OUI client, Medication, Other, Not applicable	If Other, specify reason			
		Strengths/motivation	What strengths or motivations for change will be useful in meeting the desired goal(s)?	Explain				
		Barriers	What barriers are there to meeting the desired goal(s)?	List all barriers *Develop code list?*				
		Supporting persons	Identify specific people who may be supportive and helpful and should be invited to be part of the patient's ongoing team.	Name and contact information *NB. Because of privacy concerns should this information be collected in the EMR?*				
		Contact for immediate assistance	Identify the person who should be contacted if the patient needs immediate assistance before the next appointment (e.g., family member, legal support, guardian, significant other).	Name and contact information *NB. Because of privacy concerns should this information be collected in the EMR?*				
		Documentation needed	Identify documentation that is needed to assist in the ongoing assessment and service planning (e.g., medical records, IEP, probation report)	*Develop code list? Suggestions: Medical records, IEP, Probation report, Other*	If Other, specify document			
		Individualized Treatment Plan and Review (i.e., service plan)	*Consider using existing instruments. SEE Axis I-V.*					
		For each 'Life Area' address the same questions :	Life Areas:	Describe problem identified or deferred	Provide treatment goal in general terms	Objectives to be achieved. *Provide three - be specific and use measurable terms.*	Integrated program of therapies and activities to meet objectives. *Provide three.*	Target dates for therapies/objectives (month, day, year)
			Chemical Dependence	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Daily Living Skills	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Legal	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Education/Vocation	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Employment	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Family/Social/Leisure	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			HIV Risk/Sexuality	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Medical/Health/Nutrition	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Mental Health/Lethality	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Housing	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Spirituality	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Domestic Violence	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
			Other	*same as above*	*same as above*	*same as above*	*same as above*	*same as above*
		Patient action items:	Describe those things the patient agrees to do before the next appointment.	Describe				
		Staff/team action items:	Describe those things the staff or team agrees to do before the next appointment.	Describe				
General Health - *not included in this spreadsheet*								
Mental Health - *not included in this spreadsheet*								

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Family and Social Support	Family, Marital and Interpersonal Relationships	Drug or alcohol use by family members	Has anyone in your family ever had a problem with drugs or alcohol?	Yes/No	If Yes, specify: Husband, Wife, Mother, Father, Brother, Sister, Grandparent, Aunt/Uncle, Step parent, Your children, Other *Select all that apply*	Explain problem		
		Emotional problems by family members	Has anyone in your family ever had an emotional or behavioral problem?	Yes/No	If Yes, specify: Husband, Wife, Mother, Father, Brother, Sister, Grandparent, Aunt/Uncle, Step parent, Your children, Other *Select all that apply*	Explain problem		
			Has anyone in your family attempted or committed suicide?	Yes/No	If Yes, specify: Husband, Wife, Mother, Father, Brother, Sister, Grandparent, Aunt/Uncle, Step parent, Your children, Other *Select all that apply*			
		Marital status	What is your current marital status or relationship?	Never married, Married, Separated, Divorced, Widowed, Living together as married, Same sex partner *(Does code list need revision?)*	Legal custody: Yes/No	Explain level of contact		
		Children	Do you have children?	If Yes, do you have legal custody and what level of contact do you have with them?				
		Substance abuse related conflicts with family members	Has your use of drugs or alcohol caused conflicts or disruption between yourself and other family members?	Yes/No	If Yes, explain the conflict	How troubled you have been by this conflict?		
		Conflicts with friends	Has your use of drugs or alcohol caused you to have arguments with or lose friends?	Yes/No	If Yes, explain			
		Drug or alcohol use by new friends	Do you use drugs or alcohol with any new friends made in the last 6 months?	Yes/No	If Yes, explain			
		Family violence	Has there been any domestic violence in your family?	Yes/No	If Yes, explain			
		Abuse	Have you been abused or have you abused other family members?	Yes/No	If Yes, explain			
	Social Support, including Community, Cultural, Spiritual	Adequacy of support	Who is your support system?	Support: Family, Friends, Community organization, Church or other spiritual organization, Support group *Select all that apply* *(Is code list sufficient?)*				
			Which best describes your current needs?	Needs: Can abstain on own, Need encouragement, Need supervision, Need structure and supervision, or for safety risk				
			Do you feel that your current social support is adequate?	Yes/No	If no, explain			
		Family support in treatment	Do you have family members who may wish to support you in treatment?	Yes/No	If Yes, specify: Husband, Wife, Mother, Father, Brother, Sister, Grandparent, Aunt/Uncle, Step parent, Your children *Select all that apply*			
			Do you have friends who would support you in treatment or in a lifestyle without drugs or alcohol?	Yes/No				
		Community or cultural support	Do you believe in God or a Higher Power?	Yes/No	If Yes, explain the role of your belief in your life and recovery			

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			Do you practice a religion or identify with any religious or spiritual groups?	Yes/No	If Yes, specify: Christian - Protestant, Christian - Catholic, Christian - other, Jewish, Buddhist, Hindu, Other, Choose not to answer			
			Are there cultural groups you are comfortable with that may be supportive? *Consider groups, clubs, teams, organizations, etc.*	Yes/No	If Yes, identify			
			If family or friends are not supportive, would you be willing to seek support from others?	Yes/No				
			Do you attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings?	Yes/No	If Yes, do you feel they are helpful? Explain	*NB. Some overlap with domain Addiction Treatment History & Status*		
			For adolescents: Are you involved in Adolescent Counceling Services (ACS)?	Yes/No	If Yes, do you feel it is helpful? Explain			
	Housing/Homeless Status	Housing/Homelessness	Are you currently homeless or have you been homeless in the past 30 days?	Yes/No	If Yes, explain.			
			What is your current housing arrangement?	> Live in own residence > Live in residence of children or other family members > Live in public housing > Live in mission or shelter > Out of home placement > Homeless > Other	If Other, specify			
			Are you satisfied with your current housing arrangement?	Yes/No	If No, explain why not			
			Are there transportation or other barriers to care?	Yes/No	If Yes, identify			
			Do others in your current home use drugs or alcohol?	Yes/No	If Yes, explain			
	Leisure & Recreation Status	Leisure activities	Are you active in community or recreational activities?	Yes/No	If Yes, specify			
			Have you given up recreation or leisure activities because of drug or alcohol use?	Yes/No	If Yes, explain why			
			What activities do you like to do for leisure or fun?	Activities: Gardening, Hunting/Fishing/Camping, Reading, Skiing, Golf, TV Watching, Hobbies, Music, Movies, Time with Family, Drinking/Using/Partying, Video/Computer games, Exercising, Other, None *(Is such a detailed code list useful?)*				
			What are your strengths, interests or the things that make you feel good about yourself or make your life meaningful? *Consider interests, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, club, culture, work, school, etc.*	Explain *Develop code list?*				
			Do you gamble at all? *Include playing the lottery*	Yes/No	If Yes, do you feel that gambling is a problem for you?			
			With whom do you spend most of your leisure time?	Whom: Family, Friends, Alone				
Daily Living Skills - *not included in this spreadsheet*								

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Legal/Criminal Justice Status	Legal/Criminal Justice History	Legal status	Do you have any legal charges pending?	Yes/No	If Yes, explain. Provide court date if applicable.			
			Have you been arrested in the past 6 months?	Yes/No	If Yes, how many times have you been arrested?	Explain		
			Have you ever been in prision?	Yes/No	If Yes, for what charges			
			Are you currently on probation or parole?	Yes/No	If Yes, explain. Provide period remaining on probation or parole.			
			Have you ever been convicted of a drug or alcohol related criminal offense?	Yes/No	If Yes, specify: Operating under influence (DWI/DUI/OUI), Minor in Possession, Drug Possession, Assault, Sexual Offense, Theft, Other *Select all that apply*	For each criminal offense, indicate how many times	*NB. Some overlap with domain Addiction Treatment History & Status*	
			How serious do you feel your present legal problems are?	*Suggested values:* Very, Moderately, Not at all				
		Driver's license	Do you have a valid driver's license?	Yes/No				
		Judicial order/mandate	Are you currently subject to any judicial order or mandate? *(include court ordered treatment)*	Yes/No	If Yes, explain			
		Gambling	Have you lost considerable sums of money or had problems at work, in school or with family or friends as a result of your gambling?	Yes/No	If Yes, explain			
	Child Protective Services Status	Child in custody, applicable to child/adolescent	Is the child/adolescent currently in the custody of Child Protective Services (CPS)?	Yes/No	If Yes, explain			
			Has the child/adolescent had prior involvement with Child Protective Services (CPS)?	Yes/No	If Yes, explain			
			What is the child/adolescent's perception of his/her parents, siblings, and/or family?	Explain *(Develop code list?)*				
			What is the child's/adolescent's perception of his/her relationship with his/her parents, siblings and/or family?	Explain *(Develop code list?)*				
			What are the child's/adolescent's feelings, sense of attachment, trust, security, love and affection toward his/her parents or guardian?	Explain *(Develop code list?)*				
			What is the general presentation for children 0-3 years of age?	Presentation: Crying, Clingy, Hard to soothe, Regressed, Tantruming, Disengaged, Head-banging *Select all that apply*				
			What is the general presentaation for children 4 years of age and older?	Presentation: Listless/Withdrawn, Disinterested, Anxious, Fearful, Angry, Labile, Fussy, Shocked, Hearing *Select all that apply*				
		Child in custody, applicable to parents or gardian	What are the reasons for removing the child/adolescent from the parents or guardian?	Explain *(Develop code list?)*				
			Are there other siblings or other children in the family and/or living in the same home?	Yes/No	If Yes, specify and include number: brother, sister, other			
			Are other siblings or other children n the family/home victims of abuse?	Yes/No	If Yes, has Child Protective Services (CPS) removed them?	Explain		