Tidewater Psychotherapy Services Substance Use Group/IOP Contract

1. Participants are expected to attend all group/IOP sessions and be on time to stay in program. Significant and /or repeated tardiness or excessive absences may result in termination from the program. Any episode of noncompliance could result in termination. The treatment team will review each situation on a case by case basis.
2. Participants are expected to abstain from alcohol and any unauthorized or illegal mood-altering drugs while in the program. Under no circumstances should participants attend group sessions under the influence of alcohol or drugs.
3. Weekly urine drug and alcohol screens are required and. Positive drug or alcohol screens will require further testing may result in referral to more intensive treatment.
4. Each patient’s prescription history will be verified by accessing the multi state Prescription Monitoring Program.
5. It is RECOMMENDED that program participants attend Alcoholics Anonymous or Narcotics Anonymous meetings weekly. Attendance at these meeting will be discussed during weekly group sessions.
6. Participants are required to treat each other with respect and safeguard each other’s confidentiality to ensure the safety required for open and honest discussion in the group. Confidentiality of this discussion is required.
7. Participants are expected to take an active part in defining their goals and objectives for the program. Each participant is personally responsible for his or her own recovery
8. Participants agree to work actively in the group, with emphasis on understanding their past and recent substance abuse problems and issues and establishing a game plan to avoid similar problems in the future. Participants will complete assigned work and bring it to group sessions on a timely basis.
9. Participants, who are required to have their involvement and progress in treatment shared with a referral source, must complete and sign an authorization to release information.
10. Participants may be discharged from the program for failure to comply with the program rules, including but not limited to: non payment, no shows, non compliance, if their group involvement is disruptive to the other group members. Violation of program rules will require a re-negotiation or revocation of the contract.
11. Individual and / or family counseling is also available to group members (this can be paid for through your insurance coverage( co-pay applies)
12. Participants will be charged $50 for each instance of not attending a group session without at least 24 hours prior notice unless prohibited by their health insurance/entitlement program coverage. Multiple absences may result in referral to more intensive treatment or discharge from the group and termination of Suboxone treatment. (Suboxone is a medication used in the treatment of addiction to opiates. The overall goal is to achieve a life free from all addictive substances, and tapering off Suboxone within 12 months. Therapy is a required part of this treatment program.)

I have read and understand the requirements for participation in the Tidewater Psychotherapy Services Group/IOP program and have determined goals for treatment. I agree with and indicate my intent to adhere to this contract with my signature below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature Client Printed Name Date**

Tidewater Psychotherapy Services Substance Use Group/IOP Intake

1. Which substance do you use regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is your primary substance of choice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How old were you when you first experienced substance use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. When did you start using regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What amounts are/were you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. How frequently \_\_\_\_daily\_\_\_\_\_weekly\_\_\_\_\_monthly?
7. When did you notice significant increase\_\_\_\_\_\_\_\_\_\_decrease\_\_\_\_\_\_\_\_\_\_?
8. When did you last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. What is the longest period or use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Abstinence (and when)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. What is your family history of substance use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. What are your currently medical conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. What are your current mental health symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. What is your current housing condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. What is your current employment condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
15. How would you rate your readiness to change? (circle one) Poor – Marginal - Fair – Guarded - Positive
16. What is your relapse history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
17. Who is currently involved in you care? PCP-NA-AA-Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
18. Who is involved as your support team? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tidewater Psychotherapy Services Patient and Family Health Questionnaire** **I decline participation**

**Have you or anyone in your family had a problem or condition in the following areas: in the following questionnaires**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Self | Family |  | Self | Family | Comments |
| Allergies |  |  | Abnormal Bleeding |  |  |  |
| Drugs or Medication Reaction |  |  | Blackouts |  |  |  |
| Tics or Tremors |  |  | High Blood Pressure |  |  |  |
| Seizures |  |  | Kidney problems |  |  |  |
| Asthma |  |  | Cancer |  |  |  |
| Thyroid Problems |  |  | Substance Use Disorder |  |  |  |
| Heart Disease |  |  | Bipolar |  |  |  |
| Epilepsy |  |  | Suicide |  |  |  |
| Diabetes |  |  | Mental Retardation |  |  |  |
| Chronic Pain Syndrome |  |  | Schizophrenia |  |  |  |
| 6 month post-partum |  |  | Eating Disorders |  |  |  |
| HIV |  |  | ADD.ADHD |  |  |  |
| Hepatitis |  |  | Nervous Breakdown |  |  |  |
| TB |  |  | Depression |  |  |  |
| STD’s |  |  | Anxiety |  |  |  |
| Nervous breakdown |  |  |   |  |  |  |

**Are you or anyone in your family affected by handicaps or restriction on physical activity?**

|  |  |  |
| --- | --- | --- |
| Self | Others | Comments |
|  |  |  |

**Any past hospitalizations for illness or surgeries?**

|  |  |  |
| --- | --- | --- |
| Self | Others | Comments |
|  |  |  |

**Chronic health conditions or health problems by siblings, parents or other household members?**

|  |  |  |
| --- | --- | --- |
| Self | Others | Comments |
|  |  |  |

**«ApptResDesc» «ApptDate» «ApptTime» «ApptTypeDesc» Patient #:«PNumber» Patient Name: «PName»**

**Tidewater Psychotherapy Services Patient and Family Health Questionnaire** **(continued)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please rate your health during the past 4 weeks in the following areas:** | **Excellent** | **Very****Good** | **Good** | **Fair** | **Poor** | **Very** **Poor** |
| **Overall health?** |  |  |  |  |  |  |
|  **How would you rate your present fitness level?** |  |  |  |  |  |  |
|  **What is your commitment to regular exercise?** |  |  |  |  |  |  |
| **How well can you identify barriers to regular daily exercise?** |  |  |  |  |  |  |
| **Rate your understanding of the effects of exercise on your health and mood?** |  |  |  |  |  |  |
| **How would your rate your present nutrition level?** |  |  |  |  |  |  |
| **How do you rate your knowledge of healthy meal planning?** |  |  |  |  |  |  |
| **What is your understanding or calorie intake ant the effects on health?** |  |  |  |  |  |  |
| **Rate your ability to limit binge or overeating activities?** |  |  |  |  |  |  |
| **What is your level of access to health foods vs. low cost high fat foods?** |  |  |  |  |  |  |
| **Your ability to get at least 6-8 hours of sleep at night?** |  |  |  |  |  |  |
| **What is your present level of access to a sleep environment with no TV?** |  |  |  |  |  |  |
| **How would you rate your ability to limit Alcohol intake prior to sleep?** |  |  |  |  |  |  |
| **Your ability to practice relaxation techniques prior to sleep?** |  |  |  |  |  |  |
| **Rate your access to hobbies that help you relax?** |  |  |  |  |  |  |
| **How would you rate your ability to find activates/hobbies that help you manage stress?** |  |  |  |  |  |  |
| **Describe your ability to find time to regularly engage in social interaction?** |  |  |  |  |  |  |
| **Rate your ability to regularly be part of a social or faith based group?** |  |  |  |  |  |  |
| **What is your ability to recognize barriers to your emotional health?** |  |  |  |  |  |  |
| **What is the current level of your support system?** |  |  |  |  |  |  |
| **Rate your ability to seek out help/support for your overall health?** |  |  |  |  |  |  |

**Please list all mediations both prescription and over the counter:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Strength | Dosage | Who prescribes this medicine? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Do you have an Advance Directive? I.e. living well, do not resuscitate orders?**  Yes or No (circle one)

**«ApptResDesc» «ApptDate» «ApptTime» «ApptTypeDesc» Patient #:«PNumber» Patient Name: «PName»**

|  |
| --- |
| **Tidewater Psychotherapy Services Patient and Family Health Questionnaire** **(continued)****The Alcohol Use Disorders Identification TestRead questions as written.** |
| 1. How often do you have a drink containing alcohol? |  |
| **\*Questioner may skip remaining questions, if reply to Question 1 is never, or if both answers to 2 and 3 are 0**. |
| 2. How many units of alcohol do you drink on a typical day when you are drinking? |  |
| 3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? |  |
| AUDIT-C Score /12 (complete full questionnaire if score is 3 or more) |  |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? |  |
| 5. How often during the last year have you failed to do what was normally expected from you because of drinking? |  |
| 6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? |  |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? |  |
| 8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? |  |
| 9. Have you or someone else been injured as a result of your drinking? |  |
| 10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? |  |
| The Alcohol Use Disorders Identification Test (AUDIT) Score = /40 Scores of 8 or more are considered an indicator of hazardous and harmful alcohol use |  |

**«ApptResDesc» «ApptDate» «ApptTime» «ApptTypeDesc» Patient #:«PNumber» Patient Name: «PName»**

**Tidewater Psychotherapy Services Tobacco Dependence Questionnaire**

Please circle one answer on each question. **\*Questioner may skip remaining questions, if reply to Question 1 is never**

|  |
| --- |
| How many cigarettes *[times]* per day do you usually smoke *[use your electronic cigarette]?a ([assume that one “time” consists of around 15 puffs or lasts around 10 minutes]*) (Scoring: 0–4 times/day = 0, 5–9 = 1, 10–14 = 2, 15–19 = 3, 20–29 = 4, 30+ = 5) |
| 2. On days that you can smoke *[use your electronic cigarette]* freely, how soon after you wake up do you smoke your first cigarette of the day *[first use your electronic cigarette]*?a (Scoring: 0–5 minutes = 5, 6–15 = 4, 16–30 = 3, 31–60 = 2, 61–120 = 1, 121+ = 0) |
| 3. Do you sometimes awaken at night to have a cigarette *[use your electronic cigarette]*?b (Scoring: Yes = 1, No = 0) |
| 4. If yes, how many nights per week do you typically awaken to smoke *[use your electronic cigarette]*?b (Scoring: 0–1 nights = 0, 2–3 nights = 1, 4+ nights = 2) |
| 5. Do you smoke *[use an electronic cigarette]* now because it is really hard to quit? (Scoring: Yes = 1, No = 0) |
| 6. Do you ever have strong cravings to smoke *[use an electronic cigarette]*?c (Scoring: Yes = 1, No = 0) |
| 7. Over the past week, how strong have the urges to smoke *[use an electronic cigarette]* been (Scoring: None/Slight = 0, Moderate/Strong= 1, Very Strong/Extremely Strong = 2) |
| 8. Is it hard to keep from smoking *[using an electronic cigarette]* in places where you are not supposed to? (Scoring: Yes = 1, No = 0) |
| When you haven’t used tobacco *[an electronic cigarette]* for a while or when you tried to stop smoking *[using]*…9. Did you feel more irritable because you couldn’t smoke *[use an electronic cigarette]*?c (Scoring: Yes = 1, No = 0) |
| 10. Did you feel nervous, restless, or anxious because you couldn’t smoke *[use an electronic cigarette]*?c (Scoring: Yes = 1, No = 0) |

[View it in a separate window](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4838001/table/TB1/?report=objectonly)

Total scoring: 0–3= not dependent, 4–8 low dependence, 9–12 medium dependence, 13+ = high dependence

**Tidewater Psychotherapy Services Drug Use Screening Questionnaire (DAST-10)**

The following questions concern information about your possible involvement with drugs not related to alcoholic beverages during the past **12 months.** Carefully read each statement and decide if you answer is “Yes” of “No”. The circle the appropriate response to the question.

**\*Questioner may skip remaining questions, if reply to Question 1 is no.**

 Circle your response

Have you used drugs other than those required for medical reasons? Yes No

Do you abuse more than one drug at a time? Yes No

Are you always able to stop using drug when you want to? Yes No

Have you had “blackouts” or “flashbacks” as a result of drug use? Yes No

Do you every feel bad or guilty about your drug use? Yes No

Does your spouse (or parents) ever complain about your involvement with drugs? Yes No

Have you neglected your family because of your use of drugs? Yes No

Have you engaged in illegal activities in order to obtain drugs Yes No

Have you ever experience withdrawal symptoms when you stopped taking drugs? Yes No

Have you had medical problems as a result of your drug use? Yes No

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**Tidewater Psychotherapy Services PHQ-9**

Over the last two weeks, how often have you been bothered by any of the following problems?

Use check to indicate your answer:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at All | Several Days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things
 |  |  |  |  |
| 1. Feeling down, depressed, or hopeless
 |  |  |  |  |
| 1. Trouble falling or staying asleep, or sleeping too much
 |  |  |  |  |
| 1. Feeling tired or having little energy
 |  |  |  |  |
| 1. Poor appetite or overeating
 |  |  |  |  |
| 1. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
 |  |  |  |  |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television.
 |  |  |  |  |
| 1. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.
 |  |  |  |  |
| 1. Thoughts that you would be better off dead or of hurting yourself in someway
 |  |  |  |  |

For office coding \_\_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_\_\_

 = Total Score: \_\_\_\_\_\_\_\_\_\_\_\_

If you checked off any problems, how difficulty have these problems made it for you to do your work, take care of things at home, or get along with other people: (circle one)

 Not difficult at all somewhat difficult Very difficult Extremely Difficult