

Alabama Department of Mental Health
Substance Abuse Division
UNCOPE SCREENING - Electronic Version
(AGE 18 AND ABOVE)

Completed By: _____
Date of Screening: ____/____/____
Date of Entry: ____/____/____

ASAIS ID: _____ Provider ID: _____

Name: _____
Last First Middle Maiden

Alias 1: _____ Alias 2: _____

What is the most important thing you want that made you decide to call for help:

Presenting Problems: (check all that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Abuse Victim | <input type="checkbox"/> Depressive/Mood Disorder | <input type="checkbox"/> Marital | <input type="checkbox"/> Somatic |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Medical | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Assault Victim | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Rape Victim | <input type="checkbox"/> Thought Disorder |
| <input type="checkbox"/> Criminal Justice | <input type="checkbox"/> Family | <input type="checkbox"/> Runaway Behavior | <input type="checkbox"/> None |
| <input type="checkbox"/> Daily Coping | <input type="checkbox"/> Interpersonal | <input type="checkbox"/> Social | <input type="checkbox"/> Other: _____ |

Date of Birth: _____ Age: _____

SSN#: _____ Medicaid #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County of Residence: _____ Emergency Contact: _____

Home Phone: _____ Work Phone: _____

- | | | | |
|-------------------------------------|---|---|--|
| Sex: | Race: (Check one box) | Ethnicity: (Check one box) | Marital Status: ____ yr(s) ____ mo(s) |
| <input type="checkbox"/> Female – F | <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Cuban | <input type="checkbox"/> Common Law |
| <input type="checkbox"/> Male – M | <input type="checkbox"/> American Indian | <input type="checkbox"/> Hispanic-Specific Origin not Specified | <input type="checkbox"/> Divorced |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> Mexican | <input type="checkbox"/> Married |
| | <input type="checkbox"/> Black / African American | <input type="checkbox"/> Not of Hispanic Origin | <input type="checkbox"/> Never Married |
| | <input type="checkbox"/> Caucasian / White | <input type="checkbox"/> Other Specific Hispanic | <input type="checkbox"/> Separated |
| Veteran: | <input type="checkbox"/> Multi-Racial | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Native Hawaiian / Other Pac Island | <input type="checkbox"/> Unknown | Number of Marriages: _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> Other _____ | | |

Language Preference: If other than English, please specify: _____

- Linguistic Status:**
- | | |
|--|--|
| <input type="checkbox"/> Cognitive Disability | <input type="checkbox"/> Low Literacy Level |
| <input type="checkbox"/> English Proficiency | <input type="checkbox"/> Not Literate |
| <input type="checkbox"/> Limited English Proficiency | <input type="checkbox"/> Other Disability: _____ |

Hearing Status: Hearing Hard of Hearing Deaf

- Referral Source:**
- | | | |
|---|---|--|
| <input type="checkbox"/> AOD Treatment, Inpatient/Residential | <input type="checkbox"/> Guardian | <input type="checkbox"/> Private Psychiatrist |
| <input type="checkbox"/> AOD Treatment, Not Inpatient | <input type="checkbox"/> ID 310 Program | <input type="checkbox"/> Probation/Parole |
| <input type="checkbox"/> Clergy | <input type="checkbox"/> ID ARC | <input type="checkbox"/> Recognized Legal Entity |
| <input type="checkbox"/> Court / Correctional Agency | <input type="checkbox"/> ID Regional Office | <input type="checkbox"/> School System |
| <input type="checkbox"/> DHR | <input type="checkbox"/> Multi-Service MH Agency | <input type="checkbox"/> Self |
| <input type="checkbox"/> Diversionary Program/TASC | <input type="checkbox"/> Outpatient Psych Services/Clinic | <input type="checkbox"/> Shelter for the Abused |
| <input type="checkbox"/> DUI / DWI | <input type="checkbox"/> Nursing Home/Extended Care | <input type="checkbox"/> Shelter for the Homeless |
| <input type="checkbox"/> Educational Agency | <input type="checkbox"/> Parent | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Employer / EAP | <input type="checkbox"/> Partial Day Organization | <input type="checkbox"/> State/County Psych Hospital |
| <input type="checkbox"/> Family | <input type="checkbox"/> Personal Care/Boarding Home | <input type="checkbox"/> State/Federal Court |
| <input type="checkbox"/> Formal Adjudication Process | <input type="checkbox"/> Physician | <input type="checkbox"/> Voc Rehab Services |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Police | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> General / Psychiatric Hospital | <input type="checkbox"/> Prison | |

Which is the primary referral source? _____ Secondary? _____

Reason for Referral: _____

ASAS ID: _____	LAST NAME: _____	FIRST NAME: _____	MI: _____
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Financial I receive my principal source of income from:

- Disability
 Public Assistance
 Retirement/Pension
 Wages/Salary
 None
 Other: _____

Annual Income: _____

Source of Payment:

- Blue Cross/Blue Shield
 Medicare
 Personal Resources (Self/Family)
 DMH
 No Charge (free, charity, special research or teaching)
 Service Contract (EAP, HMO, public mental health authority)
 Health Insurance Companies (Not BCBS)
 Other Government Payments: _____
 Worker's Compensation
 Medicaid

Insurance Do you have:

- Blue Cross/Blue Shield
 Other (e.g. Tricare, Champus): _____
 Health Maintenance Organization (HMO)
 Private Insurance
 Medicaid
 Unknown
 Medicare
 None

Name of Company: _____

Policy Number: _____

Group Number: _____

Special
Population:
 IV Drug User
 Pregnant Women
 Women w/dependent child
 Not applicable

UNCOPE – Age 18 and Above

 In the past year, have you ever drank or used drugs more than you meant to^{1,2}:

- YES
 NO

 Have you ever neglected some of your usual responsibilities because of alcohol or drugs²:

- YES
 NO

 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year^{1,2}:

- YES
 NO

 Has anyone objected to your drinking or drug use?^{3,1} OR has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use²:

- YES
 NO

 Have you ever found yourself preoccupied with wanting to use alcohol or drugs?² OR Have you found yourself thinking a lot about drinking or using:

- YES
 NO

 Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom^{2,1}:

- YES
 NO

Number of Positive Responses: _____ (Two or more positive responses indicate possible abuse or dependence. Four or more positive responses strongly indicate dependence.)

 1. Brown, R. L., Leonard, T., Saunders, L. A., & Papasouliotis, O. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, (2), 151-160.

 2. Hoffmann, N. G. & Harrison, P. A. (1995). *SUDDS-IV: Substance Use Disorders Diagnostic Schedule*. Smithfield, RI: Evince Clinical Assessments.

 3. Hoffmann, N. G. (1995). *TAAD: Triage Assessment for Addictive Disorders*. Smithfield, RI: Evince Clinical Assessments.

ASAIS ID: _____

LAST NAME: _____

FIRST NAME: _____

MI: _____

MINI SCREEN 6.0.0

If YES, go to the corresponding M.I.N.I. module

- | | | |
|---|--|------------|
| <p>➤ Have you been depressed or down, most of the day, nearly every day, for the past two weeks?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → A |
| <p>➤ In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → A |
| <p>➤ In the past month did you think that you would be better off dead or wish you were dead?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → B |
| <p>➤ In the past month have you thought about killing yourself?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → B |
| <p>➤ Have you ever had a period of time when you were feeling 'up' or 'high' or 'hyper' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → C |
| <p>➤ Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → C |
| <p>➤ Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells surge to a peak, within 10 minutes of starting?
CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES.</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → D |
| <p>➤ Did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → D |
| <p>➤ Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult: like being in a crowd, standing in a line (queue), when you are away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → E |
| <p>➤ In the past month did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → F |
| <p>➤ In the past month have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (e.g., the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.)</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → G |
| <p>➤ In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, or arranging things, or other superstitious rituals?</p> | <input type="checkbox"/> NO <input type="checkbox"/> YES | → H |

ASAIS ID: _____

LAST NAME: _____

FIRST NAME: _____

MI: _____

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

- Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER. NO YES
- Did you respond to the trauma with intense fear, helplessness, or horror? → H
- During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)? → H
- In the past **12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? NO YES → I
- Now I am going to show you a list (**OR READ THE LIST BELOW**) of street drugs or medicines.* In the past **12 months**, did you take any of these drugs more than once, to get high, to feel elated, to get a buzz, or to change your mood? NO YES → J
- | | | | | |
|----------------|--------------------------|-------------------------|------------------|-----------------------------------|
| amphetamines | speed, crystal meth | Dexedrine®,
Ritalin® | diet pills, rush | THC, marijuana, cannabis, hashish |
| Cocaine, crack | steroids, GHB | Valium®, Xanax® | Ativan | barbiturates |
| heroin | morphine, methadone | opium, Demerol® | codeine | Percodan®, OxyContin®, Vicodin® |
| LSD, mescaline | PCP, angel dust, ecstasy | MDA, MDMA | ketamine | inhalants glue, ether |
- Have you ever believed that people were spying on you or that someone was plotting against you or trying to hurt you? NO YES
- Have you ever heard things other people couldn't hear such as voices? NO YES
- Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES
- How tall are you?
|_|_|_| inches
- What was your lowest weight in the past 3 months?
|_|_|_| lbs
- IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS/HER HEIGHT? NO YES → M
- | | | | | | | | | | | | |
|----------------|-----|------|------|------|-----|-----|-----|-----|-----|-----|-----|
| Height (ft in) | 4'9 | 4'10 | 4'11 | 5'0 | 5'1 | 5'2 | 5'3 | 5'4 | 5'5 | 5'6 | 5'7 |
| Weight (lbs) | 81 | 84 | 87 | 89 | 92 | 96 | 99 | 102 | 105 | 108 | 112 |
| Height (ft in) | 5'8 | 5'9 | 5'10 | 5'11 | 6'0 | 6'1 | 6'2 | 6'3 | | | |
| Weight (lbs) | 115 | 118 | 122 | 125 | 129 | 132 | 136 | 140 | | | |
- In the past **three months**, did you have eating binges or times when you ate a very large amount of food within a **2-hour** period? NO YES → N
- In the last **3 months**, did you have eating binges as often as twice a week? NO YES → N
- Were you **excessively** anxious or worried about several routine things over the past 6 months? NO YES → O

* ALL BRANDS LISTED ARE TRADEMARKS OF THEIR RESPECTIVE OWNERS