

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

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

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

**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   
 Service Contract (EAP, HMO, public mental  
teaching)   
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<sup>1,2</sup>:

- YES   
 NO

 Have you ever neglected some of your usual responsibilities because of alcohol or drugs<sup>2</sup>:

- YES   
 NO

 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year<sup>1,2</sup>:

- YES   
 NO

 Has anyone objected to your drinking or drug use?<sup>3,1</sup> OR has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use<sup>2</sup>:

- YES   
 NO

 Have you ever found yourself preoccupied with wanting to use alcohol or drugs?<sup>2</sup> 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<sup>2,1</sup>:

- 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.