

Alabama Department of Mental Health
Substance Abuse Division
CRAFT SCREENING – Electronic Version
(UNDER AGE 18)

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: _____

<p>Sex:</p> <input type="checkbox"/> Female – F <input type="checkbox"/> Male – M	<p>Race: (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>Ethnicity: (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>Marital Status: ____ 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: _____
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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: _____

ASAIS ID: _____	LAST NAME: _____	FIRST NAME: _____	MI: _____
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Financial I or my parents principal source of income is:

- 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

CRAFFT - Age Less Than 18

Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs:

- YES
 NO

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in:

- YES
 NO

Do you ever use alcohol or drugs while you are by yourself or alone:

- YES
 NO

Do you ever forget things you did while using alcohol or drugs:

- YES
 NO

Do your family or friends ever tell you that you should cut down on your drinking or drug use:

- YES
 NO

Have you ever gotten into trouble while you were using alcohol or drugs:

- YES
 NO

CRAFFT Score: _____

(Two or more positive responses is highly predictive of an alcohol or drug-related disorder.)

 SOURCE: Knight JR; Shrier LA; Bravender TD; Farrell M; Vander Bilt J; Shaffer HJ. (1999) A new brief screen for adolescent substance abuse. *Archives of Pediatrics and Adolescent Medicine Jun; 153(6)*. 591-6.