



## Enrollment Assessment First Offender Driver Alcohol Education

▶ **Enrollment Date:**     /     /  
   mm   dd   yyyy

▶ **ESM Client ID:**

▶ **Provider ID:**

Questions (Q) marked with ▶ must be completed.

Boxes marked with ★ = Refer to Key at end of form

<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>	<b>Suffix:</b>
▶ 1. <b>Client Code:</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	▶ 2. <b>Intake/Clinician Initials:</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
▶ 3. <b>Do you own or rent a house, apartment, or room?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If the answer to Q. 3 is Yes, skip to Q. 5</i>			
▶ 4. <b>Are you Chronically Homeless?</b> <i>(HUD Definition in Manual)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		▶ 5. <b>ZIP Code of Last Permanent Address:</b> <i>Do <b>Not</b> put zip code of Program. See Manual for definition of Permanent.</i>	
▶ 6. <b>Where did you stay last night?</b>			
1 <input type="checkbox"/> Emergency shelter	7 <input type="checkbox"/> Jail, prison or juvenile detention facility	13 <input type="checkbox"/> Foster care home or foster care group hm	
2 <input type="checkbox"/> Transitional housing for homeless persons	8 <input type="checkbox"/> Room, apartment, or house that you own or rent	14 <input type="checkbox"/> Place not meant for habitation	
3 <input type="checkbox"/> Permanent housing for formerly homeless	9 <input type="checkbox"/> Staying or living with a family member	15 <input type="checkbox"/> Other	
4 <input type="checkbox"/> Psychiatric hospital or other psych. facility	10 <input type="checkbox"/> Staying or living with a friend	88 <input type="checkbox"/> Refused	
5 <input type="checkbox"/> Substance abuse treatment facility or detox	11 <input type="checkbox"/> <b>Room, apartment, or house to which you cannot return (future return can be uncertain)</b>		
6 <input type="checkbox"/> Hospital (non-psychiatric)	12 <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher		
▶ 7a. <b>Do you consider yourself to be transgender?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
▶ 7b. <b>If you answered Yes to Q. 7a, please specify:</b> <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/> Other, specify _____			
▶ 8. <b>Do you consider yourself to be:</b> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Refused			
▶ 9. <b>Number of days between initial contact with program by client or someone on behalf of client and the first available appointment:</b> <i>(unknown = 999)</i> <i>See manual to help determine wait time.</i>			★ <input style="width: 50px;" type="text"/>
▶ 10. <b>Source of Referral:</b> 61 <input type="checkbox"/> Court -DUI     57 <input type="checkbox"/> Registry of Motor Vehicles     58 <input type="checkbox"/> Out of State DUI Referral     09 <input type="checkbox"/> Drunk Driving Prog (transfer)			
▶ 11. <b>Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Admission:</b> <input type="checkbox"/> <input type="checkbox"/>			★
▶ 12. <b>Client Type:</b> <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Collateral			
▶ 13. <b>Additional Client Type (Check ALL that apply)</b>			
<i>New</i> <input type="checkbox"/> Student	<input type="checkbox"/> Postpartum	<input type="checkbox"/> Methadone	<i>New</i> <input type="checkbox"/> Injectable Naltrexone <input type="checkbox"/> Parole <input type="checkbox"/> Federal Parole <i>(e.g. Vivitrol)</i>
<input type="checkbox"/> Pregnant	<i>Change</i> <input type="checkbox"/> Veteran/ Any Military Service	<i>Change</i> <input type="checkbox"/> Buprenorphine <i>(e.g. Suboxone)</i>	<input type="checkbox"/> Probation <input type="checkbox"/> Federal Probation
▶ 14. <b>Do you have children?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			<i>If answer to Q. 14 is 'Yes', complete 14a-14d. If no, skip to Q. 15</i>
14a. <b>Number Children Under 6:</b> <input type="checkbox"/>	14b. <b>Number of Children 6-18:</b> <input type="checkbox"/>	14c. <b>Children Over 18:</b> <input type="checkbox"/>	
14d. <b>Are any of the children of the Native American Indian race?</b>			1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No
▶ 15. <b>Are you the primary caregiver for any children?</b> <i>🚩 If yes, see manual. You must assess in clinical assessment!</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
▶ 16. <b>Employment status at Enrollment:</b> <input style="width: 50px;" type="text"/> ★		▶ 17. <b>Number of days worked in the past 30 days?</b> <input style="width: 50px;" type="text"/>	
▶ 18. <b>Where do you usually live? (Where has the client spent/slept most of the time over the last 12 months?)</b>			
1 <input type="checkbox"/> House or apartment	3 <input type="checkbox"/> Institution	5 <input type="checkbox"/> Shelter/mission	7 <input type="checkbox"/> Foster Care
2 <input type="checkbox"/> Room/boardings or sober house	4 <input type="checkbox"/> Group home/treatment	6 <input type="checkbox"/> On the streets	88 <input type="checkbox"/> Refused

▶ **19. Who do you live with?** (Check all that apply)

Alone       Child 6-18       Spouse/Equivalent       Other Relative

Child under 6       Child over 18       Parents       Roommate/Friend

▶ **20. Use of mobility aid:** (Check all that apply)       None       Crutches       Walker       Manual Wheelchair       Electric Wheelchair

▶ **21. Vision Impairment**  \*      ▶ **22. Hearing Impairment**  \*      ▶ **23. Self Care/ADL Impairment**  \*      ▶ **24. Developmental Disability**  \*

▶ **25. Prior Mental Health Treatment:**      0  No history      1  Counseling      2  One hospitalization      3  More than one hospitalization

▶ **26. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?**      1  Yes      2  No      88  Refused      99  Unknown

▶ **27. Number of prior admissions to each substance abuse treatment modality** (0 - 5 admissions, '5' = 5 or more, 99=unknown) Do not count this tx. episode.

Detox       Outpatient       Drunk Driver       Other

Residential       Opioid       Section 35

▶ **28. Currently receiving services from a state agency:** (Check all that apply)

None       DMH does client have a case mgr.?       DTA e.g. food stamps       MCDHH Deaf

DCF was DSS       DDS was DMR       MRC Mass Rehab       Other

DYS youth services       DPH e.g. HIV/STD; not BSAS tx..       MCB Commission for Blind

*See manual for auto generated associations (e.g. Client Type Probation – OCP services.)*

▶ **29. Number of arrests in the past 30 days?**  (Section 35 is not an arrest, it is a civil commitment)

▶ **30. History Substance Mis-use, Nicotine/Tobacco Use & Gambling**

*For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (Example - If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.) Note: For the safety of the client all drugs used must be recorded in the client record. (See Manual for commercial names.)*

		Have You Ever Mis-Used/Bet		Age of First Use/Bet	Last Use/Bet	Freq of Last Use/Bet	Route of Admin Code
		Y	N				
A	Alcohol	<i>For Alcohol, enter first age of intoxication</i>					
B	Cocaine						
C	Crack						
D	Marijuana / Hashish						
E	Heroin						
F	Prescribed Opiates	<i>Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.</i>					
G	Non-prescribed Opiates	<i>Non-medical use of pharmaceutical opiates which were not prescribed for the client</i>					
H	PCP						
I	Other Hallucinogens						
J	Methamphetamine						
K	Other Amphetamines						
L	Other Stimulants						
M	Benzodiazepines						
N	Other Tranquillizers						
O	Barbiturates						
P	Other Sedatives / Hypnotics						
Q	Inhalants						
R	Over the Counter						
S	Club Drugs						
U	Other						
X	Nicotine/Tobacco	<i>Includes cigarettes, cigars, chewing tobacco, inhalers</i>					
Y	Gambling	<i>Includes any of the types listed in Q.32a</i>					N/A



★Q 11 Frequency of Attendance at Self-Help Programs			
Code		Code	
01	No attendance in the past month	05	16-30 times in past month (4 or more times per week)
02	1-3 times in past month (less than once per week)	06	Some attendance, but frequency unknown
03	4-7 times in past month (about once per week)	99	Unknown
04	8-15 times in past month (2 or 3 times per week)		

★Q 16 Employment Status at Enrollment					
Code		Code		Code	
1	Working Full Time	6	Not In Labor Force - Retired	11	Volunteer
2	Working Part Time	7	Not In Labor Force - Disabled	12	Other
3	Unemployed - Looking	8	Not In Labor Force - Homemaker	13	Maternity/Family Leave
4	Unemployed - Not Looking	9	Not In Labor Force - Other	99	Unknown
5	Not In Labor Force - Student	10	Not In Labor Force - Incarcerated		

Code	★Q. 21 Vision Impairment
0	None: Normal Vision
1	Slight: vision can be or is corrected with glasses/lenses
2	Moderate: "Legally blind" but having some minimal vision
3	Severe: No usable vision

Code	★Q. 22 Hearing Impairment
0	None: Normal hearing requiring no correction
1	Slight: Hearing is or can be adequately corrected with amplification (e.g. hearing aid)
2	Moderate: Hard of hearing, even with amplification
3	Severe: Profound deafness

Code	★Q 23 Self Care/ADL Impairment
0	None: No problem accomplishing ADL skills such as bathing, dressing and other self care
1	Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant
2	Moderate: Needs personal attendant up to 20 hours a week for ADL
3	Severe: Requires personal attendant for over 20 hours a week for ADL

Code	★Q. 24 Developmental Disability
0	None
1	Slight developmental disability
2	Moderate developmental disability
3	Severe developmental disability

Code	Last Use Substances
1	12 or more months ago
2	3-11 months ago
3	1-2 months ago
4	Past 30 days
5	Used in last week

★Q 30 SUBSTANCE MIS-USE / TOBACCO / GAMBLING HISTORY

Code	Frequency of Last Use/bet
1	Less than once a month
2	1-3 times a month
3	1-2 times a week
4	3-6 times a week
5	Daily
99	Unknown

Code	Route of Administration
1	Oral (swallow and/or chewing)
2	Smoking
3	Inhalation
4	Injection
5	Other