Enrollment Assessment
Acute Treatment

▶ ***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***

First Name: **Middle Initial:** **Last Name:** ***Suffix:***

▶ **1. Client Code:** ☐☐☐☐☐ ▶ **2. Intake/Clinician Initials:** ☐☐☐

▶ **3. Do you own or rent a house, apartment, or room?** ☐Yes ☐No *If the answer to Q3 is Yes, skip to Q3b*, if 'No', answer Q3a.

3a. Are you Chronically Homeless? *(HUD Definition in Manual)* ☐Yes ☐No

▶ **3b. ZIP Code of Last Permanent Address:** *Do **Not** enter zip code of Program. See Manual for definition of Permanent.*

▶ **3c. Where did you stay last night?**

1☐ Emergency shelter
2☐ Transitional housing for homeless persons
3☐ Permanent housing for formerly homeless
4☐ Psychiatric hospital or other psych. Facility
5☐ Substance abuse treatment facility or detox
6☐ Hospital (non-psychiatric)
7☐ Jail, prison or juvenile detention facility
8☐ Room, apartment, or house that you own or rent
9☐ Staying or living with a family member
10☐ Staying or living with a friend
11☐ Room, apartment, or house to which you cannot return (future return can be uncertain)
12☐ Hotel or motel paid for without emergency shelter voucher
13☐ Foster care home or foster care group home
14☐ Place not meant for habitation
15☐ Other Specify_____
88☐ Refused

▶ **4. Do you consider yourself to be transgender?** ☐Yes ☐No ☐Refused

4a. If you answered Yes to Q4, please specify: ☐Male to Female ☐Female to Male ☐Other, specify _____

▶ **5. Do you consider yourself to be:** ☐Heterosexual ☐Gay/Lesbian ☐Bisexual ☐Other, specify _____ ☐Refused

▶ **6. Number of days between initial contact with the program by the client or someone on behalf of the client and enrollment** : ☐☐☐ *(unknown = 999)*
See Manual to help determine wait time.

▶ **7. Source of Referral:** ☐☐✶

▶ **8. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Enrollment:** ☐☐✶

▶ **9. Additional Client Type:** *Answer Yes or No to a-j*

a. Student	☐Yes ☐No	f. Probation	☐Yes ☐No
b. Pregnant	☐Yes ☐No	g. Parole	☐Yes ☐No
c. Postpartum	☐Yes ☐No	h. Federal Probation	☐Yes ☐No
d. Veteran/ Any Military Service	☐Yes ☐No	i. Federal Parole	☐Yes ☐No
e. Prison	☐Yes ☒No	j. Section 35	☐Yes ☒No*

**If client is under a Section 35 commitment, use the Section 35 Enrollment form*

▶ **10. Do you have children?** ☐Yes ☐No ☐Refused *If answer to Q. 10 is 'Yes', complete Qs 10a-10d. If no, skip to Q. 11*

10a. Number Children Under 6: ☐ **10b. Number of Children 6-18:** ☐ **10c. Children Over 18:** ☐

10d. Are any of the children of the Native American race? (i.e., American Indian) 1☐Yes 2☐No

▶ **11. Are you the primary caregiver for any children?** *If yes, see manual. If the client is the primary caregiver of children you must assess what arrangements have been made for their care in your full clinical assessment.* ☐Yes ☐No ☐Refused

▶ **12. Employment status at Enrollment:** ☐ ✶ ▶ **13. Number of days worked in the past 30 days:** ☐

▶ **14. Where do you usually live? (***Where has the client spent/slept most of the time over the last 12 months?)*

1 ☐ House or apartment 3 ☐ Institution 5 ☐ Shelter/mission 7 ☐ Foster Care
2 ☐ Room/boarding or sober house 4 ☐ Group home/treatment 6 ☐ On the streets 88 ☐ Refused

▶ **15. 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

▶ **16. Use of Mobility Aid: (***Check all that apply)* ☐ None ☐ Crutches ☐ Walker ☐ Manual Wheelchair ☐ Electric Wheelchair

▶ **17. Vision Impairment** ☐ ✶ ▶ **18 Hearing Impairment** ☐ ✶

▶ **19. SelfCare/ADL Impairment** ☐ ✶ ▶ **20. Developmental Disability** ☐ ✶

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

▶ **22. 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

▶ **23. 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

▶ **24. Are you currently receiving Medication Assisted Treatment?**
If Yes, answer Q24a -. If No, skip to Q25 ☐ Yes ☐ No

24a. Are you receiving Methadone Treatment *(If Yes skip to Q25)* ☐ Yes ☐ No

24b. Are you receiving Suboxone or Vivitrol Treatment? *Select Below*

☐ Buprenorphine (Suboxone) ☐ Extended release injectable naltrexone (Vivitrol)

24c. Is your Suboxone or Vivitrol prescription for alcohol use disorder, opioid use disorder, or both?

☐ Alcohol Use Disorder ☐ Opioid Use Disorder ☐ Both

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

☐ None ☐ DMH *client has a case mgr.* ☐ DTA *e.g. food stamps* ☐ MCDHH *services for Deaf and Hard of Hearing*
☐ DCF *children and families* ☐ DDS *developmental disabilities* ☐ MRC *Rehabilitation Commission* ☐ Other
☐ DYS *youth services* ☐ DPH *e.g. HIV/STD; not BSAS .* ☐ MCB *services for the blind*

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

27. History Substance Misuse, Nicotine/Tobacco Use & Gambling
For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.) 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 Y	Have You Ever Mis-Used/Bet N	Age of First Use/Bet	Last Use/Bet	Freq of Last Use/Bet	Route of Admin Code
A	**Alcohol** *For **Alcohol**, enter first age of **intoxication***						
B	**Cocaine**						
C	**Crack**						
D	**Marijuana / Hashish**						
E	**Heroin**						
F	**Prescribed Opiates** *Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.*						
G	**Non-prescribed Opiates** *Non-medical use of pharmaceutical opiates which were not prescribed for the client*						
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**						
V	**Fentanyl**						
X	**Nicotine/Tobacco** *Includes cigarettes, cigars, chewing tobacco, inhalers*						
Y	**Gambling** *Includes any of the types listed in Q 29a*						**N/A**
Z	**K2/Spice or Other Synthetic Marijuana**						

28. Number of cigarettes currently smoked per day. *(Indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes)* ☐

If client uses another type of nicotine/tobacco product, mark Zero (0) If person does not use nicotine products, skip to 29a.

29a. Types of last regular gambling: *(check all that apply)* *If person does not have a gambling history, skip Q30*

☐ Lottery -Scratch Tickets ☐ Slot Machines ☐ Sports Betting ☐ Stock Market
☐ Lottery - Keno ☐ Casino Games ☐ Bingo ☐ Internet Gambling
☐ Lottery/Numbers Games ☐ Card Games ☐ Dog/Horse Tracks, Jai Alai

29b. Have you ever thought you might have a gambling problem, or been told you might? ☐ Yes ☐ No ☐ Refused

Clients must be asked if they have a SECONDARY and/or TERTIARY drug of choice. Clinicians may rank substances based on their clinical opinion after review of the substance use history and not necessarily client report. *Nicotine/Tobacco and Gambling CANNOT be marked as a primary/secondary/or tertiary drug.*

30. Rank substances by entering corresponding letter for substances listed above in Question 27. (*If no secondary or tertiary substance, leave blank)*
Primary Substance ☐ **Secondary Substance** ☐ **Tertiary Substance** ☐

31. Needle Use? 0 ☐ Never | 1 ☐ 12 or more months ago | 2 ☐ 3 t-11 months ago | 3 ☐ 1-2 months ago | 4 ☐ Past 30 days | 5 ☐ Last week

32 Have you had any overdoses in your lifetime?* ☐ Yes ☐ No *(If No, Assessment is complete)*

32a. How many overdoses have you had in your lifetime? *(1-99)* ☐ **32b. How many overdoses have you had in past year?** *(0-99)* ☐

Q7. Source of Referral at Enrollment					
Code		**Code**		**Code**	
01	Self, Family, Non-medical Professional	20	Health Care Professional, Hospital		*67 Discontinued*
02	BMC Central Intake/Room 5	21	Emergency Room	68	Office of the Commissioner of Probation
03	ATS/Detox	22	HIV/AIDS Programs	69	Massachusetts Parole Board
04	Transitional Support Services/TSS	23	Needle Exchange Programs	70	Dept. of Youth Services
05	Clinical Stabilization Services/CSS-CMID	26	Mental Health Professional	71	Dept. of Children and Families
06	Residential Treatment		*27 through 29 Discontinued*	72	Dept. of Mental Health
07	Outpatient SA Counseling	30	School Personnel, School System/Colleges	73	Dept. of Developmental Services
08	**Medication Assisted Treatment**	31	Recovery High School		*74 through 76 Discontinued*
09	Drunk Driving Program		*32 through 39 Discontinued*	77	Mass. Rehab. Commission
10	Acupuncture	40	Supervisor/Employee Counselor	78	Mass. Commission for the Blind
11	Gambling Program		*41 through 49 Discontinued*	79	Mass. Comm. For Deaf & Hard of Hearing
	12 & 13 Discontinued	50	Shelter	80	Other State Agency
14	Sober House	51	Community or Religious Organization		
15	Information and Referral		*52 through 58 Discontinued*	99	Unknown
16	Recovery Support Centers	59	Drug Court		
17	Second Offender Aftercare	60	Court - Section 35		
18	Family Intervention Program		*61 & 62 Discontinued*		
19	Other Substance Abuse Treatment	63	Court - Other		
		64	Prerelease, Legal Aid, Police		
			65 Discontinued		
		66	Office of Community Corrections		

	Q 8 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 12 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. 17 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. 18 Hearing Impairment
0	None: Normal hearing requiring no correction
1	Slight: Hearing is or can be adequately corrected with amplification (eg hearing aid)
2	Moderate: Hard of hearing, even with amplification
3	Severe: Profound deafness

Code	Q 19 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. 20 Developmental Disability
0	None
1	Slight Developmental Disability
2	Moderate Developmental Disability
3	Severe Developmental Disability

Q 26: SUBSTANCE MIS-USE / NICOTINE/TOBACCO / GAMBLING HISTORY

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

Code	Frequency of Last Use
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
6	**Electronic Devices/Vaping**