

 <h2 style="margin: 0;">Enrollment Assessment Opioid Treatment</h2>	▶ <b>Enrollment Date:</b> /        / mm   dd   yyyy
	▶ <b>ESM Client ID:</b>
	<b>Provider ID:</b>

<b>Questions (Q) marked with ▶ must be completed.</b>		<b>Boxes marked with ★ = Refer to Key at end of form</b>
<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>
<b>Suffix:</b>		
▶ <b>1. Client Code:</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	▶ <b>2. Intake/Clinician Initials:</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
▶ <b>3. Do you own or rent a house, apartment, or room?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If the answer to Q3 is Yes, skip to Q5</i>		
▶ <b>4. Are you Chronically Homeless? (HUD Definition in Manual)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
▶ <b>5. ZIP Code of Last Permanent Address:</b> <i>(Do not enter zip code of Program): .See Manual for definition of Permanent..</i>		
▶ <b>6. 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 Grp home
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"/> Room, apartment, or house to which you <u>cannot return</u> (future return can be uncertain)	
6 <input type="checkbox"/> Hospital (non-psychiatric)	12 <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	
▶ <b>7. Do you consider yourself to be transgender?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		
▶ <b>7a. 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 _____		
▶ <b>8. 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		
▶ <b>9. Number of days between initial contact with program by client or someone on behalf of client and the first available appointment :</b> <input style="width: 50px;" type="text"/> <i>See Manual to help determine wait time. (unknown = 999)</i>		
▶ <b>10. Source of Referral:</b> <input type="checkbox"/> <input type="checkbox"/> ★		
▶ <b>11. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Enrollment:</b> <input type="checkbox"/> <input type="checkbox"/> ★		
▶ <b>12. Additional Client Type: Answer Yes or No to a-i</b>		
a. Student <input type="checkbox"/> Yes <input type="checkbox"/> No	f. Probation <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	g. Parole <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Postpartum <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Federal Probation <input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Veteran/ Any Military Service <input type="checkbox"/> Yes <input type="checkbox"/> No	i. Federal Parole <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Prison <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

<p>▶ <b>13. Do you have children?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Refused    <i>If answer to Q13 is 'Yes', complete 13a-13d. If no, skip to Q14</i></p>	
<p>13a. Number Children Under 6: <input style="width: 50px;" type="text"/></p>	<p>13b. Number of Children 6-18: <input style="width: 50px;" type="text"/></p>
<p>13c. Children Over 18: <input style="width: 50px;" type="text"/></p>	
<p>13d. Are any of the children of the Native American Indian race?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No</p>	
<p>▶ <b>14. Are you the primary caregiver for any children?</b>  If yes, see manual    <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Refused</p>	
<p>▶ <b>15. Employment status at Enrollment:</b>    <input style="width: 50px;" type="text"/> *</p>	<p>▶ <b>16. Number of days worked in the past 30 days?</b>    <input style="width: 50px;" type="text"/></p>
<p>▶ <b>17. Where do you usually live? (Where has the client spent/slept most of the time over the last 12 months?)</b></p>	
<p>1 <input type="checkbox"/> House or apartment</p>	<p>3 <input type="checkbox"/> Institution</p>
<p>2 <input type="checkbox"/> Room/boardings or sober house</p>	<p>4 <input type="checkbox"/> Group home/treatment</p>
<p>5 <input type="checkbox"/> Shelter/mission</p>	<p>6 <input type="checkbox"/> On the streets</p>
<p>7 <input type="checkbox"/> Foster Care</p>	<p>88 <input type="checkbox"/> Refused</p>
<p>▶ <b>18. Who do you live with? (Check all that apply)</b></p>	
<p><input type="checkbox"/> Alone</p>	<p><input type="checkbox"/> Child 6-18</p>
<p><input type="checkbox"/> Child under 6</p>	<p><input type="checkbox"/> Child over 18</p>
<p><input type="checkbox"/> Spouse/Equivalent</p>	<p><input type="checkbox"/> Parents</p>
<p><input type="checkbox"/> Other Relative</p>	<p><input type="checkbox"/> Roommate/Friend</p>
<p>▶ <b>19. Use of mobility aid: (Check all that apply)</b>    <input type="checkbox"/> None    <input type="checkbox"/> Crutches    <input type="checkbox"/> Walker    <input type="checkbox"/> Manual Wheelchair    <input type="checkbox"/> Electric Wheelchair</p>	
<p>▶ <b>20. Vision Impairment</b>    <input style="width: 30px;" type="text"/> *</p>	<p>▶ <b>21. Hearing Impairment</b>    <input style="width: 30px;" type="text"/> *</p>
<p>▶ <b>22. SelfCare/ADL Impairment</b>    <input style="width: 30px;" type="text"/> *</p>	<p>▶ <b>23. Developmental Disability</b>    <input style="width: 30px;" type="text"/> *</p>
<p>▶ <b>24. Prior Mental Health Treatment:</b>    0 <input type="checkbox"/> No history    1 <input type="checkbox"/> Counseling    2 <input type="checkbox"/> One hospitalization    3 <input type="checkbox"/> More than one hospitalization</p>	
<p>▶ <b>25. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?</b>    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    88 <input type="checkbox"/> Refused    99 <input type="checkbox"/> Unknown</p>	
<p>▶ <b>26. 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.</b></p>	
<p><input style="width: 50px;" type="text"/> Detox</p>	<p><input style="width: 50px;" type="text"/> Outpatient</p>
<p><input style="width: 50px;" type="text"/> Residential</p>	<p><input style="width: 50px;" type="text"/> Opioid</p>
<p><input style="width: 50px;" type="text"/> Drunk Driver</p>	<p><input style="width: 50px;" type="text"/> Section 35</p>
<p><input style="width: 50px;" type="text"/> Other</p>	
<p>▶ <b>27. Currently receiving services from a state agency: (Check all that apply)</b></p>	
<p><input type="checkbox"/> None</p>	<p><input type="checkbox"/> DMH client has a case mgr.</p>
<p><input type="checkbox"/> DCF children and families</p>	<p><input type="checkbox"/> DDS developmental disabilities</p>
<p><input type="checkbox"/> DYS youth services</p>	<p><input type="checkbox"/> DPH e.g. HIV/STD; not BSAS .</p>
<p><input type="checkbox"/> DTA e.g. food stamps</p>	<p><input type="checkbox"/> MRC Rehabilitation Commission</p>
<p><input type="checkbox"/> MCDHH services for Deaf and Hard of Hearing</p>	<p><input type="checkbox"/> Other</p>
<p><input type="checkbox"/> MCB services for the blind</p>	
<p>▶ <b>28. Number of arrests in the past 30 days?</b>    <input style="width: 50px;" type="text"/>    <i>(Section 35 is not an arrest, it is a civil commitment)</i></p>	



**Clinicians may rank Secondary and Tertiary substances based on their clinical judgement, after review of the substance use history not just client report. (Nicotine/Tobacco and Gambling CANNOT be marked as a primary/secondary/or tertiary drug)**

**32. Rank substances by entering corresponding letter for substances listed above in Question 31. (If no secondary or tertiary substance, leave blank)**

▶ <b>Primary Substance</b> <input style="width: 20px;" type="checkbox"/>	<b>Secondary Substance</b> <input style="width: 20px;" type="checkbox"/>	<b>Tertiary Substance</b> <input style="width: 20px;" type="checkbox"/>
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▶ <b>33. Needle Use?</b> 0 <input type="checkbox"/> Never	2 <input type="checkbox"/> 3 to 11 months ago	4 <input type="checkbox"/> Past 30 days
1 <input type="checkbox"/> 12 or more months ago	3 <input type="checkbox"/> 1 to 2 months ago	5 <input type="checkbox"/> Last week

▶ **34 Have you had any overdoses in your lifetime?\***  Yes  No *(If No, skip to MTQAS questions)*

**34a. How many overdoses have you had in your lifetime? (1-99)**  **34b. How many overdoses have you had in past year? (0-99)**

**MTQAS/OTP Questions**

▶ **1. Is your current medication-assisted treatment for withdrawal management or maintenance?**  Maintenance  Withdrawal Management

▶ **2. Do you have a current prescription for buprenorphine (e.g Suboxone) or naltrexone (e.g Vivitrol)?**  Yes  No  
*(If Yes, Q2a and Q2b are required.)*

**2a If yes, select the medication prescribed.**

Buprenorphine  Naltrexone

**2b. Is this prescription for alcohol use disorder, opioid use disorder, or both?**

Alcohol use disorder  Opioid use disorder  Both

▶ **3. Current Criminal status:**  None  Probation  Parole  In Jail  On Bail

▶ **4. Number of arrests in lifetime: (0-99):**

▶ **5. Frequency of injected drug use in the past 12 months**

1 <input type="checkbox"/> None	3 <input type="checkbox"/> 1-3 times per month	5 <input type="checkbox"/> 3-6 times per week
2 <input type="checkbox"/> Less than once per month	4 <input type="checkbox"/> 1-2 times per week	6 <input type="checkbox"/> Daily

▶ **6. In general, how would you describe your current health?**

1  Excellent      2  Very Good      3  Good      4  Fair      5  Poor

▶ **7. During the past 12 months, how much difficulty did you have doing your daily activities, both inside and outside the home, due to physical or emotional problems?**

None       A little bit       Some       Quite a bit       Unable to do daily activities

▶ **8. During the past 12 months, how many nights were you hospitalized for physical problems? (0 -366):**

▶ **9. During the past 12 months, how many nights were you in a detox facility? (0 -366):**

▶ **10. During the past 12 months, how many visits to an emergency room and/or urgent care facility did you make? (0 -100):**

▶ 11. In the past 12 months, how much were you distressed (bothered) by...				
	1 Not at all	2 A little/slightly	3 Moderately	4 A lot/extremely
a. Nervousness or shakiness inside?				
b. Suddenly being scared for no reason?				
c. Feeling fearful?				
d. Spells of terror or panic?				
e. Feeling that something bad is going to happen?				
▶ 12. In the past 12 months, how much were you distressed (bothered) by...				
	1 Not at all	2 A little/slightly	3 Moderately	4 A lot/extremely
a. Blaming yourself for things?				
b. Feeling blue?				
c. Worrying too much about things?				
d. Feeling no interest in things?				
e. Feeling hopeless about the future?				
f. Feeling worthless?				
g. Feeling guilty for things that may not be your fault?				
▶ 13. Did you stay overnight somewhere for treatment of problems with your emotions, nerves, or mental health?*				
			1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 14. Did you ever get outpatient treatment or counseling for an emotional or mental health problem?*				
			1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 15. In the past 12 months, did you think about suicide?*				
			1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 16. In the past 12 months, did you attempt suicide?				
			1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 17. How supportive would you say the people closest to you are of your seeking substance abuse treatment at this time?				
1 <input type="checkbox"/> Not supportive or opposed		2 <input type="checkbox"/> Not very supportive		3 <input type="checkbox"/> Somewhat supportive
			4 <input type="checkbox"/> Very supportive	
▶ 18. Would you say that none of the people, a few of the people, or most of the people you are close to are currently abusing drugs?				
1 <input type="checkbox"/> None		2 <input type="checkbox"/> One or a few		3 <input type="checkbox"/> Most

★ Q10. Source of Referral at Enrollment					
Code		Code		Code	
01	Self, Family, Non-medical Professional	20	Health Care Professional, Hospital	67	Department of Corrections
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 Care 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	<b>Medication Assisted Treatment</b>	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
	Note: Sec 35 Options are grouped although numbers are not in sequence. Select correct #	50	Shelter	80	Other State Agency
12	Sec 35 (WATC & MATC)	51	Community or Religious Organization	99	Unknown
24	Sec 35 Bridgewater MASAC		52 through 58 Discontinued		
25	Sec 35 Framingham MCI	59	Drug Court		
	13 Discontinued	60	Court - Section 35		
14	Sober House		61 & 62 Discontinued		
15	Information and Referral	63	Court - Other		
16	Recovery Support Centers	64	Prerelease, Legal Aid, Police		
17	Second Offender Aftercare	65	County House of Corrections/Jail		
18	Family Intervention Program	66	Office of Community Corrections		
19	Other Substance Abuse Treatment				

★ Q 121 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 15. 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. 20 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. 21 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 22 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. 23 Developmental Disability
0	None
1	Slight developmental disability
2	Moderate developmental disability
3	Severe developmental disability

★ Q 29: SUBSTANCE MIS-USE / NICOTINE/TOBACCO / GAMBLING HISTORY

Code	Last Use Substances	Code	Frequency of Last Use/bet	Code	Route of Administration
1	12 or more months ago	1	Less than once a month	1	Oral (swallow and/or chewing)
2	3-11 months ago	2	1-3 times a month	2	Smoking
3	1-2 months ago	3	1-2 times a week	3	Inhalation
4	Past 30 days	4	3-6 times a week	4	Injection
5	Used in last week	5	Daily	5	Other
		99	Unknown	6	<b>Electronic Devices/Vaping</b>