MIGISI ALCOHOL AND DRUG TREATMENT CENTRE
ADULT INTAKE/REFERRAL FORM

ALL SECTIONS MUST BE COMPLETED
INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS
If any information is not applicable: indicate as NA; unknown as UNK; unavailable as UNA.

A. General Information

Date Application Received by Community Worker		Date Application Received by Treatment Centre	
Surname:	First Name:	Nickname or other name known by:	
Date of Birth:	Age:	Sex:	Provincial Health Card Number:
Address:			Telephone:
Language Spoken:	Language Preferred:	Language Understood:	
Emergency Contact Name:	Telephone:	Relationship:	
Nation Status:	Status Number: (10-digit registration number)	Band Name:	

Education Level ☐ Less than Gr. 8 ☐ Completed High School ☐ Not Completed High School ☐ Completed Post-secondary ☐ Some Post-secondary	Literacy: ☐ Literate ☐ Illiterate ☐ Needs assistance	Employment Status:

Family/Relationships

Marital Status:
☐ Common-law ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Does Client have dependent children?	☐ Yes ☐ No
If yes, do they have access to adequate childcare while in treatment?	☐ Yes ☐ No ☐ Not Applicable
Are the children in care?	☐Yes ☐ No ☐ Not Applicable
Does the client have other dependents?	☐Yes ☐No

Family Supports:

Family Strengths:

Legal Status

Most recent involvement in the justice system at entry	☐No Involvement ☐Criminal Court ☐Family Court ☐Drug Court Treatment ☐Probation ☐Charges Pending ☐Court Referral ☐Court Order ☐Restorative Justice
Has client been court ordered to attend treatment?	☐Yes ☐No
If yes, provide details (include details/copy of Probation Order if applicable and/or available):	
Is the client under any of the following legal conditions?	☐Bail ☐Parole ☐Temporary Absence Order ☐Probation Order
Other (provide details, dates, etc.):	

Treatment History

Has client participated in a non-residential/community based substance abuse program?	☐Yes ☐No
Has client participated in a non-residential/community based mental health program?	☐Yes ☐No
Has client participated in a residential treatment program before?	☐Yes ☐No

If yes, please provide information on previous treatment experience:

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐Yes ☐No	
			☐Yes ☐No	

Reason(s) for currently requesting treatment:

B. Withdrawal Symptoms:
Has the client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptom	Describe
Blackouts: ☐Yes ☐No ☐Not Applicable ☐Unknown	
Hallucinations: ☐Yes ☐No ☐Not Applicable ☐Unknown	
Nausea/Vomiting: ☐Yes ☐No ☐Not Applicable ☐Unknown	
Seizures: ☐Yes ☐No ☐Not Applicable ☐Unknown	
Shakes: ☐Yes ☐No ☐Not Applicable ☐Unknown	
Delirium Tremens (DT's): ☐Yes ☐No ☐Not Applicable ☐Unknown	**Ever experience DTs?** ☐Yes ☐No

C. Process/Behavioral Addictions *Has client experienced problems with any of the following?*	
Process/Behavioral Addiction	**Describe**
Gambling (slots, cards, Keno, bingo, etc) ☐Yes ☐No ☐Not Applicable ☐Unknown	
Eating (obesity, anorexia, bulimia, etc.) ☐Yes ☐No ☐Not Applicable ☐Unknown	
Sex (promiscuity, etc.) ☐Yes ☐No ☐Not Applicable ☐Unknown	
Internet/texting ☐Yes ☐No ☐Not Applicable ☐Unknown	
Other ☐Yes ☐No ☐Not Applicable ☐Unknown	
Other ☐Yes ☐No ☐Not Applicable ☐Unknown	

D. Mental Health Issues *Provide the following information about the client's health status*	
Mental Illness	**Describe**
Been diagnosed with a mental illness ☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently being treated ☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently on psychiatric medication ☐Yes ☐No ☐Not Applicable ☐Unknown	
Taking medication consistently ☐Yes ☐No ☐Not Applicable ☐Unknown	
Previous suicide attempts/ideation ☐Yes ☐No ☐Not Applicable ☐Unknown	
If yes, when?	
Hospitalized for suicide attempts ☐Yes ☐No ☐Not Applicable ☐Unknown	
If yes, when?	
Currently suicidal ☐Yes ☐No ☐Not Applicable ☐Unknown	
Name of psychiatrist/psychologist (if applicable):	

E. Other Issues/Needs	
Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:	☐Yes ☐No
Does client have any literacy or learning needs or issues we need to be aware of? If yes, please describe:	☐Yes ☐No
Are there any other significant issues we need to be aware of? If yes, please describe:	☐Yes ☐No
Does the client understand Migisi Treatment Centre has a 3 strike policy in effect; and not following the Expectations (house rules) of Migisi Treatment Centre can result in a discharge of treatment?	☐Yes ☐No
Does client understand there is an expectation they have been alcohol and drug free for at least 10 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify the treatment Centre prior to admission).	☐Yes ☐No
Personal Strengths:	

F. Application Checklist	
Confirmation of transportation to Treatment Centre through referral	☐Yes ☐No
Confirmation of transportation back home	☐Yes ☐No
Client has been notified and understands the Non-Insured Health Benefits policy change whereby anytime during treatment and the client self-terminates, or the Treatment Centre terminates the client, and medical transportation benefits have been provided, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.	☐Yes ☐No

Client Authorization
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by the Treatment Centre.

Client Signature	**Date**
Referral Signature	**Date**

REFERRAL INFORMATION

Name of Referral:	Title/Position	Name of Referral Agency:	
Address:	Postal Code:	Phone No:	Fax:

Will you continue to see the client once he/she has completed treatment?	☐Yes ☐No

What other supports would be available to your client in their community upon completion of treatment?

Name/Resource	Description of Support

Client's Stage of Readiness:
☐Pre-contemplation - Not considering change; resistant to change ☐Contemplation - Unsure of whether or not to change; chronic indecision ☐Determination - Preparation; committed to changing behaviour within one month ☐Action - Begin changing behavior ☐Maintenance - Behavior change has persisted for 6 months or more
Please list any questions or concerns the client has indicated during the intake process:
What other areas might need to be addressed in treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):
Referral Agent assessment of client's strengths and potential challenges for completing treatment:

Referral Checklist: *Please initial each item that has been completed:*		
Please check items attached to this application		
Item	**Attached**	**Initials**
Application (completed thoroughly)	☐Yes ☐No	
Medical Assessment Form (completed by a medical examiner)	☐Yes ☐No	
Expectations (Reviewed & Signed)	☐Yes ☐No	
AMIS Consent (Reviewed & Signed)	☐Yes ☐No	
DUSI-R: Substance Abuse Profile/Assessment (All questions completed)	☐Yes ☐No	
Additional Information (Assessments, Legal documents, etc.)	☐Yes ☐No	
Please initial each item that has been completed:		**Initials**
Confirmation of transportation to the treatment Centre		
Confirmation of transportation back home after completion of treatment		
All medical, dental and optical appointments have been dealt with prior to treatment		
All financial matters have been dealt with prior to treatment		
All legal matters have been dealt with prior to treatment		
Referral Signature	Date (D/M/Y)	

MIGISI ALCOHOL & DRUG TREATMENT CENTRE

MEDICAL ADMISSION FORM

Information must be completed by a Medical Examiner

Patients Name:	Patients Date of Birth:
Health Card Number:	

Please indicate whether the patient has any history of the following:	
Allergies:	Injectable Drug Use:
Cancer:	Hepatitis A, B, C:
Diabetes:	HIV/AIDS:
Epilepsy:	Vaginal Discharge:
Heart Disease:	Venereal Disease:
Other:	

Tuberculosis (TB) Screen:

Has the client ever had TB? Yes No

Has the applicant had a TB skin test? Yes No

Does the Medical Examiner suspect any concerns? Yes No

Date of test: _____ Test Results:

_____

Chest X-ray (if applicable): Yes No Results: _____

Treatment Provided:

_____

If you are aware of any peculiarity or problems that we should consider in treatment, please provide details: *(Extreme Anxiety, Potential Suicide Tendencies, Depression, etc.)*

Operation and/or Serious Illness

Please give approximate dates, names of physicians or surgeons, medications involved, and results of treatment:

Psychiatric/Psychologist Services:
Please give approximate dates, treatment facilities, and names of psychiatrist/psychologist:

Please list current medication			
Current Medication	Prescribed by	Date of Prescription	Is the client able to refrain for 28 days?

Attach additional sheet if needed

Does the physician request that the following applicant receive psychological services? ***YES / NO***

If so, please print name of client.

_____ will be receiving treatment for alcohol and/or drug abuse at Migisi Treatment
(Name of Client)
Centre. He/she may receive additional treatment by a chartered psychologist. We are requesting that you refer him/her for assessment and further consultation.

Name of Physician/Nurse: _____

Office Address: _____

Office Telephone Number: _____

Date of Medical: _____

Physician/Nurse Signature: _____

Office Stamp:

MIGISI ALCOHOL AND DRUG TREATMENT CENTRE

EXPECTATIONS

1. ALCOHOL AND DRUGS:

The use or possession of alcohol or drugs while in treatment is strictly prohibited. A search for drugs and/or inappropriate materials will be conducted and confiscated. Failure to comply will result in immediate dismissal. Random room checks will be made by Program Staff at any time.

2. VIOLENCE / AGRESSION:

Violence against persons and/or property is prohibited. Residents threatening anyone, fighting or destroying property will be discharged. ACTS OF INTIMIDATION towards another resident or staff will result in immediate dismissal from the program. Weapons are strictly prohibited. Anyone found in possession of a weapon will be immediately discharged.

3. RELATIONSHIPS:

Any intimate/sexual relationships between residents, visitors or staff will not be tolerated. All involved parties will be discharged under the suspicion or observance of these relationships developing.

4. HEALTH AND SAFETY:

a. Absolutely NO SMOKING or VAPING anywhere in the buildings (dorm and garage).
b. Smoking/Vaping is allowed outside only at designated areas; please ensure cigarette butts are placed in cans provided.
c. Residents must not hang towels, etc. over heaters as this may result in a fire.
d. Absolutely NO FOOD/BEVERAGES during programming at any time. This includes gum and candy.
e. NO FOOD/BEVERAGES are allowed in the lecture room at any time.
f. Upon arrival, all medication must be handed to staff. Staff will witness as client dispense medication.
g. Residents are expected to exercise good personal hygiene such as daily showers and clean clothes. Laundry facilities are available.
h. Residents must use the bed assigned. Beds must be made every morning and rooms cleaned before breakfast.
i. Residents are assigned daily chores and are expected to clean up after themselves at **ALL TIMES.** Failure to comply will result in loss of privileges or could result in a staff-discharge.
j. Periodic room checks by the Program Staff are made throughout the night to ensure the safety and well-being of residents. Doors must remain open throughout the night, if applicable. Residents are expected to report any problems to the Program Staff.

k. The Fire drill procedure is posted in the dorm and main building:
   i. Close all windows and doors if possible, then leave through the **NEAREST EXIT;**
   ii. Walk quickly, please **DO NOT** run;
   iii. Walk to **the PARKING LOT- EAST DOOR and approximately 100 feet away;**
   iv. Wait until **ATTENDANCE** has been completed and permission is given to return to the building;
   v. **ALWAYS** leave the building when you hear the **ALARM** go off.

l. Absolutely **NO SWIMMING IN THE LAKE OR WALKING ON THE ICE OR DOCK AREA** at any time

5. SCHEDULE AND ATTENDANCE:

a. Residents must be up at 6:30 a.m. each day. After breakfast, chores are to be completed immediately. Morning Medications are to be taken between 8:30am-9am and then residents are to report to the Lecture Room by 9:00 a.m. for morning smudge and sharing circle.

b. Quiet hours are from 10:30 p.m. - 6:30 a.m. Dorm lounge will be closed during this time.

c. Lights out at 10:30 p.m. each night.

d. Absolutely NO SLEEPING during the day. Unless authorized by Program staff.

e. All residents are to refrain from staying in their rooms during the day. Exceptions are made only for bathroom uses.

f. Bedroom doors must be open at all times during the day except when showering or changing. *ABSOLUTELY NO VISITING IN THE BEDROOMS.*

g. Residents must attend all sessions. Residents who miss sessions or are late will lose privileges or will be discharged.

h. ***Meal Schedule (Please be punctual):***

Breakfast	7am-7:30am (W/D))	8am-8:30am (W/E)
Lunch	12pm-12:30 pm	
Supper	4pm-5pm	
Snack Time	During evening (free time)	

PLEASE NOTE: Unless a client is on a special diet, everyone will eat what is served

6. LAUNDRY:

Residents are expected to share the laundry facilities. The laundry room will be open at 6:30 am to 10:00 pm. Each room is assigned a different day beginning with Room #1 on Monday and ending with Room #7 on Sunday. Residents are responsible for their own linen and please remember to use full loads.

7. ADMINISTRATION OFFICE:

Residents must not loiter around the reception area except when getting medication, when meeting with their Counselor, meeting with support workers or making purchases. Residents must ask receptionist if their Counselor is available.

EXPECTATIONS CONTINUED:

8. STAFF/SELF DISCHARGE:

a. ***Self-Discharge (voluntary)*:** When a resident leaves treatment on his/her own. There is a waiting period of six (6) months before he/she can return. All clients are required to sign a voluntary discharge.

b. ***Staff-Discharge:*** When a resident is discharged by the staff. There is a waiting period of twelve (12) months for re-admission.

9. DAILY WALKS:

WALKS ARE MANDATORY. They are to be taken after meals, when chores are completed. There must be two or more residents for all walks during the day. The boundary for all walks/jogs is to the junction where the 'Migisi/Youth & Elders Centre' sign is posted.

10. VISITORS:

Residents must notify staff in advance the names of all incoming visitors.

a. Visiting hours are from 1:00 pm – 4:00 pm on Saturdays after two (2) complete weeks of treatment.

b. Visitors under the influence of alcohol or drugs will be asked to leave the premises.

c. Visiting is confined to the **dining room area only**.

11. OTHER

a. **No Jackets or hats** are to be worn during sessions. Sunglasses must not be worn in the buildings.

b. Residents must dress appropriately. No clothing advertising alcohol and/or drugs.

c. Gambling is prohibited during treatment.

d. Residents must keep staff informed of their whereabouts at all times. No unauthorized outings.

e. Residents are encouraged to interact and socialize with one another.

f. Any abusive, vulgar or assaultive language could result in loss of privileges, or a staff-discharge.

g. NO SMOKING/VAPING in the main building, dorm, or in the van at any time.

h. Cell Phones, iPods, iPads, musical instruments, razors, lighter fluid, butane refills, nail polish, perfumes/colognes etc. will be turned in on arrival. They will be returned upon completion of treatment.

i. MIGISI STAFF are not responsible for articles or clothing left behind.

j. All clients/residents are requested to leave their personal vehicles at home as they are not allowed on the premises. Other transportation arrangements must be made when coming to the Centre.

k. No writing on the Migisi van or any vehicle parked in the parking lot.

3 STRIKE POLICY:

3 infractions of the expectations list will result in an automatic dismissal by staff

PLEASE SIGN AND DATE TO INDICATE THE REFERRAL AND APPLICANT HAVE READ AND UNDERSTAND MIGISI TREATMENT CENTRE'S EXPECTATIONS:

(Please attach signature page with application upon submission)

EXPECTATIONS
As a resident and/or applying applicant of Migisi Alcohol and Drug Treatment Centre, I have read and understand the treatment expectations, and I hereby fully agree to abide by them.
Resident Signature:
Referral Worker Signature:
Date:

CONSENT TO COLLECT AND SHARE TREATMENT INFORMATION

MIGISI ALCOHOL AND DRUG TREATMENT CENTRE participates in a National addictions treatment data base with other NNADAP and NYSAP Centre's across Canada. This system is known as "AMIS" (Addictions Management Information system). The system allows aggregate reporting of treatment data. No identifiers are used in any aggregate reporting. For the purpose of this form MIGISI ALCOHOL AND DRUG TREATMENT CENTRE and the other participating treatment providers are referred to as "Treatment Centre's".

With your permission, our participation in AMIS does three things:

1. It collects aggregate information to allow us to make better program improvement and treatment decisions for the populations we serve.
2. It provides a more secure electronic method for us to transfer confidential health information about you to other Treatment Centres who are treating you and request your information; and,
3. It allows other Treatment Centres to electronically disclose their confidential health information about you to us if we request your information for our treatment of you.

The purpose of this Consent is to obtain your permission for the sharing of a limited summary of your Treatment record between Treatment Centre's belonging to AMIS who may be involved with your treatment. The limited summary of your NNADAP/NYSAP treatment record will include (as applicable) the following components:

- Demographic Information including name, date of birth, SIN, Treaty Number and previous treatment episodes

With your consent we, as an AMIS participant, will deliver the limited summary of your treatment record which will store it electronically to another AMIS participant should you request future treatment. AMIS's record about you will be updated as we and other Treatment Centres, always with your consent, send additional information from later visits.

Your health information is private and confidential and is protected by law. These laws relate to your health information generally, as well as mental and behavioral health information and alcohol and drug abuse treatment information. AMIS Treatment centres are bound by these laws and various treatment centre accreditation standards related to protecting privacy.

CONSENT TO DISCLOSE CONFIDENTIAL PROTECTED HEALTH INFORMATION

Client Name: _____

Date of Birth: _____

I consent to the collection and limited disclosure of a limited summary of my treatment record which includes:

Demographic Information including name, date of birth, and Treaty number

I consent to the following actions:

- MIGISI TREATMENT CENTRE may store my treatment information in the AMIS data base
- MIGISI TREATMENT CENTRE may disclose a limited summary of my treatment record through AMIS to any other AMIS Participant which requests such information in order to treat me and has my consent
- MIGISI TREATMENT CENTRE may incorporate the limited summary of my treatment record it receives through AMIS into TREATMENT CENTRE own files.

Client Rights

I understand that the law gives me the following rights:

- I may refuse to sign this Consent.
- I understand that my refusal to sign this Consent will not prevent me from receiving addictions care
- I may revoke this Consent. I understand that I may revoke this Consent in writing at any time except to the extent that and AMIS Participant has already relied on this form.

Expiration Date: I understand that unless revoked sooner, this Consent expires in 18 months from the date I signed it

Print Name: _____

Client/Guardian Signature: _____ Date: _____

DUSI-R
Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

Ordinarily, how many times each month have you used each of the following drugs in the past year?

Alcohol

1. Beer, Wine, Liquor	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
2. Non-Potable Alcohol - Hairspray, Sanitizer, Mouthwash, Aftershave	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

Stimulants

3. Cocaine, Uppers, Khat	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
4. Methamphetamine - Crystal Meth	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
5. Methamphetamine - Ice/Glass	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
6. Methamphetamine - Speed	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

Caffeine

7. Coffee, Tea, Soda/Pop, Energy Drinks, Chocolate	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
8. Over the counter Cold Remedies	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
9. Over the counter Weight Loss Aids	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

Opioids

10. Prescription Suboxone	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
11. Prescription Methadone	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
12. Prescription Oxycontin, Oxycodone, Codeine, Morphine	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
13. Non-Prescription Oxycontin	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
14. Non-Prescription Oxycodone	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
15. Non-Prescription Codeine	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

DUSI-R
Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

16. Non-Prescription Morphine	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
17. Non-Prescription Heroin	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
18. Diverted Methadone	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
19. Diverted Suboxone	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
20. Fentanyl	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Sedatives, hypnotics, or anxiolytics

21. Benzodiazepines	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
22. Barbiturates	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
23. Sleeping Medications	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
24. Antianxiety Medications	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
25. Prescribed Sleeping Medications	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
26. Prescribed Antianxiety Medications	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Hallucinogens (phencyclidine)

27. Phencyclidine - PCP, Angel Dust, Ketamine, Cyclohexamine, Disocilpine	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
28. Other - LSD, Mescaline, MDMA/Ecstacy, DOM/STP, DMT, Magic Mushrooms, Morning Glory Seeds, Jimson Weed, Salvia Divinorum	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Cannabis

29. Marijuana/Pot/Weed/Hash	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
30. Shatter	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

DUSI-R
Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

31. Prescribed Cannabis	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
32. Prescribed CBD	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
33. Synthetic Cannabis - K2, Spice and others	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Inhalants

34. Glue	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
35. Gas/Fuels, Butane Lighters	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
36. Paint, Paint Thinner, Lacquer	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
37. Propane	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
38. Aerosols	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
39. Other Volatile Compounds	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Tobacco

40. Smoking	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
41. Chewing	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
42. Smokeless Tobacco	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Other (or unknown)

43. Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

44. Which drug caused you the most problems? (circle one)

None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxzone, Fentanyl, Benzodiazephines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstacy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer,

DUSI-R
Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_____

	Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas
45. Which drug do you prefer the most? (circle one)	None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxzone, Fentanyl, Benzodiazephines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstacy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer, Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas

Answer ALL of the following questions. Even if a question does not apply exactly, answer according to whether it is MOSTLY YES (TRUE) or MOSTLY NO (FALSE). Answer the questions as they apply to you within the <u>past year</u> and leading up to the present time. If a question does not apply to you, answer NO.

46. *	Have you had a craving or very strong desire for alcohol or drugs?	○ Yes	○ No
47. *	Have you had to use more and more drugs or alcohol to get the effect you want?	○ Yes	○ No
48. *	Have you felt that you could not control your alcohol or drug use?	○ Yes	○ No
49. *	Have you felt that you were "hooked" on alcohol or drugs?	○ Yes	○ No
50. *	Have you missed out on activities because you spend too much money on drugs or alcohol?	○ Yes	○ No
51. *	Did you break rules, miss curfew, or break the law because you were high on alcohol or drugs?	○ Yes	○ No
52. *	Did you change rapidly from very happy to very sad or from very sad to very happy because of drugs?	○ Yes	○ No
53. *	Did you have a car accident after using alcohol or drugs?	○ Yes	○ No
54. *	Have you accidentally hurt yourself or someone else after using alcohol or drugs?	○ Yes	○ No
55. *	Have you had a serious argument or fight with a friend or a family member because of your drinking or drug use?	○ Yes	○ No
56. *	Have you had trouble getting along with any of your friends because of alcohol or drug use?	○ Yes	○ No
57. *	Have you experienced any withdrawal symptoms following use of alcohol or drugs (e.g., headaches, nausea, vomiting, shaking)?	○ Yes	○ No
58. *	Have you had a problem remembering what you had done while you were under the effects of drugs or alcohol?	○ Yes	○ No
59. *	Did you drink large quantities of alcohol when you went to parties?	○ Yes	○ No
60. *	Did you have trouble resisting using alcohol or drugs?	○ Yes	○ No
61. *	Have you ever told a lie in your lifetime?	○ Yes	○ No
62. *	Did you argue a lot?	○ Yes	○ No
63. *	Did you brag a lot?	○ Yes	○ No

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64. *	Did you tease or do harmful things to animals?	Yes	No
65. *	Did you yell a lot?	Yes	No
66. *	Have you been stubborn?	Yes	No
67. *	Were you suspicious of other people?	Yes	No
68. *	Did you swear or use dirty language a lot?	Yes	No
69. *	Did you bully, be mean to others a lot?	Yes	No
70. *	Did you have a bad temper?	Yes	No
71. *	Have you been very shy?	Yes	No
72. *	Did you threaten to hurt people?	Yes	No
73. *	Did you talk louder than most other people?	Yes	No
74. *	Were you easily upset?	Yes	No
75. *	Did you do things a lot without first thinking about the consequences?	Yes	No
76. *	Did you do risky or dangerous things a lot?	Yes	No
77. *	Did you take advantage of people?	Yes	No
78. *	Did you generally feel angry?	Yes	No
79. *	Did you spend most of your free time by yourself?	Yes	No
80. *	Were you a loner?	Yes	No
81. *	Were you very sensitive to criticism?	Yes	No
82. *	In your lifetime, do you behave better when you are around people you don't know?	Yes	No
83. *	Have you had a physical exam or been under a doctor's care?	Yes	No
84. *	Have you had any accidents or injuries that still bother you?	Yes	No
85. *	Did you either sleep too much or too little?	Yes	No
86. *	Have you either lost or gained more than 10 pounds?	Yes	No
87. *	Did you have less energy than you think you should have?	Yes	No
88. *	Did you have trouble with your breathing or with coughing?	Yes	No
89. *	Did you have any concerns about sex or trouble with your sex organs?	Yes	No
90. *	Have you had sex with someone who shot up drugs?	Yes	No
91. *	Have you had trouble with abdominal pain or nausea?	Yes	No

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Adult Past Year Time Frame **Name:**_____

92. *	Have your eye whites ever turned yellow?	Yes	No
93. *	In your lifetime, did you ever feel that you wanted to swear?	Yes	No
94. *	Have you intentionally damaged someone else's property?	Yes	No
95. *	Have you stolen things?	Yes	No
96. *	Have you gotten into physical fights?	Yes	No
97. *	Have you been a fidgety person?	Yes	No
98. *	Have you been restless and unable to sit still?	Yes	No
99. *	Did you get frustrated easily?	Yes	No
100. *	Did you have trouble concentrating?	Yes	No
101. *	Did you feel sad a lot?	Yes	No
102.*	Did you bite your fingernails?	Yes	No
103. *	Did you have trouble sleeping?	Yes	No
104. *	Have you been nervous?	Yes	No
105. *	Did you get easily frightened?	Yes	No
106.*	Did you worry a lot?	Yes	No
107. *	Did you have trouble getting your mind off things?	Yes	No
108. *	Did people stare at you?	Yes	No
109. *	Did you hear things that no one else around you heard (outside of cultural or ceremonial activities)?	Yes	No
110. *	Did you have special powers nobody else has (outside of dreams, cultural, or ceremonial activities)?	Yes	No
111. *	Were you afraid to be around people?	Yes	No
112. *	Did you often feel like you wanted to cry?	Yes	No
113. *	Did you have so much energy that you did not know what to do with yourself?	Yes	No
114. *	Have you ever felt tempted to steal something in your lifetime?	Yes	No
115. *	Were you disliked by others?	Yes	No
116. *	Were you usually unhappy with how well you did in activities with your friends?	Yes	No
117. *	Was it difficult to make friends in a new group?	Yes	No
118. *	Did people take advantage of you?	Yes	No

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119. *	Were you afraid to stand up for your rights?	Yes	No
120. *	Was it hard for you to ask for help from others?	Yes	No
121. *	Were you easily influenced by other people?	Yes	No
122. *	Did you prefer doing things with people much older or younger than you?	Yes	No
123. *	Did you worry about how your actions would affect others?	Yes	No
124. *	Did you have difficulty standing up for your opinions?	Yes	No
125. *	Did you have trouble saying "no" to people?	Yes	No
126. *	Did you feel uncomfortable if someone gave you a compliment?	Yes	No
127. *	Did people see you as being unfriendly?	Yes	No
128. *	Did you avoid eye contact when talking to friends and family?	Yes	No
129. *	Has your mood ever changed in your lifetime?	Yes	No
130. *	Has a member of your family (mother, father, brother, or sister) ever used drugs to get high like marijuana, cocaine, or heroin?	Yes	No
131. *	Has a member of your family used alcohol to the point of causing problems at home, work, or with friends?	Yes	No
132. *	Has a member of your family ever been arrested?	Yes	No
133. *	Did you have frequent arguments with your children, parents or spouse which involved yelling and screaming?	Yes	No
134. *	Did your family hardly do things together?	Yes	No
135. *	Were your parents or spouse unaware of your likes and dislikes?	Yes	No
136. *	Were there no clear rules about what you can and cannot do?	Yes	No
137. *	Were your parents or spouse unaware of what you really think or feel about things that are important to you?	Yes	No
138. *	Did you argue with your parents or your spouse or other family members a lot?	Yes	No
139. *	Were your parents or your spouse often unaware of where you were and what you were doing?	Yes	No
140. *	Were your parents or your spouse away from home most of the time?	Yes	No
141. *	Did you feel that either your parents or your spouse don't care about you?	Yes	No
142. *	Were you unhappy about your living arrangements?	Yes	No
143. *	Did you feel in danger at home?	Yes	No
144. *	In your lifetime, did you ever get angry?	Yes	No
145. *	Did you dislike school?	Yes	No

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146. * Did you have trouble concentrating in school or when studying? ○ Yes ○ No
147. * Were your grades below average? ○ Yes ○ No
148. * Did you cut/skip school more than two days a month? ○ Yes ○ No
149. * Were you absent from school a lot? ○ Yes ○ No
150. * Have you thought seriously about quitting school? ○ Yes ○ No
151. * Did you often not do your school assignments? ○ Yes ○ No
152. * Did you often feel sleepy in class? ○ Yes ○ No
153. * Were you often late for class? ○ Yes ○ No
154. * Did you have different friends at school this year than you did last year? ○ Yes ○ No
155. * Did you feel irritable and upset when in school? ○ Yes ○ No
156. * Were you bored in school? ○ Yes ○ No
157. * Were your grades in school worse than they used to be? ○ Yes ○ No
158. * Did you feel in danger at school? ○ Yes ○ No
159. * Have you failed a grade in school? ○ Yes ○ No
160. * Did you feel unwelcome in school clubs or extracurricular activities? ○ Yes ○ No
161. * Have you missed or been late to school because of alcohol or drugs? ○ Yes ○ No
162. * Have you been in trouble at school because of alcohol or drugs? ○ Yes ○ No
163. * Has your use of alcohol or drugs interfered with your homework or school assignments? ○ Yes ○ No
164. * Have you been suspended? ○ Yes ○ No
165. * In your lifetime, did you ever put things off that you needed to do? ○ Yes ○ No
166. * Have you had a paying job that you were fired from? ○ Yes ○ No
167. * Have you stopped working at a job because you just didn't care? ○ Yes ○ No
168. * Did you need help from others to go about finding a job? ○ Yes ○ No
169. * Have you been frequently absent or late for work? ○ Yes ○ No
170. * Did you find it difficult to complete work tasks? ○ Yes ○ No
171. * Have you made money doing something that was against the law? ○ Yes ○ No
172. * Have you used alcohol or drugs while working on a job? ○ Yes ○ No
173. * Have you been fired from a job because of drugs? ○ Yes ○ No

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Name:_____

174. * Did you have trouble getting along with bosses? ○ Yes ○ No

175. * Did you mostly work so that you can get money to buy drugs? ○ Yes ○ No

176. * In your lifetime, are you more happy if you win than lose a game? ○ Yes ○ No

177. * Did any of your friends regularly use alcohol or drugs? ○ Yes ○ No

178. * Did any of your friends sell or give drugs away? ○ Yes ○ No

179. * Did any of your friends lie a lot? ○ Yes ○ No

180. * Did your parents or spouse dislike your friends? ○ Yes ○ No

181. * Have any of your friends been in trouble with the law? ○ Yes ○ No

182. * Were most of your friends older than you? ○ Yes ○ No

183. * Did your friends cut school or work a lot? ○ Yes ○ No

184. * Did your friends get bored at parties when there was no alcohol served? ○ Yes ○ No

185. * Have your friends brought drugs to parties? ○ Yes ○ No

186. * Have your friends stolen anything from a store or damaged property on purpose? ○ Yes ○ No

187. * Did you belong to a gang? ○ Yes ○ No

188. * Were you bothered by problems you were having with a friend? ○ Yes ○ No

189. * Was there no friend to confide in? ○ Yes ○ No

190. * Compared to most people, did you have few friends? ○ Yes ○ No

191. * Have you ever in your lifetime been talked into doing something you didn't want to do? ○ Yes ○ No

192. * Compared to most people, did you do less sports? ○ Yes ○ No

193. * Did you usually stay out late on nights when you had to go to school or work the next morning? ○ Yes ○ No

194. * On a typical day, do you watch more than two hours of TV? ○ Yes ○ No

195. * Did you go to bars/bootleggers, house parties, or bush parties with your friends on a regular basis at least twice a week? ○ Yes ○ No

196. * Did you exercise less than most people you know? ○ Yes ○ No

197. * Was your free time spent just hanging out with friends? ○ Yes ○ No

198. * Were you bored most of the time? ○ Yes ○ No

199. * Did you do most of your recreation or leisure activities alone? ○ Yes ○ No

200. * Did you use alcohol or drugs for recreational reasons? ○ Yes ○ No

201. * Compared to most people, were you less involved in hobbies or outside interests? ○ Yes ○ No

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Name:_____

202. *	Were you dissatisfied with how you spend your free time?	Yes	No
203. *	Did you get tired very quickly when you exerted yourself?	Yes	No
204. *	Have you ever bought anything in your lifetime that you did not need?	Yes	No
205. *	Have you felt your cultural identity doesn't matter?	Yes	No
206. *	Have you had frequent nightmares?	Yes	No
207. *	Have you felt helpless to change your life?	Yes	No
208. *	Have you experienced frequent emotions like fear, anger, guilt, or shame?	Yes	No
209. *	Have you frequently thought about ending your life?	Yes	No
210. *	Have you felt alienated from family, friends, or community?	Yes	No
211. *	Have you harmed yourself (cutting, scratching, etc.)?	Yes	No
212. *	Have you felt guilty about experiencing pleasant emotions?	Yes	No
213. *	Have you felt overwhelmed by upsetting memories?	Yes	No
214. *	Have you felt betrayed by others?	Yes	No
215. *	Have you lacked motivation to care for your health (diabetes, heart, diet, exercise, hygiene)?	Yes	No

OFFICE USE ONLY

Date of Completion _____

NOTES: