AODTS002

FOR STAFF ONLY

UR Number:

Surname:

Given name:

Date of birth:

(Please fill in if no label available)

SELF-COMPLETION FORM

Please complete the following form as best as you can to help us understand you and your needs.

Tick the boxes that best describe your situation, and write in the spaces provided.

Don't worry if you cannot complete all the questions.

Your worker will go over everything with you. And if you prefer not to complete it at all, that's OK too.

FOR STAFF ONLY

Clinician name:

Agency: Catchment:

Date: Signature:

Version No. 2

VICTORIA State Government

UR Number: .....

The following questions ask about how you are going with your alcohol or drug use and other areas of your life. This will help us see how you progress.

STAGE: ☐ Start of treatment ☐ Review

SECTION 1: SUBSTANCE USE

In the past four weeks (28 days) have you used any of the following substances? (If you were in hospital/ prison/rehab in the previous month, consider your substance use in the four weeks before that) ☐ Yes ☐ No (if no skip to section 2)

If yes, record number of days and how much you used in the past four weeks.

	If yes, days of use (1-28)
Alcohol	☐ No ☐ Yes: .....
Cannabis (e.g. marijuana, pot, grass, hash, synthetic cannabis etc)	☐ No ☐ Yes: .....
Methamphetamine (e.g., ice, speed, base)	☐ No ☐ Yes: .....
Other amphetamine type stimulants (e.g. MDMA /ecstasy, diet pills etc)	☐ No ☐ Yes: .....
Prescribed sedatives or sleeping pills (e.g. benzodiazepines, xanax, valium, serapax, rohypnol, stilnox etc)	☐ No ☐ Yes: .....
Non-prescribed benzodiazepines	☐ No ☐ Yes: .....
Prescribed Opioids (e.g. methadone/buprenorphine)	☐ No ☐ Yes: .....
Non-prescribed Opioids (e.g. heroin, codeine, methadone, oxycodone, morphine, fentanyl etc)	☐ No ☐ Yes: .....
Cocaine	☐ No ☐ Yes: .....
Inhalants (e.g. nitrous, glue, petrol, paint thinner, Amyl etc)	☐ No ☐ Yes: .....
Hallucinogens (e.g. LSD, acid, mushrooms, PCP, ketamine, synthetic hallucinogens etc)	☐ No ☐ Yes: .....
Tobacco	☐ No ☐ Yes: .....
GHB	☐ No ☐ Yes: .....
Other substances (e.g. steroids caffeine/energy drinks, new and emerging drugs etc)	☐ No ☐ Yes: .....

Have you injected drugs in the past four weeks? (If no, skip to section 2) ☐ No ☐ Yes Number of days injected: .....

If yes, did you inject with equipment used by someone else? ☐ No ☐ Yes

SECTION 2: HEALTH AND WELLBEING

What is your employment status? ☐ Employed ☐ Unemployed ☐ Studying ☐ Home duties ☐ Other (Please specify): .....

How many days of paid work (not including voluntary work) have you had in the past four weeks? .....

How many days of school, tertiary education or vocational training have you had in the past four weeks? .....

In the past four weeks:

What type of accommodation have you been living in in the past 4 weeks?
(e.g. private residence, boarding house, residential care facility):

Have you been homeless?	☐ No ☐ Yes
Have you been at risk of eviction?	☐ No ☐ Yes
Have you been arrested?	☐ No ☐ Yes
Have you been violent (incl. family violence) towards someone?	☐ No ☐ Yes
Has anyone been violent (incl. family violence) towards you?	☐ No ☐ Yes
Have you been attended to by an ambulance or been in hospital?	☐ No ☐ Yes

How would you rate your **psychological health status** in the past four weeks (anxiety, depression and problem emotions and feelings)

POOR 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ GOOD

How would you rate your **physical health status** in the past four weeks (extent of physical symptoms and bothered by illness)

POOR 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ GOOD

How would you rate your overall **quality of life** in the past four weeks (e.g. able to enjoy life, get on well with family and partner, satisfied with living conditions)

POOR 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ GOOD

FOR STAFF ONLY

Clinician name: ..... Position: ..... Signature: ..... Date: .....

UR Number:

ALCOHOL USE (AUDIT)

The following questions will give us a picture of your recent alcohol use, and will help us determine how best to help you. Please circle the response that best describes your drinking. If you haven't been drinking alcohol you don't need to answer the questions.

Have you drunk any alcohol in the last year? (Please tick yes or no)

☐ Yes Please answer the questions below ☐ No If you answer no, skip to the next page →

		0	1	2	3	4
1	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3	How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	How often during the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

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UR Number:

USE OF DRUGS OTHER THAN ALCOHOL (DUDIT)

The next questions will help us to understand whether use of all drugs other than alcohol is a problem for you. This *includes* illicit drugs & pharmaceutical medications (e.g. sleeping pills, pain killers). It does *not include* medication that you take as *prescribed* by your doctor. Please circle the response that best describes your use of all drugs (other than alcohol). If you haven't been using any, then you don't need to answer the questions.

Have you used drugs other than alcohol in the last year?

☐ Yes Please answer the questions below ☐ No If you answer no, skip to the next page →

		0	1	2	3	4
1	How often do you use drugs other than alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How often do you use more than one drug on the same occasion?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
3	How many times do you take drugs on a typical day when you use drugs?	0	1 or 2	3 or 4	5 or 6	7 or more
4	How often are you influenced heavily by drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	Over the past year, have you felt your longing for drugs was so strong that you could not resist it?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often over the past year have you taken drugs and then neglected to do something you should have done?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
10	Have you or anyone else been hurt (mentally or physically) because you used drugs?	No		Yes, but not in the last year		Yes, during the last year
11	Has a relative or a friend, a doctor or a nurse, or anyone else been worried about your drug use or said to you that you should stop using drugs?	No		Yes, but not in the last year		Yes, during the last year

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HOW HAVE YOU BEEN FEELING DURING THE PAST 30 DAYS? (K10)

The following questions ask about how you have been feeling during the past 30 days. It's important to understand how you are feeling and where you are at. For each question, tick the box that best describes how often you had this feeling.

	DURING THE PAST 30 DAYS, HOW OFTEN DID YOU FEEL	NONE OF THE TIME 1	A LITTLE OF THE TIME 2	SOME OF THE TIME 3	MOST OF THE TIME 4	ALL OF THE TIME 5
1	**...tired for no good reason?**	☐	☐	☐	☐	☐
2	**...nervous?**	☐	☐	☐	☐	☐
3	**...so nervous that nothing could calm you down?**	☐	☐	☐	☐	☐
4	**...hopeless?**	☐	☐	☐	☐	☐
5	**...restless or fidgety?**	☐	☐	☐	☐	☐
6	**...so restless that you could not sit still?**	☐	☐	☐	☐	☐
7	**...depressed?**	☐	☐	☐	☐	☐
8	**...so depressed that nothing could cheer you up?**	☐	☐	☐	☐	☐
9	**...that everything was an effort?**	☐	☐	☐	☐	☐
10	**...worthless?**	☐	☐	☐	☐	☐

Thank you for completing this form. Please hand it to the worker who will review your responses and will be able to address any questions you have.

FOR STAFF ONLY

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