

# FOLLOW UP INTERVIEW WORKSHEET

Instructions: Please answer each question by checking only one box per question or writing in the number of times you have done what the question is asking about. If you check "Other" for any answer, please provide a brief description, with the specific answer that didn't fit into any of the other categories.

**IF YOU ARE PRESENTLY STRUGGLING WITH SUBSTANCE USE AND WOULD LIKE HELP IN FINDING RESOURCES TO ASSIST YOU, PLEASE CALL BPA HEALTH AT (800) 922-3406 TO TALK WITH SOMEONE THAT CAN HELP.**

Client Full Name	First: _____  Last: _____
Employment Status	<input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> In the Armed Forces <input type="checkbox"/> Other/Description: _____ <input type="checkbox"/> Resident/Inmate <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal Employee: In Season <input type="checkbox"/> Seasonal Employee: Out of Season <input type="checkbox"/> Student <input type="checkbox"/> Unemployed
Living Arrangement	<input type="checkbox"/> Adult living with parents, relatives, or guardians <input type="checkbox"/> Alone (without supervision) <input type="checkbox"/> Halfway House <input type="checkbox"/> Homeless <input type="checkbox"/> Jail/Correctional Facility <input type="checkbox"/> Safe and Sober Housing <input type="checkbox"/> Other/Description: _____
Primary Source of Income	<input type="checkbox"/> Disability <input type="checkbox"/> None <input type="checkbox"/> Other/Description: _____ <input type="checkbox"/> Public Assistance <input type="checkbox"/> Retirement/Pension <input type="checkbox"/> Wages/Salary

Arrests in Prior 30 Days	# of arrests: _____
Self Help Group in Past 30 Days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Education/Training Program in Past 30 Days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Graduate from E/T Program in Past 30 Days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Primary Substance Description	<input type="checkbox"/> Barbiturates <input type="checkbox"/> Nicotine <input type="checkbox"/> Inhalants <input type="checkbox"/> Other Sedatives or Hypnotics <input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish/THC/Cannabis <input type="checkbox"/> Non-Prescription Methadone <input type="checkbox"/> Heroin <input type="checkbox"/> Other opiates/Synthetics <input type="checkbox"/> PCP - Phencyclidine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Methamphetamine/Speed <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Other Tranquilizers <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Over-The-Counter Medications <input type="checkbox"/> Other/Description: _____
Primary Intake Type Description	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection (intravenous, intramuscular, intradermal, or subcutaneous) <input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> N/A <input type="checkbox"/> Other/Description: _____

<p>Primary Frequency Description</p>	<input type="checkbox"/> Daily <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> No use in the past month <input type="checkbox"/> N/A
<p>Secondary Substance Description</p>	<input type="checkbox"/> Barbiturates <input type="checkbox"/> Nicotine <input type="checkbox"/> Inhalants <input type="checkbox"/> Other Sedatives or Hypnotics <input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish/THC/Cannabis <input type="checkbox"/> Non-Prescription Methadone <input type="checkbox"/> Heroin <input type="checkbox"/> Other opiates/Synthetics <input type="checkbox"/> PCP - Phencyclidine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Methamphetamine/Speed <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Other Tranquilizers <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Over-The-Counter Medications <input type="checkbox"/> Other/Description: _____
<p>Secondary Intake Type Description</p>	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection (intravenous, intramuscular, intradermal, or subcutaneous) <input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> N/A <input type="checkbox"/> Other/Description: _____
<p>Secondary Frequency Description</p>	<input type="checkbox"/> Daily <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> No use in the past month <input type="checkbox"/> N/A

Tertiary Substance Description	<input type="checkbox"/> Barbiturates <input type="checkbox"/> Nicotine <input type="checkbox"/> Inhalants <input type="checkbox"/> Other Sedatives or Hypnotics <input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Marijuana/Hashish/THC/Cannabis <input type="checkbox"/> Non-Prescription Methadone <input type="checkbox"/> Heroin <input type="checkbox"/> Other opiates/Synthetics <input type="checkbox"/> PCP - Phencyclidine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Methamphetamine/Speed <input type="checkbox"/> Other Amphetamines <input type="checkbox"/> Other Stimulants <input type="checkbox"/> Other Tranquilizers <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Over-The-Counter Medications <input type="checkbox"/> Other/Description: _____
Tertiary Intake Type Description	<input type="checkbox"/> Inhalation <input type="checkbox"/> Injection (intravenous, intramuscular, intradermal, or subcutaneous) <input type="checkbox"/> Oral <input type="checkbox"/> Smoking <input type="checkbox"/> N/A <input type="checkbox"/> Other/Description: _____
Tertiary Frequency Description	<input type="checkbox"/> Daily <input type="checkbox"/> 3-6 days in the past week <input type="checkbox"/> 1-2 days in the past week <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> No use in the past month <input type="checkbox"/> N/A
Received Substance Use Disorder Treatment Since Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Currently in Substance Use Disorder Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
# of Days in Past 30 Missed Work/School Due to Drinking/Drug Use	# of days: _____

Significant Periods of Psychological Distress in Past 30 Days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
# of Emergency Room Visits Since Discharge	# of visits: _____
# of Hospitalizations for Medical Problems Since Discharge	# of hospitalizations: _____
Pregnant at Time of Follow Up?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Health Insurance	<input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Other/Description: _____ <input type="checkbox"/> Private Insurance (other than BC/BS or HMO)
Date Completed	Date: _____