DARA Thailand
DRUG & ALCOHOL REHAB ASIA

DARA – Thailand by Asia Health Co., Ltd.
CLIENT ASSESSMENT FORM

Please provide us with the following information as carefully and truthfully as you can (get help from a family member if needed). As full a picture as possible of your substance use and past history is essential. This allows us to best determine the safest Intake procedure and Detox to meet your needs.
Please note: Filling in this form is an essential preparation for admission to DARA

Todays Date: dd / mm / yy

Surname: First Name:

Passport Number: Expiry Date: /

Nationality: (as shown in passport) Date of Birth: dd / mm / yy

Gender: Male Female

Contact Address:

Postcode:

Country: Your Contact email:

Emergency Contact Person: Relationship:

Emergency Contact Number:

GENERAL INFORMATION

How did you learn about DARA?

The primary language used at the center is English. Do you have a problem with understanding, reading or writing the English language?

Yes No

What is your preferred length of residential stay?

4 Weeks 8 Weeks 12 Weeks Others (please specify)

What was the crisis or precipitating event for entering treatment?

Who initiated treatment?

What do you want help with?

How motivated are you to change your drinking or drug use?

Low Medium High

PATTERN/FREQUENCY/AMOUNT OF SUBSTANCES USED

Substance	First Use (Age)	Method of Use (Oral/Snort/Inhale/IV)	Current Use (Daily/Weekly/Binge)	How Much (Vol/Weight)
Alcohol				
Cocaine / Crack				
Heroin				
Methamphetamine				
Amphetamine (Ritalin / Benzedrine / Adderal / Dexedrine)				
Designer Drugs Ecstasy / MDMA/GBH				
Tranquilizers/Benzos Valium / Xanax / Klonopin / Librium / Ambien / Temazepam / Halcion				
Other Opiates Hydrocodone / Oxycodone / Oxycontin / Morphine / Codeine / Methadone / Dilaudid / Fentanyl				
Marijuana				
Hallucinogens (LSD / Mushrooms / PCP / Mescaline)				
Inhalants Aerosols / Gases / Solvents / Glue				
Ketamine				
Others				

How long have you been using your particular drug of choice or alcohol above and when did you last use?

Have you used or drank in the last week?

☐ Yes ☐ No

Is it likely you will have used or drank 5 days before coming to treatment?

☐ Yes ☐ No

When you use or drink have you experienced (please tick)

☐ Loss of Memory ☐ Passing Out ☐ Domestic Violence ☐ Being Verbally Abusive

☐ A Drink / Drug Driving Offence ☐ Homicidal Thoughts ☐ Police Problems (Please give details)

ABSTINENCE AND WITHDRAWAL

What is the longest period of total abstinence that you have had in the past 5 years and why did you stop?

When you stop drinking or using do you get sick? If so, describe the symptoms:

When you stop drinking or using have you ever had (Please tick)

- ☐ Depression
- ☐ Insomnia
- ☐ Slept too much
- ☐ Lost your appetite
- ☐ Body sweats
- ☐ Headache
- ☐ Irritability
- ☐ Restlessness
- ☐ Shakes
- ☐ Nausea
- ☐ Vomiting
- ☐ Fits
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Disorientation
- ☐ Diarrhoea
- ☐ Confusion

How many times have you attempted to stop or control your drinking or using?

Have you ever participated in any kind of drug or alcohol rehabilitation program before? (Please give details of how many times, when, where, how long, and any detox complications.)

Number of times

Month/Year	Facility Name	Level of Care	How Long	Complications
mm/yy				
mm/yy				
mm/yy				
mm/yy				

Do you think you will need detox?

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MEDICAL HISTORY :

Have you been hospitalized or treated for any serious health problems in the past year? ☐ Yes ☐ No
If yes, please specify:

Heart Conditions or High Blood Pressure? ☐ Yes ☐ No
If yes, please specify:

Respiratory Conditions eg. Asthma? ☐ Yes ☐ No
If yes, please specify:

Physical or Mobility P roblems? ☐ Yes ☐ No
If yes, please specify:

Visual or Hearing Disability? ☐ Yes ☐ No
If yes, please specify:

Diabetes or Thyroid Problems? ☐ Yes ☐ No
If yes, please specify:

Liver Problems? ☐ Yes ☐ No
If yes, please specify:

Fits or Epilepsy? ☐ Yes ☐ No
If yes, please specify:

PSYCHIATRIC HISTORY

Have you ever been treated for a mental illness? ☐ Yes ☐ No
If yes, please specify:

Any history of anxiety or depression? ☐ Yes ☐ No
If yes, please specify:

Any history of deliberate self-harm / past suicide attempts / recent suicidal thoughts? ☐ Yes ☐ No
If yes, please specify:

Panic Attacks? ☐ Yes ☐ No
If yes, please specify:

OTHER ADDICTIVE BEHAVIOURS PAST OR PRESENT (Please tick)

☐ Gambling ☐ Eating Disorders ☐ Sex ☐ Work ☐ Others ☐ None

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CURRENT MEDICATIONS

Any drug allergies? ☐ Yes ☐ No
If yes, please specify:

Details of medications currently being used, both prescribed and over the counter:

REFERRING DOCTOR

Primary Physician that prescribed current medication:

Surname: First Name:

Phone Number: Email:

Psychiatrist that prescribed current medication:

Surname: First Name:

Phone Number: Email:

Are you comfortable with us contacting your doctors after your admission if it becomes necessary?

☐ Yes ☐ No

Dietary requirements. Do you have any food allergies or any foods you do not eat?

What obstacles might prevent you from coming into treatment?

Any other information you feel might be helpful to us!

THANK YOU