



# SUBSTANCE USE ASSESSMENT PATIENT INFORMATION

CROSSROADS WELLNESS, LLC 7465 W. Lake Mead Blvd., Ste. 100 • Las Vegas, NV 89128  
702.480.4891 (Chad) • 702.480.4834 (Pam) • 702.562.1221 (Fax)

Date: \_\_\_\_\_

## Personal Information:

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (primary): \_\_\_\_\_

City	State	Zip
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▪ Social Security Number or Employee ID Number \_\_\_\_\_

## Telephone Contact information:

Please list the numbers where we may contact you.

Home: \_\_\_\_\_ May a message be left at this number?  Yes  No

Cell: \_\_\_\_\_ May a message be left at this number?  Yes  No

Work: \_\_\_\_\_ May a message be left at this number?  Yes  No

## Background Information

Highest grade level completed: \_\_\_\_\_ Special Ed:  Yes  No

Marital status:  Single  Married  Living with significant other  
 Divorced  Separated  Widowed

Length of current significant relationship/marriage: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

**Counseling/Psychological History**

	<b>YES</b>	<b>NO</b>
Are you currently in counseling or under psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever participated in psychological counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Individual counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Couple/marriage counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Group counseling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever participated in addictions counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Alcohol counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Drug counseling?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Gambling counseling?	<input type="checkbox"/>	<input type="checkbox"/>

**Medications**

Current Prescription Medications	Dosage	Prescribing Physician

Current Non-prescription/Over-the-counter medications	How long have you been taking these medications?

**Court Information (if applicable)**

<b>Court Jurisdiction</b>	
<b>Case Number</b>	
<b>Return-to-court Date</b>	
<b>Charges</b>	



## CONSENT TO ASSESSMENT & OFFICE POLICY STATEMENT

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### Assessment

Assessment will include evaluation, historical information provided by the patient, and formal testing. You are expected to play an active role in this assessment. If you and/or I believe that a referral to another professional would be appropriate during the course of this assessment, you will be given referrals for other community agencies and/or private substance abuse/mental health practitioners who may meet your needs.

Medical issues (e.g., medications or diagnoses) may be discussed during this assessment; however, it should be noted that the counselor is NOT a medical doctor, and that any such discussions pertinent to your medical care should be directed to your physician.

### Fees

Fees are due at the end of each session. The following is my list of fees:

Service	Fee
Substance use assessment interview and Nevada evaluation report completion ( <i>excluding chemical testing</i> )	\$125.00
Substance use assessment computerized testing ( <i>required</i> )	\$25.00
Substance use assessment <u>out-of-state</u> form completion ( <i>if applicable</i> )	\$25.00
Substance abuse chemical testing ( <i>if required by court</i> )	
♦ Urinalysis (10-panel drug + adulterants)	\$25.00 (UA)
♦ Breathalyzer (Volatilized blood-alcohol content)	\$10.00 (BAC)
Telephone consultation (per 15 minutes)	\$25.00
Outside consultation (e.g., attorney, court, school, etc.)	\$350/hour

### Confidentiality (Privacy of Information)

A record of all assessment sessions is kept. This information is confidential. Information about your assessment cannot be shared with anyone (e.g., insurance companies, attorneys, physicians, family members, and others) without your written consent. However, certain laws and ethical standards limit confidentiality of treatment information.

Limits of confidentiality are as follows:

- Signed Release of Information form
- Suspected incidents of child or elder abuse
- Potential danger to self or others
- Periodic consultation with supervisors
- Signed court order (per USC Title 42)

**Risks/Benefits**

Therapy/assessment has been demonstrated to help many individuals. One of the primary risks of therapy/assessment is that the process may include discussing problems or events that may evoke unpleasant feelings. If this occurs, please inform the counselor immediately so that these feelings may be addressed in a timely and appropriate manner.

**Emergencies**

If you have a psychological emergency, you may call 911 or Montevista, a psychiatric facility that provides 24-hour crisis assistance (702.364.1111).

**The Therapeutic Relationship**

As a professional I will use my best knowledge and skills to perform the assessment. Additionally, I must abide by the rules and standards set forth by my professional licensing and certification Boards. In your best interests, these Boards put limits on the relationship between a therapist and a client, and I will abide by these limits.

**My signature below indicates that I have read and understand the nature and limits of the services provided. I agree to voluntarily participate in therapy services and will aid in the formation and completion of this assessment. Further, I agree to provide full and accurate information throughout the assessment process. I acknowledge that Crossroads Wellness, LLC will provide a summary based on my self-report responses and agree that Crossroads Wellness, LLC will not be held legally liable for providing treatment recommendations that are based on the professional judgment of the counselor(s).**

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature (if required)	Date
_____	_____
Chad L. Cross, PhD, MS NCC, MAC, SAP, LCADC, MFT	Date

**Licenses and Certifications for Chad L. Cross, PhD, MS**  
*MS: Counseling (University of Nevada Las Vegas)*  
*PhD: Statistics/Quantitative Ecology (Old Dominion University)*  
 NPI: 1477769438

- National Certified Counselor (NBCC: 87287)
- Master Addictions Counselor (NBCC: 87287)
- Substance Abuse Professional (NADAAC: 80855)
- Licensed Clinical Alcohol & Drug Counselor (NV: 125-LC)
- Licensed Marriage & Family Therapist (NV: MF01117)



**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

2660 Crimson Canyon Dr., Ste. 150 • Las Vegas, NV 89128

**CROSSROADS WELLNESS, LLC** 702.480.4891 (Chad) • 702.480.4834 (Pam) • 702.562.1221 (Fax)

I, \_\_\_\_\_, authorize the following agencies:

**Agency A**

**Agency/Person B**

**Crossroads Wellness, LLC**

7465 W. Lake Mead Blvd.  
Suite 100  
Las Vegas, NV 89128

702-480-4891 (Chad)  
702-562-1221 (Fax)

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

To make the following transaction:

\_\_\_\_\_ **Agency A and Agency/Person B** to disclose information specified below to **each other**  
*Initials*

**I authorize the release of the following information:**

*All information pertinent to the interview, testing, and summary documents related to my assessment.*

**For the purpose of:**

*Fulfilling personal/agency request for substance use assessment.*

This release is effective from: \_\_\_\_\_ to \_\_\_\_\_  
MM/DD/YY MM/DD/YY

***I understand that I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. I agree to release Crossroads Wellness, LLC from any legal action in regards to disclosure of my records.***

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Chad L. Cross, PhD, MS**

\_\_\_\_\_  
Date

- National Certified Counselor (NBCC: 87287)
- Master Addiction Counselor (NBCC: 87287)
- Substance Abuse Professional (NAADAC: 13014)
- Licensed Clinical Alcohol & Drug Counselor (NV: 125-LC)
- Licensed Marriage & Family Therapist (NV: MF01117)