



Enrollment Assessment Parole Re-entry Centers

▶ Enrollment Date: / / mm dd yyyy
▶ ESM Client ID:
▶ Provider ID:

Questions (Q) marked with ▶ must be completed. **Boxes marked with ★ = Refer to Key at end of form**

First Name:	Middle Initial:	Last Name:	Suffix:
▶ 1. Client Code: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		▶ 2. Intake/Clinician Initials: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
▶ 3. Do you own or rent a house, apartment, or room? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If the answer to Q.3 is Yes, skip to Q. 5</i>			
▶ 4. Are you Chronically Homeless? <i>(HUD Definition in Manual)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		▶ 5. ZIP Code of Last Permanent Address: <i>Do Not put zip code of Program. See Manual for definition of Permanent</i>	
▶ 6. Where did you stay last night?			
1 <input type="checkbox"/> Emergency shelter	7 <input type="checkbox"/> Jail, prison or juvenile detention facility	13 <input type="checkbox"/> Foster care home or foster care group hm	
2 <input type="checkbox"/> Transitional housing for homeless persons	8 <input type="checkbox"/> Room, apartment, or house that you own or rent	14 <input type="checkbox"/> Place not meant for habitation	
3 <input type="checkbox"/> Permanent housing for formerly homeless	9 <input type="checkbox"/> Staying or living with a family member	15 <input type="checkbox"/> Other	
4 <input type="checkbox"/> Psychiatric hospital or other psych. facility	10 <input type="checkbox"/> Staying or living with a friend	88 <input type="checkbox"/> Refused	
5 <input type="checkbox"/> Substance abuse treatment facility or detox	11 <input type="checkbox"/> Room, apartment, or house to which you cannot return (future return can be uncertain)		
6 <input type="checkbox"/> Hospital (non-psychiatric)	12 <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher		
▶ 7a. Do you consider yourself to be transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
▶ 7b. If you answered Yes to Q. 7a, please specify: <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/> Other, specify _____			
▶ 8. Do you consider yourself to be: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Refused			
▶ P1. Number of previous incarcerations <input type="checkbox"/>		▶ P2. Has alcohol and/or drugs ever been a factor that led to your being incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ P3. Parole Field Office where client is enrolled (check one)			
<input type="checkbox"/> Brockton	<input type="checkbox"/> Framingham	<input type="checkbox"/> Laurence	<input type="checkbox"/> Mattapan
<input type="checkbox"/> New Bedford	<input type="checkbox"/> Quincy	<input type="checkbox"/> Springfield	<input type="checkbox"/> Worcester
▶ 9. Number of days between initial contact with program by client or someone on behalf of client and the first available appointment : <i>(unknown = 999)</i> <input type="checkbox"/> <i>See manual to help determine wait time.</i>			
▶ 10. Source of Referral: 01 <input type="checkbox"/> Self 14 <input type="checkbox"/> Sober House 65 <input type="checkbox"/> House of Correction 67 <input type="checkbox"/> Dept of Correction 69 <input type="checkbox"/> Mass parole Board			
▶ 11. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Enrollment: <input type="checkbox"/> <input type="checkbox"/> ★			
▶ 12. Client Type <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Collateral			
▶ 13. Additional Client Type (Check ALL that apply)			
<i>New</i> <input type="checkbox"/> Student	<input type="checkbox"/> Postpartum	<input type="checkbox"/> Methadone	<i>New</i> <input type="checkbox"/> Injectable Naltrexone <input type="checkbox"/> Parole <i>(e.g. Vivitrol)</i>
<input type="checkbox"/> Pregnant	<i>Change</i> <input type="checkbox"/> Veteran/ Any Military Service	<i>Change</i> <input type="checkbox"/> Buprenorphine <i>(e.g. Suboxone)</i>	<input type="checkbox"/> Probation
▶ 14. Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <i>If answer to Q. 14 is 'Yes', complete 14a-14d. If no, skip to Q. 15</i>			
14a. Number Children Under 6: <input type="checkbox"/>	14b. Number of Children 6-18: <input type="checkbox"/>	14c. Children Over 18: <input type="checkbox"/>	
14d. Are any of the children of the Native American Indian race? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
▶ 15. Are you the primary caregiver for any children? <i>If yes, see manual. You must assess in clinical assessment!</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
▶ 16. Employment status at Enrollment: <input type="checkbox"/> ★		▶ 17. Number of days worked in the past 30 days? <input type="checkbox"/>	
▶ 18. Where do you usually live? (Where has the client spent/slept most of the time over the last 12 months?)			
1 <input type="checkbox"/> House or apartment	3 <input type="checkbox"/> Institution	5 <input type="checkbox"/> Shelter/mission	7 <input type="checkbox"/> Foster Care
2 <input type="checkbox"/> Room/boarding or sober house	4 <input type="checkbox"/> Group home/treatment	6 <input type="checkbox"/> On the streets	88 <input type="checkbox"/> Refused

▶ **19. Who do you live with?** (Check all that apply)

Alone Child 6-18 Spouse/Equivalent Other R relative

Child under 6 Child over 18 Parents Roommate/Friend

▶ **20. Use of mobility aid:** (Check all that apply) None Crutches Walker Manual Wheelchair Electric Wheelchair

▶ **21. Vision Impairment** * ▶ **22. Hearg Impairment** * ▶ **23. SelfCare/ADL Impairment** * ▶ **24. Developmental Disability** *

▶ **25. Prior Mental Health Treatment:** 0 No history 1 Counseling 2 One hospitalization 3 More than one hospitalization

▶ **26. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?** 1 Yes 2 No 88 Refused 99 Unknown

▶ **27. Number of prior admissions to each substance abuse treatment modality** (0 - 5 admissions, '5' = 5 or more, 99=unknown) Do not count this tx. episode.

Detox Outpatient Drunk Driver Other

Residential Opioid Section 35

▶ **28. Currently receiving services from a state agency:** (Check all that apply)

None DMH does client have a case mgr.? DTA e.g. food stamps MCDHH Deaf

DCF was DSS DDS was DMR MRC Mass Rehab Other

DYS youth services DPH e.g. HIV/STD; not BSAS tx.. MCB Commission for Blind

See manual for system generated associations (e.g. Client Type Probation – OCP services.)

▶ **29. Number of arrests in the past 30 days?** (Section 35 is not an arrest, it is a civil commitment)

		Have You Ever Mis-Used/Bet		Age of First Use/Bet	Last Use/Bet	Freq of Last Use/Bet	Route of Admin Code
		Y	N				
A	Alcohol	<i>For Alcohol, enter first age of intoxication</i>					
B	Cocaine						
C	Crack						
D	Marijuana / Hashish						
E	Heroin						
F	Prescribed Opiates	<i>Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.</i>					
G	Non-prescribed Opiates	<i>Non-medical use of pharmaceutical opiates which were not prescribed for the client</i>					
H	PCP						
I	Other Hallucinogens						
J	Methamphetamine						
K	Other Amphetamines						
L	Other Stimulants						
M	Benzodiazepines						
N	Other Tranquillizers						
O	Barbiturates						
P	Other Sedatives / Hypnotics						
Q	Inhalants						
R	Over the Counter						
S	Club Drugs						
U	Other						
X	Nicotine/Tobacco	<i>Includes cigarettes, cigars, chewing tobacco, inhalers</i>					
Y	Gambling	<i>Includes any of the types listed in Q.32a</i>					N/A

31a. Number of cigarettes currently smoked per day (Indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes) <input style="float:right;" type="text"/>					
If client uses another type of nicotine/tobacco product, mark Zero (0) and go to Q. 31b . <i>If client does not have a history of nicotine/tobacco use, skip Q 31a & b and go to Q 32a.</i>					
31b. Interest in stopping nicotine/tobacco use at Enrollment:					
1 <input type="checkbox"/> No	3 <input type="checkbox"/> Yes, Within 30 days	88 <input type="checkbox"/> Refused			
2 <input type="checkbox"/> Yes, Within 6 Months	4 <input type="checkbox"/> Does Not Apply (already stopped)	99 <input type="checkbox"/> Unknown			
32a. Types of last regular gambling (check all that apply) If person does not have a gambling history, skip Q. 32a & 32b and go to Q. 33.					
<input type="checkbox"/> Lottery -Scratch Tickets	<input type="checkbox"/> Slot Machines	<input type="checkbox"/> Sports Betting	<input type="checkbox"/> Stock Market		
<input type="checkbox"/> Lottery - Keno	<input type="checkbox"/> Casino Games	<input type="checkbox"/> Bingo	<input type="checkbox"/> Internet Gambling		
<input type="checkbox"/> Lottery/Numbers Games	<input type="checkbox"/> Card Games	<input type="checkbox"/> Dog/Horse Tracks, Jai Alai			
32b. Have you ever thought you might have a gambling problem, or been told you might? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused					
<i>Nicotine/Tobacco and Gambling CANNOT be marked as a primary/secondary/or tertiary drug. This applies for Substances A through U Only.</i> <i>IT IS VITAL THAT PATIENTS BE ASKED IF THEY HAVE a SECONDARY and/or TERTIARY DRUG OF CHOICE. Clinicians may rank substances based on their clinical opinion after review of the substance use history and not necessarily client report.</i>					
▶ 33. Rank substances by entering corresponding letter for substances listed above in Question 30. (If no secondary or tertiary substance, leave blank)					
Primary Substance <input style="width:40px;" type="text"/>	Secondary Substance <input style="width:40px;" type="text"/>	Tertiary Substance <input style="width:40px;" type="text"/>			
▶ 34. Needle Use?					
0 <input type="checkbox"/> Never	1 <input type="checkbox"/> 12 or more months ago	2 <input type="checkbox"/> 3 to 11 months ago	3 <input type="checkbox"/> 1 to 2 months ago	4 <input type="checkbox"/> Past 30 days	5 <input type="checkbox"/> Last week
▶ 35a. How many overdoses have you had in your lifetime: <input style="width:40px;" type="text"/>	▶ 35b. How many overdoses have you had in past year? <input style="width:40px;" type="text"/>				

★Q 11 Frequency of Attendance at Self-Help Programs			
Code		Code	
01	No attendance in the past month	05	16-30 times in past month (4 or more times per week)
02	1-3 times in past month (less than once per week)	06	Some attendance, but frequency unknown
03	4-7 times in past month (about once per week)	99	Unknown
04	8-15 times in past month (2 or 3 times per week)		

★Q 16 Employment Status at Enrollment					
Code		Code		Code	
1	Working Full Time	6	Not in Labor Force - Retired	11	Volunteer
2	Working Part time	7	Not in Labor Force - Disabled	12	Other
3	Unemployed - looking	8	Not in labor force - Homemaker	13	Maternity/Family Leave
4	Unemployed – Not Looking	9	Not in labor force - Other	99	Unknown
5	Not in labor force – Student	10	Not in labor force - Incarcerated		

Code	★Q. 21 Vision Impairment
0	None: Normal Vision
1	Slight: vision can be or is corrected with glasses/lenses
2	Moderate: "Legally blind" but having some minimal vision
3	Severe: No usable vision

Code	★Q. 22 Hearing Impairment
0	None: Normal hearing requiring no correction
1	Slight: Hearing is or can be adequately corrected with amplification (eg hearing aid)
2	Moderate: Hard of hearing, even with amplification
3	Severe: Profound deafness

Code	★ Q 23 Self Care/ADL Impairment
0	None: No problem accomplishing ADL skills such as bathing, dressing and other self care
1	Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant
2	Moderate: Needs personal attendant up to 20 hours a week for ADL
3	Severe: Requires personal attendant for over 20 hours a week for ADL

Code	★Q. 24 Developmental Disability
0	None
1	Slight developmental disability
2	Moderate developmental disability
3	Severe developmental disability

★Q 30: SUBSTANCE MIS-USE / NICOTINE/TOBACCO / GAMBLING HISTORY

Code	Last Use Substances
1	12 or more months ago
2	3-11 months ago
3	1-2 months ago
4	Past 30 days
5	Used in last week

Code	Frequency of Last Use/bet
1	Less than once a month
2	1-3 times a month
3	1-2 times a week
4	3-6 times a week
5	Daily
99	Unknown

Code	Route of Administration
1	Oral (swallow and/or chewing)
2	Smoking
3	Inhalation
4	Injection
5	Other