COMPASS

CASE MANAGEMENT, INTERVENTION AND RECOVERY SUPPORT SERVICES

Confidential Client Information & Recovery Assessment

Please complete what you feel comfortable sharing. You may leave optional questions blank or discuss them privately. This is a coaching intake, not a medical assessment.

1 Personal information

Date completed / consultation date

_____

Full legal name / preferred name

_____

Date of birth

_____

Street address / city / state / ZIP

_____

Cell phone / email

_____

Emergency contact / relationship / phone

_____

Referred by

_____

Preferred communication ☐ Call ☐ Text ☐ Email

Safe to leave voicemail or text? ☐ Yes ☐ No

Living situation ☐ Own/rent ☐ With family ☐ Sober living ☐ Transitional ☐ Unstable ☐ Other

Relationship status / employment or school status

_____

2 Family and support system

Contact 1: name / relationship / phone / email / role in recovery

_____

Contact 2: name / relationship / phone / email / role in recovery

_____

Contact 3: name / relationship / phone / email / role in recovery

_____

Who is your strongest support?

_____

_____

Relationships you hope to improve or rebuild

_____

_____

People you do NOT wish involved

_____

_____

Are family members receiving support or education?

_____

_____

Listing a contact does not authorize Compass to disclose information. Separate written permission is required.

3 Substance use and recovery history

Primary substance(s) of concern and other substances

_____

_____

Age of first use / when problems began

_____

_____

Most recent use (optional)

_____

_____

Longest recovery period and what helped

_____

_____

Previous returns to use and possible triggers

_____

_____

Situations, emotions or environments that increase risk

_____

_____

Coping strategies that have helped

_____

_____

Current status ☐ Abstinent ☐ Using ☐ Reducing ☐ Medication-supported ☐ Discuss privately

Past concerns ☐ Withdrawal ☐ Seizures ☐ Overdose ☐ Hospitalization ☐ Blackouts ☐ Other ☐ Prefer not to answer

Any immediate concerns about withdrawal, overdose or safety?

_____

4 Treatment and clinical support

Prior care ☐ Detox ☐ Residential ☐ PHP ☐ IOP ☐ Outpatient ☐ Therapy ☐ Psychiatry ☐ Group ☐ Sober living ☐ Coaching

Treatment program 1: name / approximate dates / type / what helped

_____

_____

Treatment program 2: name / approximate dates / type / what helped

_____

_____

Current therapist: name / practice / phone

_____

_____

Psychiatrist or prescriber: name / practice / phone

_____

_____

Primary care clinician: name / phone

_____

_____

Current outpatient treatment or counseling

_____

_____

Medications relevant to safety or recovery (optional)

_____

_____

Medication treatment for substance use (optional)

_____

_____

What has and has not helped in treatment?

_____

_____

Would you like help coordinating with clinicians? ☐ Yes ☐ No ☐ Unsure

5 Mental and physical wellness

Concerns you wish to share ☐ Anxiety ☐ Depression ☐ Trauma ☐ Sleep ☐ Mood ☐ Attention ☐ Grief ☐ Other ☐ Prefer not to answer

Significant health conditions, allergies, or accessibility needs

_____

_____

Stress-management strategies

_____

_____

Do you currently feel safe?

_____

_____

Any immediate thoughts of harming yourself or someone else? (Discuss privately if preferred)

_____

_____

Urgent medical, psychiatric or safety concerns require emergency or qualified clinical care. Coaching is not crisis response.

6 Faith, spirituality and values — optional

Religious, spiritual or philosophical orientation, if any

_____

_____

Would you like faith or spiritual resources included?

_____

_____

Personal or cultural values you would like respected

_____

_____

7 Hobbies and daily life

Hobbies and interests you enjoy

_____

_____

Activities you would like to resume or explore

_____

_____

What would a healthy, fulfilling day look like?

_____

_____

Interests ☐ Fitness ☐ Outdoors ☐ Sports ☐ Arts ☐ Reading ☐ Volunteering ☐ Mindfulness ☐ Community ☐ Other

8 Recovery community

Experience with ☐ AA ☐ NA ☐ SMART ☐ Recovery Dharma ☐ Celebrate Recovery ☐ Other ☐ None

Sponsor, mentor or accountability partner

_____

_____

Preferred recovery support approach

_____

_____

Interest in additional community resources

_____

_____

9 Practical stability and legal considerations

Employment ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Student ☐ Unemployed ☐ Retired ☐ Other

Employment or education goals

_____

_____

Housing, transportation or financial pressures affecting recovery

_____

_____

Legal or court obligations affecting appointments (optional)

_____

_____

Resources or referrals that would be helpful

_____

_____

10 Goals and motivation

Why seek recovery support now?

_____

_____

Top three goals for the next 60 days

_____

_____

Greatest concerns about the next 60 days

_____

_____

Personal strengths and sources of hope

_____

_____

What would success look like in six months?

_____

_____

Readiness for change (1–10) and what would increase it

_____

_____

11 Coaching preferences

Desired support ☐ Accountability ☐ Encouragement ☐ Structure ☐ Planning ☐ Family ☐ Referrals ☐ Clinical coordination

Preferred days/times for weekly in-person sessions

_____

_____

Preferred Friday and Sunday call times

_____

_____

Communication boundaries and preferences

_____

_____

Anything else you would like Dan to know?

_____

_____

Monthly family Zoom participation ☐ Yes ☐ No ☐ Undecided

12 Collaborative 60-day planning — complete together

Priority 1 / Priority 2 / Priority 3

_____

_____

Barriers and strengths

_____

_____

Immediate referral or resource needs

_____

_____

First coaching appointment / next steps

_____

_____

Client acknowledgment

I understand that this information supports individualized nonclinical recovery coaching. Coaching does not replace medical care, psychotherapy, psychiatric care, or emergency services. Information sharing with family or outside providers requires appropriate authorization.

Client signature / date

_____

Recovery coach signature / date

_____