



S.A.A.M.C.O.*5 hr

**Substance Abuse Assessment for Municipal Court
Offenders**

Health Recovery Services, Inc.

Please print clearly.

Name _____ SS# _____
last first mi.

Current address _____

City _____ State _____ Zip code _____ County _____

Telephone Number _____ Male _____ Female _____

Date of Birth _____ / _____ / _____ Age _____

Client Information:

Referring Agency/Court: _____ Contact name: _____

Address: _____

(We will need the name, address and a contact name from the agency/court before the program).

What were you charged with? _____ Is this your first
offense? Yes _____, No _____ if no, what other offenses have you had _____

Before this offense, have you ever had legal, school, work, financial, or family problems due to your use
of alcohol and/or other drugs? If yes, explain. _____

Has the abuse of alcohol or other drugs adversely affected any member of your family? If yes, explain.

Do you use a combination of alcohol and other drugs? If yes, which drugs? _____

Health Recovery Services (HRS) is granted my permission to release and/or obtain information from the
referring court, attorney, prosecutors, and/or arresting agency about registration information, BAC results, arrest
report and/or driving record. The full fee of **\$100.00** must be paid in full with cash, money order or credit card
(MasterCard or Visa). **No checks. No refunds are given.** No shows must reschedule and repay.

Client signature: _____ Date: _____

Program date requested: _____ Receipt # _____

Staff: _____