ADMISSION SC

REENING FORM

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| PERSONAL INFORMATION |
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NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP STATUS (CIRCLE): SINGLE MARRIED DIVORCED SEPERATED DATING ENGAGED

EMPLOYED yes\_\_\_ no\_\_\_ Disability: yes\_\_\_ no\_\_\_\_\_ pending\_\_\_\_\_\_

Monthly Income $\_\_\_\_\_\_\_\_\_ Referring Agency or Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPS WORKER\_\_\_\_\_\_\_\_\_\_\_\_ Probation/Parole: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| SUBSTANCE HISTORY |
| Circle all of the substances used present/past) |

ALCOHOL, COCAINE, HEROIN, SEDATIVES (XANAX, VALIUM ETC), MARIJUANA, OPIATES (PAIN PILLS),

ECSTACY, INHALANTS, HALLUCINOGENS (ACID), AMPHETAMINE (METH)

OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IV USE YES\_\_\_\_\_ NO \_\_\_

DRUG OF CHOICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST USE DATE AND DRUG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been in treatment house/program before? If so where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| CURRENT MEDICATION |

Please explain any mental health issues:

Have you ever had a mental health diagnosis? YES \_\_\_\_\_ NO \_\_\_\_\_\_

If yes, please explain and give the Diagnosing Doctor’s name and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been prescribed psychotropic medication? YES \_\_\_\_ NO \_\_\_\_\_\_

If yes, what medication and dosage? Please give the prescribing Doctor’s name and contact information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier (if available)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| INTERVEIWER NOTES/COMMENTS:  |