# INITIAL CONTACT AND SCREENING DATA

Date: _____

Patient Name: _____Referral Source / Name: _____

Referral Source Phone Number: _____

Home Phone: _____ Cell Phone: _____ E mail: _____

Interested in help for: □ Self □ Friend □ Family Member □ Employee □ Other: _____

**SCREENING FOR ADMISSION:** Name: _____Phone: _____ Age: _____

Address: _____ SSN: _____-____- _____

DOB _____/_____/_____ Sex: □ Male □ Female If Female: Pregnant? □ Yes □ No Due Date: _____

Driver License #_____ DL State_____ Race: □ Caucasian □ African American □ Hispanic□ Other_____

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widow/Widower

Employment Status: □ Employed □ Unemployed □ Student □ Retired □ Disabled/Social Security

SUBSTANCE USE HISTORY

| **Substance** | **Route** | **Frequency** | **Amount** | **Age of 1st use** | **Date of last use** |
|---|---|---|---|---|---|
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| | | | | | |
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Prior Substance Abuse Treatment: □ No □ Yes Where: _____

What type: _____ When: _____ Outcome: _____Type of discharge: _____

Are you seeking Opioid Treatment Services? □ Yes □ No
If yes, what type □ Methadone □ Subutex □ Rx Suboxone □ Vivitrol □ Outpatient Counseling (without medication)

Any history of mental health issues? □ No □ Yes If yes please describe: _____

History of Suicide Attempts: □ Yes □ No Date of Last Attempt:_____ Current Suicidal/Homicidal thoughts: □ Yes □ No

Current Prescribed medications: _____

Current Providers/Practice Name:_____

Currently involved in pain management? □ Yes □ No

TREATMENT FEE PAYMENT SOURCE
□ Self-Pay □ Insurance/ Managed Care Policy/Medicaid # _____
□ VA benefits □ Other _____
□ Family Member or Friend

INTERNET INTAKE SCREENING FORM DATE RECEIVED_____
Appointment Scheduled by _____ For: date_____ time_____
If not appropriate; Referred to:_____