Stepping Stones Behavioral Health Services, Inc.

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Competence **Integrity** **Compassion**

Initial Intake for Addiction Services

Name: _____ Maiden: _____ SS#: _____ Date: _____

Address: _____

Phone:_____ E-mail: _____

DOB: _____Age: _____ Gender: _____ Pronouns:_____

How would you best describe your sexual orientation? _____

Race: _____ Tribe: _____ Ethnicity: _____

Level of Education: ____ GED? ____ Year obtained: _____ School: _____

Contact Person: _____ Relationship to you: _____

Address: _____ Phone: _____

Are you a Veteran? ☐ Yes ☐ No Branch: _____ Type of Discharge: _____ Year: _____

Marital Status: ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed
☐ Married *(including Common Law)* ☐ Never Married *(including annulled)*

Employment Status: ☐ Full-Time ☐ Unemployed
☐ Part-Time ☐ Public Assistance Depleted

Name of Employer: _____

If not in labor force, check one:

☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Inmate ☐ Other: _____

What is your annual family income? _____

Have you ever been convicted of DUI? ___ If yes, how many times? ____ Court: _____

Number of arrests in past 30 days: _____

Have you been court-ordered or recommended for an evaluation? ☐ Yes ☐ No

Who recommended the Chemical Dependency evaluation? _____

Have you been to Chemical Dependency Treatment before? If yes, how many times? _____

Where? _____

_____

What is your drug of choice?_____

On the average, how often (frequency) do you use? _____

On the average, how much (quantity) do you use? _____

What other drugs have you used? _____

Have you ever been diagnosed with a mental illness? ___ If yes, what & when? _____

_____

Intake Patient: _____

Please answer yes/true or no/false to the following:		Yes	No
Other people have commented on my ability to hold (tolerate) drugs or alcohol.	*	☐	☐
I have wondered about my capacity to use/drink and have been somewhat proud of it.		☐	☐
I can use/drink more than others and not show it too much.		☐	☐
I have been hospitalized because of my drinking/using.	*	☐	☐
In the past, I have needed help with alcohol/drug withdrawal symptoms.		☐	☐
During the past 72 hours, I have felt shaky, sweaty, or nervous.		☐	☐
I have taken a drink or used drugs in the morning.		☐	☐
Do you sometimes drink/use until there is nothing left?	*	☐	☐
I sometimes use/drink more than I planned.		☐	☐
I have stopped to drink/use when I planned to go straight home.		☐	☐
I have tried to control my drinking/using by quitting only to start up again.	*	☐	☐
I have continued to drink/use despite my intentions to not drink/use.		☐	☐
I sometimes try to cut down on my drinking/using but it does not last very long.		☐	☐
I have hidden alcohol/drugs around the house thinking I may need them later.	*	☐	☐
I sometimes drink/use before going to a party.		☐	☐
I have lost a job because of my drinking/using.	*	☐	☐
I mostly hang out with others who drink/use like I do.		☐	☐
I have lost friends or a significant other because of my drinking/using.		☐	☐
I have gotten into trouble with the law because of my drinking/using.	*	☐	☐
I sometimes get into fights when drinking/using.		☐	☐
My drinking/using behavior has caused me embarrassment, but I drink/use anyway.		☐	☐

Do you have health insurance: ☐ No ☐ Yes — Name of Insurance: _____

What do you hope to gain by participating in treatment? _____

_____

What else would you like us to know about you? _____

_____

_____ _____

Patient Signature Date Staff Signature Date