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Initial Intake for Addiction Services

Name:_________________________ Maiden:____________ SS#:_____________ Date:________

Address:____

Phone:____________________ e-mail:____

DOB:______________ Age:____________ Number of arrests in past 30 days:__________

Level of Education:____ GED?___ Year obtained:_________ School: _________________________

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

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

Who recommended the Chemical Dependency evaluation? __________________________________

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

Gender: ____ Race:___________ Tribe:__________________ Ethnicity:_____________________

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

Contact Person_________________________________ Relationship to you____________________

Address____ Phone #__________________

Employment Status: ☐ Full-Time ☐ Unemployed
☐ Part-Time ☐ Public Assistance Depleted
☐ Not in Labor Force (check one):
☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Inmate ☐ Other:___________________

What is your annual family income?____

Have you attended a self-help, support group (e.g., AA, NA, etc.) in the past 30 days? _____________

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

Where?____

____

Frequency (during heaviest period of use) (**Use for chart below**)
0=No use 1=1-3x 2=1x/mo 3=2-3x/mo 4=1x/wk 5=2-6x/wk 6=1x/day 7=2-3x/day 8=4+x/day

Route of Administration (**Use for chart below**)
1=Oral 2=Inhalation 3=Smoking 4=IM Injection 5=IV Injection 6=Other:________________

	Primary Problem (Most Severe)	Secondary Problem (2nd Most Severe)	Tertiary Problem (3rd Most Severe)
Drug Name (Alcohol, Meth, Heroin, Marijuana, etc.)			
Frequency of use (Use chart above)			
Age at first use			
Usual Administration (Use chart above)			
Date of Last Use			

What is your drug of choice?____

What other drugs have you used?____

Intake Patient: ____________________

IV Drug Usage: ☐ Never ☐ Not in the last 12 months but since 1978
☐ During the last 12 months ☐ Not since 1978 but before 1978

What drugs have you used IV?____

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

____

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's 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 in spite of my intentions to not drink/use.	____	____
I sometimes try to cut down on my drinking/using but it doesn't 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 Ins ________________________________

Occupation:____

____
Employer Address Phone

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

____

Intake Patient: ____________________

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

____

____ ____
Patient Signature Date Staff Signature Date