# Client Admission/Intake

*Office use only*

Date _____
Admit _____

Admission Status: ☐ DUI 2 ☐ DUI2x ☐ DUI3 ☐ Outpatient
☐ Individual ☐ SA evaluation ☐ MH evaluation

Counselor_____ Group assignment_____

***Note: This form must be filled in completely**

Name_____ SS#_____ Marital Status_____

DOB_____ Age_____ Race_____ Ethnicity_____

Street Address_____ City_____ State_____ Zip_____

Phone_____ Email _____

**Health Insurance Type**
Insurance Company____ _____ Group #_____

Name of insured_____ Copay: _____

☐ Is the deductible meet?

**Tell us why you are here today?**

_____

_____

_____

**Family/Social**

Living arrangement:

☐ Alone in own dwelling unit
☐ Family, Significant other, relatives
☐ Other group quarters
☐ Homeless, short-term
☐ Hospital, rehab facility, nursing home
☐ Prison, jail, correction facility
☐ Homeless, long-term
☐ Residential treatment program

Number of children under age 18 in household_____

Total number of children_____ Residence of Children_____

Do you maintain contact with children ☐ Yes ☐ No; Explain_____

Are you satisfied with your current situation ☐ Yes ☐ No; Explain_____

_____

Are you currently in a relationship ☐ Yes ☐ No Explain_____

_____

_____

Describe the current relationship with your family_____

_____

_____

Any history of abuse: Physical ☐ Yes ☐ No Explain_____

Sexual ☐ Yes ☐ No Explain_____

Emotional ☐ Yes ☐ No Explain_____

Domestic Violence ☐ Yes ☐ No Explain_____

Have you been the perpetrator of any of the above ☐ Yes ☐ No; If yes, explain_____

_____

How long have you lived in this area_____ Do you have friends in this area ☐ Yes ☐ No

Are they clean and sober ☐ Yes ☐ No

Who/What makes up your support system_____

Hobbies and special interest_____

Do you spend time doing things you enjoy ☐ Yes ☐ No; Explain_____

What are your strengths_____

**Education/Employment**

Any learning disabilities ☐ Yes ☐ No; Explain_____

Highest grade completed _____ (GED = 12) Diploma ☐ Yes ☐ No

Any problems in school? _____

Employment Status: ☐ Full Time - 35 hours or more a week
☐ Part Time - less than 35 hours a week
☐ Unemployed
☐ Disabled
☐ Retired
☐ Student Full-time ☐ Student Part-time

Primary source of income or support for self and/or family during the last 12 months:

☐ None ☐ Disability ☐ Other
☐ Wages/Salary ☐ Unemployment ☐ TANF
☐ Public Assistance ☐ Family/Friend
☐ Retirement ☐ Illegal gain

Current employer_____

Months employed by current employer? _____

Are you satisfied with your current situation ☐ Yes ☐ No Explain_____
_____

**Legal**

Have you been arrested in the past 12 months? ☐ No ☐ Yes, how many times, and what for?
_
_____

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_____

Criminal Justice involvement ☐ Yes ☐ No; Parole ☐ Yes ☐ No; Probation ☐ Yes ☐ No

Parole/Probation officer's Name_____ Phone_____

Ever been to prison ☐ No ☐ Yes; How many times_____; Date of last release_____

Ever been to jail ☐ No ☐ Yes; How many times_____; Date of last release_____

Court supervision ☐ No ☐ Yes; Judge_____

House arrest ☐ No ☐ Yes; Caseworker_____

Please list your legal history

| Charge | Where | Sentence | Alcohol/Drugs | Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Explanation of past crimes_____

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_____

**Medical**

Current medical problems in the past 30 days_____

Current Medication:

| Medication | Purpose | Dosage | Duration of Use | Prescribing Dr. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**For Women** Are you pregnant or chance of being pregnant? ☐ No ☐ Yes

**Substance Abuse**

Any addictions in your family ☐ No ☐ Yes, who_____

Did your mother drink while pregnant ☐ No ☐ Yes ☐ Unknown

Do you feel you have a problem with Alcohol? ☐ No ☐ Yes

Do you feel you have a problem with drugs? ☐ No ☐ Yes

How many prior detox admissions have you entered?_____

How many prior treatment programs have you entered (non-detox)_____

How many prior treatment programs have you successfully completed_____

How many months since last discharge from any substance abuse treatment program?_____

In the last 30 days, how many days abstinent from all substances?_____

Do you use tobacco ☐ No ☐ Yes, How much_____

Have you ever used IV drugs? ☐ No ☐ Yes, last used_____

Date of last use of any chemical – Alcohol or other substances_____

Longest period of abstinence from all substances and alcohol_____

How was that obtained_____

Do you gamble ☐ No ☐ Yes; Where and how much do you usually spend_____

_____

_____

In the past 30 days, how many days have you attended chemical dependency group meetings?_____

Check all the chemicals that you have ever used:

☐ None
☐ Alcohol
☐ Amphetamines
☐ Cannabis
☐ Cocaine
☐ Crack
☐ Heroin
☐ Hallucinogens
☐ Inhalants
☐ Non Rx Methadone
☐ Opiates/Analgesics
☐ Sedatives/Hypn/Trnq
☐ PCP
☐ Over the counter drugs
☐ Ecstacy (XTC, MDMA)
☐ Steriods
☐ Other:_____

| Substance | Past 30 days Yes or No | Age First Used | Age Last Used | Route of use | Pattern/amount/frequency Date of last use |
|---|---|---|---|---|---|
| Alcohol – Any use at all | | | | | |
| Alcohol – To intoxication | | | | | |
| Amphetamines | | | | | |
| Cannabis | | | | | |
| Cocaine | | | | | |
| Crack | | | | | |
| Heroin | | | | | |
| Hallucinogens | | | | | |
| Inhalants | | | | | |
| Non prescribed Methadone | | | | | |
| Opiates/Analgesics | | | | | |
| Sedatives/Hypn/Trnq | | | | | |
| OTC Medications | | | | | |
| Ecstacy (XTC, MDMA) | | | | | |
| Steriods | | | | | |
| Other | | | | | |
| More than one substance | | | | | |

Drug of Choice:

| | **PRIMARY** | **SECONDARY** | **TERTIARY** |
|---|---|---|---|
| Substance | | | |
| Route | | | |
| Date Last Use | | | |

**Psychological Status/History**

Have you ever had any past suicide attempts and or thoughts ☐ Yes ☐ No

If yes: age & circumstances _____
_____
_____

Are you currently having any suicidal ideations ☐ Yes ☐ No

If yes: plan and way to carry out plan ☐ Yes ☐ No

Have you ever been diagnosed, treated or seen by a doctor for:

Depression ☐ No ☐ Yes, when_____ Treatment_____
Bi-Polar ☐ No ☐ Yes, when_____ Treatment_____
Anxiety ☐ No ☐ Yes, when_____ Treatment_____
ADD/ADHD ☐ No ☐ Yes, when_____ Treatment_____
Other_____

Current medications_____

Past medications_____

Last use of any medications_____

Any past history of hallucinatory experiences without substances ☐ No ☐ Yes, when_____

Any external life stressors at this time ☐ No ☐ Yes, _____

What have you done recently for fun_____

Are you currently experiencing any symptoms of psychological or mental health problems ☐ No ☐ Yes
If yes, please explain_____

Have you ever been hospitalized for a mental health concern ☐ No ☐ Yes
If yes, please explain

Do you see any barriers to counseling ☐ Yes ☐ No; Describe_____