CLIENT SELF-REFER INTAKE SCREENING

Fill out during phone screen with client:

Intake Information

Date of Self-Referral

How did you hear about us?

Client Information

Name | Date of Birth
Social Security # | Phone #
Email
Address | City, State, Zip | County
Insurance? | Insurance Provider
Yes | Member # or ID | Group
No | PMI # | Group Name

Chemical Use

Primary DOC, Additional DOCs

Frequency of Use / Use History

Tolerance / Quantity of Use

Last Date of Use / Withdrawal Potential

Mental Health

Known Diagnoses

Current Mental Health Services

Hallucinations? Y N

History of suicidal attempts/ideation? Y N