

INTAKE QUESTIONS FORM

NAME: _____ **DOB:** _____

- | | | | |
|------------|---|------------|----------------------|
| 1. | Prior Treatment: <i>Where:</i> _____ <i>When (mo/yr):</i> _____ | Yes | No |
| 2. | Are you currently facing any charges?
<i>Court date:</i> _____ <i>Where:</i> _____ <i>Type of charge:</i> _____ | Yes | No |
| 3. | Are you on Probation? <i>PO name:</i> _____ <i>Ph#</i> _____ | Yes | No |
| 4. | Do you have any children involved in Social Services?
<i>Social Worker:</i> _____ <i>Ph#</i> _____ | Yes | No |
| 5. | History of Battery, Assault, Domestic Violence
<i>Where:</i> _____ <i>When (mo/yr):</i> _____ <i>Days in jail:</i> _____ | Yes | No |
| 6. | Gang Related | Yes | No |
| 7. | Medical Problems
<i>What kind:</i> _____ <i>Meds Taking:</i> _____ | Yes | No |
| 8. | Have you been to jail or prison?
<i>Days in Jail (past 2 years):</i> _____ <i>Mo./Yr:</i> _____ <i>Where:</i> _____
<i>Days in Prison (past 2 years):</i> _____ <i>Mo./Yr:</i> _____ <i>Where:</i> _____ | Yes | No |
| 9. | Public Intoxication/Protective Custody History
<i>Where/when:</i> _____ <i>time's in 1 year:</i> _____
<i>Where/when:</i> _____ <i>time's in 1 year:</i> _____ | Yes | No |
| 10. | Emotional/Mental/Psychiatric Problems
<i>What kind:</i> _____ <i>Meds Taking:</i> _____ | Yes | No |
| 11. | History of harming self/others or attempted suicide
<i>Last attempt:</i> _____ <i>Last thought:</i> _____ | Yes | No |
| 12. | List all drugs used: (include nicotine/cigarettes)
<i>Type:</i> _____ <i>Last use:</i> _____
<i>Type:</i> _____ <i>Last use:</i> _____
<i>Type:</i> _____ <i>Last use:</i> _____ | Yes | No |
| 13. | Alcohol use
<i>Last Use:</i> _____ | Yes | No |
| 14. | Withdrawal Symptoms:
<i>What kind:</i> _____ | Yes | No |
| 15. | Pregnant | N/A | Yes No |
| 16. | Physical (required) | Yes | No |
| 17. | TB Test (required) | Yes | No |
| 18. | Letter of Interest received | Yes | No |
| 19. | Medical Insurance: _____ ID# _____ | Yes | No |

THE FOLLOWING QUESTION WILL BE ANSWERED BY THE CLINICAL DIRECTOR

Accepted for Treatment _____	Yes	No
Kevin Foley, PhD. Clinical Director	Date _____	