Addict Assist...

Intake Assessment Form

Name: D.O.B. Address: Telephone: Gender Male Female

Intake Date:

Race:

African American Caucasian Latino Other

Emergency Contact Name:

Relationship:

Address:

Telephone:

Alcohol/Substance Abuse History

1. What drugs do you currently use?

Drug	Route	Frequency	Amount	Date 1st Use	Last Use
Heroin					
Crack					
Meth					
Marijuana					
Cocaine					
Hallucinogens					
Alcohol					

Other:

Do you use more than one substance per day?

Yes

No

If Yes, what substances

At what age did you start using drugs?

DETOX

How many times have you been in Detox? When was the last time (date) you were in Detox? What was the name of the last Detox program?

TREATMENT

Have you ever entered treatment for substance abuse?

Yes

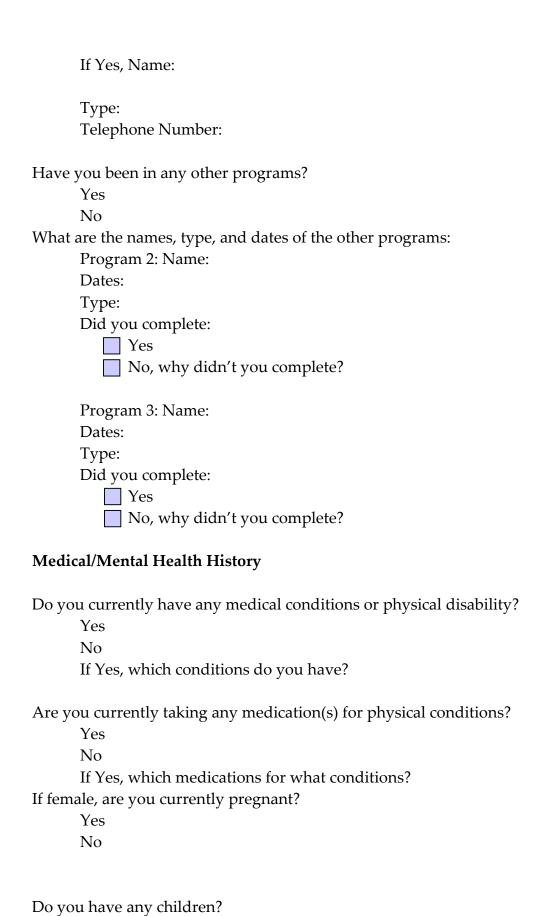
No

If Yes, how many times have you entered treatment for drugs?

Are you currently in substance abuse treatment?

Yes

No



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Yes
      No
      If Yes, how many?
How many do you have custody of?
Who has custody of any children that you don't have custody for?
Do you have a psychiatric or emotional problem?
      Yes
      No
Has anyone ever told you that you have a psychiatric/mental health diagnosis?
      Yes
      No
      If Yes, what was the diagnosis?
Have you ever been convicted of a sex offense?
      Yes
      No
Have you ever committed a sex offense?
      Yes
      No
Have you ever thought about hurting yourself?
      Yes
      No
Have you ever thought about killing yourself?
      Yes
      No
Have you ever thought about killing someone else?
      Yes
      No
Have you ever physically hurt someone else?
      Yes
      No
Have you ever heard any sounds or voices that other people could not hear?
      Yes
      No
Have you ever seen things that other people cannot see?
      Yes
      No
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Have you ever been hospitalized for any mental health reason?
      Yes
      No
      If Yes, were these hospitalizations:
Inpatient hospitalizations
      Yes
      No
Psychiatric Emergency Room (ER) visits
      Yes
      No
Both
      Yes
      No
Which hospitals, if known?
Are you currently taking any medications for any mental health reason?
      Yes
      No
      If Yes, which medications for what conditions.
Have you taken any medications in the past for psychiatric/mental health problems?
      Yes
      No
      If Yes, what?
Are you currently in psychiatric/mental health treatment now? (check all that apply)
      None
      Outpatient clinic
      Day treatment
      Residential
      Jail Medication/counseling
      Other,
      Where, if known?
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27. Have you received psychiatric treatment in the past?
      Yes
      No
      If Yes, what? (circle all that apply)
             None
             Outpatient clinic
             Day treatment
             Residential
             Jail Medication/counseling
             Other,
Entitlements/Benefits
Have you ever served in the Military?
      Yes
      No
      If Yes, what branch, years and Type of discharge?
Employment/Educational History
Are you employed?
      Yes
      No
      If Yes, what is your position:
Is it:
      Full-time or
      Part-time
Work Address:
Telephone:
Are you a student?
      Yes
      No
      If Yes, name of school:
Are you:
      Full-time or
      Part-time
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If No, do you have a high school diploma?
Yes
No
Do you have a GED?
Yes
No
What grade completed?
Services needed
What services are needed? (circle all that apply)
Housing (temporary or permanent)
Detox
Rehab
Residential treatment (long or short term)
O Counseling- Psychiatric
Health Care, what