

Contact Date _____

ICIS: _____

Admit: _____

Referred: _____

Personal Information

First Name (Legal) Middle Last

Home Address County

Mailing Address County

Phone # with area code Cell #

DOB Age Race

Next of Kin Relationship Phone

Referral Title Phone

____ Yes, you may contact my next of kin for admission needs _____ (initial)

____ Yes, you may contact my referral for admission needs _____ (initial)

Photo ID AND BC or SS card REQUIRED for admission

Employment

in Household Household Income Last Day Worked

Employer Employer Address Phone

Insurance Company Policy # Phone

SSI Income SSDI Income Family Support Income

How do you plan on paying for services? _____

Program Fees-\$4,200.00

Copies of W2/2 consecutive pay stubs or Notarized statement of Unemployment

Medical Y-Yes N-No

<input type="checkbox"/> Medical Needs	<input type="checkbox"/> Detox Needed	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression
<input type="checkbox"/> Dental Needs	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Migraines	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Psychiatric Needs	<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Bi-Polar
<input type="checkbox"/> Taking Medication	<input type="checkbox"/> Taking Pain Medication	<input type="checkbox"/> Pos TB	<input type="checkbox"/> Hep C

If yes, explain: _____

Do you read and write in English: _____ Yes _____ No

List all medications to be taken during treatment

Date of last Physical Physician Phone

____ Yes, I can have a 60 day supply of medication.

Status: Reason for seeking treatment /Criminal Background Y-Yes N -No

<input type="checkbox"/>	Drug Court	<input type="checkbox"/>	Community Sentencing	<input type="checkbox"/>	Voluntary	<input type="checkbox"/>	Sexual Assault Charge
<input type="checkbox"/>	Pending legal Case	<input type="checkbox"/>	DHS	<input type="checkbox"/>	Domestic Violence Charge	<input type="checkbox"/>	Prison
<input type="checkbox"/>	Court Referred	<input type="checkbox"/>	P.O.	<input type="checkbox"/>	Weapons Charge	<input type="checkbox"/>	

If yes, explain: _____

Place the total number of **DAYS** you used the substance in a 1 month time frame **AND** total number of **YEARS** you have used the drug **AND** the way you take the drug: **O=Oral N=Nasal S=Smoking I=IV**

Use

Substance Used	30 Days	Lifetime (Yrs)	Rt. of Adm	Age 1st Use	Comment (Last Use)
Alcohol	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Marijuana	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Opiates (Lortab, Oxycotin)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Cocaine	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Sedatives (Xanax, Valium)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Meth	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Amphetamines (Pills, Adderal)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Hallucinogens	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Inhalants	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____
Other	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>	_____

Drug of Choice: _____

On a scale of 0-4 (with 4 being EXTREMELY) how would you rate your need for services? _____

Why did you rate yourself the way you did AND why do you want to be accepted for admissions? Provide any information that may aid in admissions:

By signing below I am stating that I have completed this form and that all information is true and accurate. I realize that any false information provided can exclude me from services.

_____	_____
Signature	Date
_____	_____
Staff Signature	Date