Substance Abuse Intake Questionnaire

Name:	Date of 1st Call:
DOB:	Date of phone Intake:
Address:	
	Referred by:
Telephone:	
	☐ ***If referred by another facility or agency, request all medical and clinical info be faxed to Hampstead Hospital for review.***
Insurance:	
ID#:	**Desired Level of Care**
Authorization Info:	☐ Inpatient Detox
	Recover y Matters: ☐ ART ☐ PHP ☐ Sub Acute Rehab
	☐ Quitting Time IOP

Current Treatment

☐ Inpatient:	☐ Residential:	☐ Outpatient :	☐ None
Admit Date: Anticipated D/C date:	Anticipated D/C date:		

Substance(s) of Choice	Frequency	Amount	Route	Last Use	Detox Needed?

Prior Treatment (Inpatient/Resi/PHP/IOP) in the last 6 months

Program Name	Level of Care & Date	Program Completed? (explain)	Length of sobriety

Mental Health Screening

Psych Diagnosis:	Active Symptoms:
	Current SI: ☐ No ☐ Yes Plan:
Therapist Name:	Prior Suicide Attempt: ☐ No ☐ Yes
Psychiatrist Name:	History of aggression? ☐ No ☐ Yes
Previous psychiatric hospitalizations:	

Medical History

PCP Name:		Last Physical Exam Date:	
***RM requires documentation of PE within last 30 days**		***QT requires documentation of PE within last year**	
☐	Cardiac (heart) Problems	☐	Respiratory (breathing) Problems
☐	Liver Problems	☐	Seizure history
☐	Diabetes	☐	Blood Pressure Problems
Other Medical Concerns:			

Current Medications

Social Situation

Job or school jeopardy? ☐ No ☐ Yes (explain)
Current living situation:
Sober environment: ☐ Yes ☐ No (explain)
Do you have transportation? ☐ Yes ☐ No

Legal Issues

Current or previous legal issues/charges: ☐ No ☐ Yes (explain)
Currently on probation or parole: ☐ No ☐ Yes (explain)
Next scheduled court date:

Additional Information

Recommended Level of Treatment

☐	Inpatient Detox	☐	Recovery Matters	☐	Quitting Time	☐	Other:

☐ ***Documentation of Physical Exam must be available at time of evaluation***

Please Review for Recovery Matters Program

- ☐ Physical Exam and Medication Authorization Form must be completed prior to scheduling evaluation
- ☐ Prescription medication must be in original prescription bottles and 30 supply is recommended
- ☐ OTC medications must be in original containers and sealed/unopened
- ☐ Smoking is at designated times with staff supervision
- ☐ Highly structured supportive environment providing intensive substance abuse treatment

Admission Staff Signature:_______________________________________Date & Time:________________________
Reviewed by: ____Date & Time: _______________________

Comments/further info request: