Addict Assist™

Intake Assessment Form

Intake Date:
Name:
D.O.B.
Address:

Telephone:

Gender
- Male
- Female

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

If Yes, Name:

Type:
Telephone Number:

Have you been in any other programs?
Yes
No
What are the names, type, and dates of the other programs:
Program 2: Name:
Dates:
Type:
Did you complete:
- [ ] Yes
- [ ] No, why didn't you complete?

Program 3: Name:
Dates:
Type:
Did you complete:
- [ ] Yes
- [ ] No, why didn't you complete?

Medical/Mental Health History

Do you currently have any medical conditions or physical disability?
Yes
No
If Yes, which conditions do you have?

Are you currently taking any medication(s) for physical conditions?
Yes
No
If Yes, which medications for what conditions?
If female, are you currently pregnant?
Yes
No

Do you have any children?

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

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?

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

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)
- Counseling- Psychiatric
- Health Care, what