

Ohlhoff Recovery Programs

Program Intake Form

Today's Date: _____ Counselor: _____ Admit Date: _____

- SF Outpatient/Adult SF Outpatient/Adolescent Marin Outpatient/Adult Marin Outpatient/Adolescent
- Primary Residential Men's Residential Men's Residential North

IDENTIFYING INFORMATION:

Full Name: _____ Age: _____ DOB: _____

Home Address: _____

Phone: _____ (home) _____ (cell) _____ (work)

Okay to contact at home? Y N May we say "Ohlhoff Recovery Programs"? Y N

Okay to contact work? Y N May we say "Ohlhoff Recovery Programs"? Y N

Driver's License #: _____ Social Security #: _____

Marital Status: Single Married Living with Partner Divorced/Separated Widowed

Race/Ethnicity: African American Asian/Pacific Islander White Latino Native American

Other _____

Sexual Orientation: Straight Gay Bisexual Undecided Living Situation: Own Rent Homeless

Referral Source: Self Prop 36 Other (include contact information) _____

Parent's Name and Address (if adolescent):

Father: _____ Phone: _____

Mother: _____ Phone: _____

Parent's Relationship Status (if adolescent): Single Married Living with Partner Divorced/Separated Widowed

Name of Step-parent (if adolescent): _____ Phone: _____

Name of legal guardian (if adolescent): _____ Phone: _____

Emergency Contact: _____

Address: _____ Phone#: _____

Relationship: _____

Why are you seeking treatment now?

INSURANCE INFORMATION:

Name of Insurance Carrier: _____ Policy #: _____

Name of Insured: _____

Do you have alcohol and drug treatment benefits? Y N Unknown

EDUCATIONAL/TRAINING INFORMATION:

GED High School College Degree Master’s Degree Doctoral Degree Other _____

Last grade completed (if adolescent): _____ Current school (if adolescent): _____

Primary source of income: Employed Disability Retired Other _____

Monthly income amount: _____

Employer: _____ Occupation: _____

Parent’s Employer (if adolescent):

Father: _____ Occupation: _____ Monthly income: _____

Mother: _____ Occupation: _____ Monthly income: _____

When was the last time you worked? _____ Occupation: _____

Did your using or drinking ever cause problems at your job(s) or school? Y N

Describe: _____

FAMILY INFORMATION:

Who do you live with? _____

If you are in a relationship, describe your relationship with your primary partner:

Does your primary partner drink and/or use drugs? _____

If anyone in your family has suffered from alcohol or chemical dependency problems, please indicate by filling in the information below:

Family Member	Drug of Choice	Treatment	Currently Using?
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Please list all family members:

Name _____ Relationship _____ Residence _____ Age _____

Name _____ Relationship _____ Residence _____ Age _____

Name _____ Relationship _____ Residence _____ Age _____

Name _____ Relationship _____ Residence _____ Age _____

Name _____ Relationship _____ Residence _____ Age _____

Are you close with any family members? _____

Are there supportive, close friends nearby? _____

I would consider most of my friends as drinking/using buddies: Y N

Are any of your close friends in recovery? Y N

Has your drinking and/or using interfered in your relationships with family members? Y N

Describe: _____

Has your drinking and/or using interfered in relationships with any other relationships? Y N

Describe: _____

Are you currently in contact with any of your family members? Y N

Describe: _____

How does your family feel about your alcohol and/or drug use? _____

Do you have your family's support regarding treatment? _____

I would describe myself as social: Y N

I would describe myself as: INTROVERT EXTROVERT BOTH

HISTORY OF ABUSE:

As a child or adolescent, have you had any physical abuse/neglect (basic needs, medical, dental, physical safety)? _____

As a child or adolescent, have you had any sexual abuse (sex with an adult as a minor, sexual touching, voyeurism, used for sexual pleasure of another person in any way against your will as a minor)? _____

As a child or adolescent, have you ever had any emotional, mental, or spiritual abuse? _____

Have you ever experienced any type of abuse as an adult? _____

Have you ever used over these issues? _____

MEDICAL/PSYCHIATRIC INFORMATION:

Do you have any medical/health problems? Y N _____

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Therapist: _____ Phone: _____

Are you currently on any medications? Y N

Medication	Purpose	Dosage	How long on meds	Prescribing physician

Have you ever had any psychiatric treatment? Y N

Where	Dates	Outpatient	Inpatient	Duration	Diagnosis	Outcome

Have you ever had any thoughts or plans of suicide? Thoughts only No plan Plan History of attempts

Describe: _____

LEGAL INFORMATION:

of Incarcerations _____ # of Arrests _____ # of DUI's _____

History of incarcerations: _____

History of arrests: _____

History of DUI's: _____

Currently on Probation/Parole Y N

Probation/Parole Officer: _____ Phone: _____ Fax: _____

What are the conditions of your probation/parole? _____

Pending legal action? Y N Explain: _____

Court date(s): _____

Have you ever been involved in any violence when you were drinking? Y N

Describe: _____

SUBSTANCE ABUSE INFORMATION:

1st Drug of choice? _____ 2nd Drug of choice? _____ 3rd Drug of choice? _____

IV Smoked Drank Snort Inhale Oral-Ingest

Multiple/Daily Daily Several Times/Week Weekly Binge Use

Amounts used? _____

Age use began? _____ Age abuse began? _____

Clean and sober status since:

Date _____ Number of days _____ How did you maintain sobriety? _____

Current withdrawal symptoms (e.g., cravings, depression, anxiety, sleep disturbance, seizures): _____

Cravings? Y N How did you not use after having a craving? _____

History of chemical dependency treatments? Y N # of Treatments _____

Program	Location	Inpt or Outpt	Dates	Length of stay	Completed?	Reason not Completed

Involvement with any 12-Step Programs? _____

Relapse Triggers/Behaviors: _____
(describe yourself in a relapse mode)

Current motivation for recovery (circle)

Low 1 2 3 4 5 6 7 8 9 10 High

What areas of your life have been affected by your drug and/or alcohol use?

- Family Housing Relationships Financial Children Health Education
Employment Legal Self-esteem

What would you like to work on in treatment? _____

HEALTH QUESTIONNAIRE SCORING KEY

This self-administered questionnaire is designed to provide programs with a set of general guidelines to assist in determining an individual's suitability for treatment/recovery services in a non-medical facility. It is intended as a guideline only and should not be substituted for common sense or any other available data which contradicts this questionnaire. When in doubt, always consider the severity of the issue and, above all, the well being of the client. The potential value of a thorough Health Screening administered by a nurse practitioner or physician should never be underestimated.

Section 1

A **yes** answer to any of the questions in section 1 indicates the existence of a potentially life threatening condition. You should strongly consider referring the individual to a qualified physician, requesting that they provide you with a medical clearance to participate in a program. Enrollment in the program prior to receiving a medical clearance is at the discretion of the program.

Section 2

A **yes** answer to any of the questions in section 2 indicates the existence of a serious health condition. Although admission into your program may be appropriate, a thorough Health Screening should be scheduled at the time of admission. Continuing participation in the program should be at the discretion of program.

Section 3

A **yes** answer to any of the questions in section 3 does not necessarily indicate the existence of a serious health condition. However, **multiple yes** answers could be cause for concern and indicative of a generally poor health condition. Multiple yes answers in section 3 may warrant a Health Screening. At a minimum information gathered in section 3 should be available to staff in order to better serve the client.

The high incidence of illness at time of admission to a program calls for caution and attention to detail. No client can benefit from a program if he or she is too ill to participate fully. Conversely, no program can succeed if its clients are unable to utilize the services offered.

HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Date: _____ Social Security # _____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.

No Yes Date: _____

2. Have you ever had a stroke? If yes, please give details.

No Yes Date: _____

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.

No Yes Date: _____

4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.

No Yes Date: _____

5. Have you experienced or suffered any chest pains? If yes, please give details.

No Yes Date: _____

Section 2

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.

No Yes Date: _____

7. Do you take any medications for a heart condition? If yes, please give details.

No Yes Date: _____

8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.

No Yes Date: _____

9. Have you ever had high-blood pressure or hypertension? If yes, please give details.

No Yes Date: _____

10. Do you have a history of cancer? If yes, please give details.

No Yes

11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.

No Yes

Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance. If yes, please give details.
No Yes
-
13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.
No Yes Date: _____
-
14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
No Yes Date: _____
-
15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.
No Yes Date: _____
-
16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.
No Yes Date: _____
-
17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
No Yes
-
18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder. If yes, please give details.
No Yes Date: _____
-
19. Do you have any of the following; arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details, including any ongoing pain or disabilities.
No Yes
-
20. Please describe any surgeries or hospitalizations due to illness or injury that you have had.
Date: _____
-
21. When was the last time you saw a physician? What was the purpose of the visit?
Date: _____
-
22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).
No Yes
-
23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.
No Yes
-
24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.
No Yes
-

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.

No Yes

26. When was your last dental exam? Date:

27. Are you in need of dental care? If yes, please give details.

No Yes

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.

No Yes

29. Are you pregnant?

No Yes

Due Date:

30. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

31. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

I declare that the above information is true and correct to the best of my knowledge:

Signature: _____

Today's Date: _____

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC/MEDICAL RECORDS

NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____

This authorization is for use or disclosure of psychiatric/medical information, including diagnosis and treatment of mental disorders and/or conditions related to alcohol/drug abuse.

RELEASE TO: _____
(Program Name, Address and Program Director's Name)

I hereby authorize the following person/agency to furnish the above named recipient with the records and information listed below:

The recipient may use the information authorized only for the following purposes:

This authorization shall remain in effect until _____.
Date

I understand that I may revoke this authorization at any time, except to the extent that the person/agency has already acted in reliance on it.

I understand that the recipient may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

No _____ Yes _____ Initial

Information Requested:

- | | |
|---|---|
| <input type="checkbox"/> Medical Examination | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Screening Evaluation | <input type="checkbox"/> Summary of Treatment |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Other _____ | |

Authorizing Participant Signature Date

Authorized Program Representative, if applicable Date