DATE OF INTAKE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF INFO CHANGE

**PATIENT NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT ID #

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#

Address

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code

Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #

Ethnicity:

**EMERGENCY CONTACT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation

Address

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code

Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #

**REFERRAL SOURCE**

Name and Title

Name of Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #

**PLEASE CIRCLE ONE**

DCPP PROBATION/PAROLE SAI MEDICAID/MEDICARE

SELF-PAY DRUG COURT OTHER:

|  |
| --- |
| **TO BE FILLED OUT BY STAFF** |

**LEVEL OF CARE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OMT/MAT** | **OP** | **IOP** | **PARTIAL CARE** | **START DATE** |

**Substance Abuse History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug of Choice** | **1.** | **2.** | **3.** | **4.** |
| First Use:  Last Use: | First Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Route(s) of Administration: | IV \_\_\_\_ Snort \_\_\_\_  IM \_\_\_\_Smoke\_\_\_\_  Oral \_\_\_\_ Other\_\_\_\_\_ | IV \_\_\_\_ Snort \_\_\_\_  IM \_\_\_\_Smoke\_\_\_\_  Oral \_\_\_\_ Other\_\_\_\_\_ | IV \_\_\_\_ Snort \_\_\_\_  IM \_\_\_\_Smoke\_\_\_\_  Oral \_\_\_\_ Other\_\_\_\_\_ | IV \_\_\_\_ Snort \_\_\_\_  IM \_\_\_\_Smoke\_\_\_\_  Oral \_\_\_\_ Other\_\_\_\_\_ |
| Amount /  Frequency: |  |  |  |  |
| No. of Years Using Illicit Substances: |  |  |  |  |

**Treatment History (in the last 3 years)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Dates of Treatment** | **Facility** | **Type of Treatment** | **Treatment Completed?** | **Discharged in NJSAMS?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Mental Health / Psychiatric Treatment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Facility/MD** | **Diagnosis** | **Medication** | **How Often Med is Taken** | **Are you still under MD Treatment?** |
|  |  |  |  |  |  |

To the best of your knowledge are you **pregnant**? Yes \_\_\_\_\_\_\_\_ No

If you are pregnant, how many weeks?

Medical Mental Education Legal Nicotine Employment