Admissions

Please complete Clearly and Legibly

Client's Full Legal Name:		Client's Address:	
Client's Phone #:		Email Address:	
DOB (dd/mm/yyyy)	Age:	Social Security #:	
Marital Status:		Gender Identity:	
Sexual Identity:		Ethnicity:	
Primary Language:		Religious Preference:	

Primary Insurance:		ID#:
Secondary Insurance:		ID#:
Referral Source:		

Presenting Problem

Events/circumstances leading to assessment/admission (include the client's feeling(s) about being in treatment). Please share your account as to why you are in your current situation:

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Current Negative Consequences (Legal, Relationship, Employment, Self-Esteem, Spiritual)

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Does client require/need assistance with Reading and Comprehension? ☐ Yes ☐ No

Is client currently employed? ☐ Yes ☐ No Issues?:_____________________________________

Dimension 1- Acute Intoxication and/or Withdrawal Potential

☐ Yes ☐ No Current Risk for withdrawal?:

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☐ Yes ☐ No Client has a history of withdrawal symptoms?:

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	Physical	Notes (Occurrence Frequency, Associated Substance)		Mental	Notes (Occurrence Frequency, Associated Substance)
☐	Vomiting		☐	Irritability	
☐	Nausea		☐	Anxiety	
☐	Increased Perspiration		☐	Depression	
☐	Seizures		☐	Mood Swings	
☐	Delirium Tremens		☐	Suicidal Ideation	
☐	Gastrointestinal Issues		☐	Hallucinations	
☐	Rapid Heart Rate		☐	Delusions	
☐	Changes in Appetite		☐	Paranoia	
☐	Body Aches		☐	Insomnia	
☐	Headaches		☐	Hypersomnia	
☐	Lethargy		☐	Cognitive Impairments	
☐	Poor Motor Control		☐	Confusion	
☐	History of Overdose		☐	Hostility / Aggression	
☐	Other: Click here to enter text.		☐	Poor Concentration	
☐	Other: Click here to enter text.		☐	Racing Thoughts	
☐	Other: Click here to enter text.		☐	Memory Issues	

☐ Yes ☐ No Client has a history of seizures (substance or non-substance related)?: If yes - expand on date of last seizure and does client have a seizure disorder (If yes, does client take medications, when was the last seen by a physician)?:

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Dimension 2- Biomedical Conditions and Complications

☐ Yes ☐ No Were all developmental milestones met? (i.e. walking, talking, crawling) If no, explanation of issue:

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☐ Yes ☐ No Does client use alternative heath approaches: (if yes, describe – ex: yoga, meditation, acupuncture):

____

____

☐ Yes ☐ No Client is pregnant? (If yes, expand on gestation):. Client lacks current prenatal care and is in need of prenatal care? (If yes, document care plan for client):

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☐ Yes ☐ No History of high risk behaviors? (Ex. unprotected sex, driving while intoxicated, IV use, etc.)

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☐ Yes ☐ No **Hearing Impairment** ☐ Yes ☐ No **Speech Impairment** ☐ Yes ☐ No **Vision Impairment**

☐ Yes ☐ No **Learning Disability** (If yes, expand):____

☐ Yes ☐ No **Exposure to substance(s) in utero**? (If yes, expand): ______________________________________

____

Medication History/Current medication (Both medical and behavioral):

Medication	Dosage	Reason	Start Date	End Date	Efficacy	Prescriber

____

____

Communicable Disease Questionnaire:

Does the client have or have they ever had: (check boxes)

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox
☐ Hepatitis ☐ HIV ☐ Tuberculosis ☐ MRSA
☐ Staph ☐ Other:

☐ Yes ☐ No Has client been tested for communicable diseases (i.e. HIV, Hep C, STDs)?

☐ Yes ☐ No Is the client now under the care of a physician or taking any medication for a communicable disease?:

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☐ Yes ☐ No Has the client had recent contact with someone with any of the above illnesses?

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____

☐ Yes ☐ No Have you met with a physician in the last year for a physical?

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____

☐ Yes ☐ No Does client have any drug or food allergies (If yes, expand):

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____

Previous Treatment- Medical and Behavioral Health

Treatment Type	Conditions Treated	Facility Name	Admit Date	Discharge Status	Sobriety Following

Dimension 3- Emotional, Behavioral and Cognitive Conditions and Complications

☐ Yes ☐ No Client reports current or past psychiatric conditions? (If yes, need previous diagnosis and treatment history):

Facility Name	Year	Reason	Notes

☐ Yes ☐ No Current behaviors, emotions or cognitive difficulties related to addiction?

____
____
____

☐ Yes ☐ No Client has current or past thoughts or attempts of self-harm and/or suicide?

☐ Yes ☐ No Client has experienced, witnessed, or perpetrated abuse, neglect, violence, sexual assault or other traumatic experiences in their past? Does the client experience homicidal ideations?

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Dimension 4- Readiness to Change

☐ Yes ☐ No Client is aware of the relationship between substance use and negative life consequences? Please explain:

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____

☐ Yes ☐ No Client is ready, willing and able to make changes in their behavior? Please explain:

____
____

☐ Yes ☐ No Client identifies behaviors related to process addiction? (gambling, eating disorder, sexual addiction, codependency, video games):

____
____

☐ Yes ☐ No Uses tobacco products (includes vaping, chewing, etc.)? If yes, please expand:

____

____

Substance Use Matrix

SUBSTANCE	PAST 30 Days	AGE 1st Used	Route of Administration	Date of Last Use	Amount of Last Use
Alcohol – any use at all					
Alcohol – to intoxication					
Heroin					
Methadone					
Opiates					
Barbiturates					
Benzodiazepines					
Buprenorphine					
Sedatives/hypnotics/tranquilizers					
Cocaine					
Amphetamines					
Methamphetamines					
Cannabis					
Hallucinogens					
Inhalants					
Kratom					
Spice					
Other Drug:					

☐ Yes ☐ No Has client overdosed on drugs? (If yes, please explain):

____

____

Primary Drug of choice: ____

Based on the following criteria:

☐ using for a longer period of time or more than intended
☐ desire to cut down or attempts to control use
☐ spending a great deal of time in activities to obtain/use/recover from use
☐ cravings and/or strong desire to use
☐ use resulting in failure to fulfill major role obligations
☐ continued use despite persistent social or interpersonal problems caused or exacerbated by use
☐ having given up or reduced social/occupational/recreational activities in order to use
☐ recurrent use in physically hazardous situations
☐ continued use despite knowledge it causes/exacerbates physical/psychological problems
☐ experiencing a build-up of tolerance
☐ experiencing withdrawal during cessation

Secondary Drug of choice: ____

Based on the following criteria:

☐ using for a longer period of time or more than intended
☐ desire to cut down or attempts to control use
☐ spending a great deal of time in activities to obtain/use/recover from use
☐ cravings and/or strong desire to use
☐ use resulting in failure to fulfill major role obligations
☐ continued use despite persistent social or interpersonal problems caused or exacerbated by use
☐ having given up or reduced social/occupational/recreational activities in order to use
☐ recurrent use in physically hazardous situations
☐ continued use despite knowledge it causes/exacerbates physical/psychological problems
☐ experiencing a build-up of tolerance
☐ experiencing withdrawal during cessation

Dimension 5- Relapse/Continued Use Potential

☐ Yes ☐ No Client is able to identify triggers?

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____

☐ Yes ☐ No Client struggles with managing triggers, peer pressure and stress?

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____

☐ Yes ☐ No Client has coping skills?

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____

Client feels addiction and/or mental health is negatively impacting the following life areas:

☐ Yes ☐ No Social:

____

____

☐ Yes ☐ No Employment/school:

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____

☐ Yes ☐ No Family:

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____

☐ Yes ☐ No Spiritual:

____
____

☐ Yes ☐ No Does the client have a family history of addiction, mental illness and/or medical?

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____
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Dimension 6- Recovery Environment

Describe childhood environment:

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Describe high school experience:

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____

Highest grade completed?: _____________________

☐ Yes ☐ No Client has legal issues?

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☐ Yes ☐ No Client is a veteran? (where deployed? How affected?)

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☐ Yes ☐ No Client has cultural considerations for treatment?

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☐ Yes ☐ No Client has a spiritual belief?

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☐ Yes ☐ No Client had or has involvement with the self-help community?

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____

Client's sober support:

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____

Describe current living situation:

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