



A SERVICE OF MID-STATE HEALTH

RISE
RECOVERY

Recovery Services
New Client Intake

PERSONAL INFORMATION AND HISTORY

Full Name: _____ Date of Birth: _____

Are you currently employed? No Yes Name of Employer/Job: _____

Housing status: Own Rent Temporary (With Friends or Family) Other: _____

Do you have children? No Yes Please list their ages: _____

If you have children, how is that relationship? Good Strained Other: _____

Have you had any involvement with DCYF? No Yes

Comments/Explain: _____

Level of Education: Didn't Graduate High School College Advanced Degree

If you left school prior to graduating, why? _____

What are your family's thoughts on addiction/recovery? Supportive Not Supportive

Comments/Explain: _____

MEDICAL HISTORY

Do you have a Primary Care Provider? No Yes

Provider Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

When was your last preventative health exam: _____

Have you ever been tested for Hepatitis or HIV/AIDS? No Yes

What were the results? _____

Are you currently pregnant, or is there a possibility you are? No Yes Does not apply to me

Do you have problems with chronic pain? No Yes Explain: _____

SUBSTANCE USE AND TREATMENT HISTORY

Do you, or have you, ever used any of the following substances:

DRUG	AMOUNT	AGE WHEN FIRST USED	AGE WHEN LAST USED	ROUTE OF ADMINISTRATION	CURRENTLY USING?
Alcohol					
Suboxone					
Heroin					
Percocet/Vicodin					
Cocaine/Crack					
Methamphetamine					
Benzodiazepines					
Marijuana / Spice					
Hallucinogens					
Tobacco					
Amphetamines					

Any other substances that were not mentioned?

Do you have any other addictive behaviors? (Such as sex, shopping, exercise, gambling, etc.)

Have you ever experienced an overdose? No Yes Was Narcan given? No Yes

How many times?

Have you received treatment for substance use in the past? No Yes

DATES OF TREATMENT	WHERE	FOR / WHY	COMPLETED DATE

Do you feel treatment for your substance use is necessary / beneficial at this time? No Yes

Why?

FAMILY PSYCHIATRIC HISTORY

Please fill in the below regarding immediate family members (parents, grandparents, siblings, aunts/uncles) and their history, to the best of your ability:

DIAGNOSIS	WHO	DIAGNOSIS	WHO
Alcoholism		Hypochondriasis	
Substance Use		OCD	
Depression		Schizophrenia	
Anxiety		Psychosis	
Panic Attacks		Suicide / Attempt	
Bipolar Disorder		Other Personality Disorder	
Dementia			

CRIMINAL HISTORY

Please fill in the below regarding your criminal history, to the best of your ability.

DATE	REASON FOR ARREST	DISPOSITION

Are you currently under any Court Ordered Supervision? (such as Parole, Probation, Drug Court, Court Diversion, etc.)

No Yes With who? _____

City: _____ State _____ Zip: _____ Phone: _____

Expected Release Date:

Have you ever had a DUI / DWI? No Yes How many?
Where?

Were you mandated to receive treatment? No Yes

Describe:

MENTAL HEALTH HISTORY

Please fill in the information below on your self-reported psychiatry history:

Psychiatric Evaluation		Hypochondriasis	
Psychiatric Hospitalization		Schizophrenia	
Depression		Other Personality Disorder	
Seasonal Affective Disorder		Psychosis	
Generalized Anxiety		Suicide / Attempt(s)	
Panic Attacks		Domestic Violence	
Bipolar Disorder		Sexual Abuse	
OCD		Overdose	

Have you ever received mental health treatment? No Yes

DATES OF TREATMENT	WHERE	FOR / WHY	COMPLETED DATE

GOALS AND BARRIERS

What are some of your goals for treatment?

- 1.
- 2.
- 3.

What do you see as potential barriers to getting treatment?

- 1.
- 2.
- 3.

ADDITIONAL NEEDS:

We may be able to offer additional support for you outside of your substance treatment. Please check off any other needs you may have at this time:

Housing	Banking	Legal	Child Care Assistance	Domestic Violence
Employment	Medical	Dental	Nutrition / Food	Insurance
Advocate	Social Support	Personal Hygiene	Daily Living Functions	Financial Assistance
Transportation	Medication Assisted Treatment			

How did you hear about our program?

- Friend/Family
- Online
- Social Media
- Emergency Room
- Law Enforcement
- Other: _____

FOR OFFICE USE ONLY

Intake Completed By: _____ Date: _____
Staff Name and Credentials