



## NEW RESIDENT INTAKE FORM

Jasmine Cassidy Victory 1 2 3 4 (circle one)

Date _____		Social Security # _____		Clean/Sober Date _____	
First Name _____		MI _____	Last Name _____		Maiden _____
Age _____	Date Of Birth _____		<input type="checkbox"/> Addict	<input type="checkbox"/> Alcoholic	
<b>Ethnicity</b> <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other: _____		<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black		<b>Relationship Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<b>Most Recent Address</b>					
Street Address		City		State	Zip
Cell Phone	<input type="checkbox"/> May We Leave A Message?	Email Address		<input type="checkbox"/> May We Send A Message?	
Permanent Address		City		State	Zip
Permanent Phone		<input type="checkbox"/> May We Leave A Message?			
<b>Treatment History</b>			12 step groups have you attended		What is the longest amount of clean/sober time in the past? _____
How many previous treatment options have you had? __1__2__3__4__5__6+			<input type="checkbox"/> AA <input type="checkbox"/> NA <input type="checkbox"/> CA <input type="checkbox"/> Other		
Name of Treatment		Name of Treatment		Name of Treatment	
Substances I've abused/used (Check all that apply)		How long have I used/drank?		Drug of choice? (Please only list <u>one</u> )	
<input type="checkbox"/> Opiates <input type="checkbox"/> Cocaine <input type="checkbox"/> PCP <input type="checkbox"/> Alcohol <input type="checkbox"/> Heroin <input type="checkbox"/> Bath Salts <input type="checkbox"/> LSD <input type="checkbox"/> K2 (spice) <input type="checkbox"/> Marijuana <input type="checkbox"/> Ecstasy <input type="checkbox"/> Benzos (Xanax, Clonipin) <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Amphetamines					
<b>Transportation</b>					
<input type="checkbox"/> I do NOT have my own vehicle and will use public transportation.			<input type="checkbox"/> I have my own vehicle		
			Make: _____ Year _____		
<input type="checkbox"/> Please mark this box if you are currently on probation or parole			Name of PO: _____		
<input type="checkbox"/> Please mark this box if you have ever been on probation in the past			Phone Number of PO: _____		
<input type="checkbox"/> Please mark this box if you have ever been on parole in the past			County of Probation/Parole: _____		
<b>Please indicate who referred you to Recovery Inn</b>					<b>Referral Name &amp; Number</b>
Referral Type <input type="checkbox"/> Self <input type="checkbox"/> Sponsor <input type="checkbox"/> Treatment Center <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Other					
<b>Employment:</b>					
<input type="checkbox"/> I DO currently have a job:			<input type="checkbox"/> I do not currently have a job		
Name of Employer: _____					
Telephone Number: _____ Name of Supervisor: _____					

**Please read the following questions and mark those to which you would respond "yes."**

- |  |  |
|--|--|
| <input type="checkbox"/> Have you previously been involved in counseling?<br><input type="checkbox"/> Do you currently use alcohol or other non-prescription drugs?<br><input type="checkbox"/> Is there a history of mental health problems in your family?<br><input type="checkbox"/> Have you ever been physically abused?<br><input type="checkbox"/> Have you ever been emotionally abused?<br><input type="checkbox"/> Do you have a problem with substance abuse?<br><input type="checkbox"/> Have you ever attempted suicide? | <input type="checkbox"/> Have you ever been hospitalized for mental health reasons?<br><input type="checkbox"/> Is there a history of alcohol or drug problems in your family?<br><input type="checkbox"/> Have you ever been in legal trouble?<br><input type="checkbox"/> Have you ever been sexually abused or assaulted?<br><input type="checkbox"/> Are you currently taking any prescription medications?<br><input type="checkbox"/> Do you want help for your substance abuse problem? |
|--|--|

If you are currently taking any medication(s), please list the type, dosage, and the purpose for each below:

If you responded yes to any of the above statements, please briefly explain:

**Please use the following scale to answer the next three questions:**

	1	2	3	4
	Not at all	Mildly	Moderately	Highly
1. How serious do you consider your present concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How motivated are you to resolve your concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How optimistic are you that your concern(s) can be resolved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family History**

Mother's Age \_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_  
 Father's Age \_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_  
 If your parents are separated, how old were you then? \_\_\_\_\_  
 Number of brother(s) \_\_\_\_\_ What are their ages? \_\_\_\_\_  
 Number of sister(s) \_\_\_\_\_ What are their ages? \_\_\_\_\_

**Religious Affiliation**

- |   |   |
|---|---|
| <input type="checkbox"/> Jewish<br><input type="checkbox"/> Catholic<br><input type="checkbox"/> Protestant | <input type="checkbox"/> None, but I believe in God<br><input type="checkbox"/> Atheist or agnostic<br><input type="checkbox"/> Other |
|---|---|

**Do you have children?**     Yes     No    **If yes, please list below and indicate who has custody.**

**Children:** Please list all of your children below:

Please mark if you have an open CPS Case?

Name: \_\_\_\_\_ Age: \_\_ M / F    Who has custody? \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_ M / F    Who has custody? \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_ M / F    Who has custody? \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_ M / F    Who has custody? \_\_\_\_\_

**Please mark all of the following that apply**

**Feelings**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Helpless    | <input type="checkbox"/> Anxious             |
| <input type="checkbox"/> Depressed   | <input type="checkbox"/> Out of Control      |
| <input type="checkbox"/> Shameful    | <input type="checkbox"/> Afraid              |
| <input type="checkbox"/> Angry       | <input type="checkbox"/> Numb                |
| <input type="checkbox"/> Guilty      | <input type="checkbox"/> Relaxed             |
| <input type="checkbox"/> Hopeless    | <input type="checkbox"/> Happy               |
| <input type="checkbox"/> Lonely      | <input type="checkbox"/> Excited             |
| <input type="checkbox"/> Sad         | <input type="checkbox"/> Hopeful             |
| <input type="checkbox"/> Stressed    | <input type="checkbox"/> Inferiority Feeling |
| <input type="checkbox"/> Unhappy     | <input type="checkbox"/> Mood Shifts         |
| <input type="checkbox"/> Other _____ |  |

**Thoughts**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Confused      | <input type="checkbox"/> Racing       |
| <input type="checkbox"/> Unintelligent | <input type="checkbox"/> Obsessive    |
| <input type="checkbox"/> Worthless     | <input type="checkbox"/> Distracted   |
| <input type="checkbox"/> Unmotivated   | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Unattractive  | <input type="checkbox"/> Paranoid     |
| <input type="checkbox"/> Unlovable     | <input type="checkbox"/> Suicidal     |
| <input type="checkbox"/> Confident     | <input type="checkbox"/> Sensitive    |
| <input type="checkbox"/> Worthwhile    | <input type="checkbox"/> Honest       |
| <input type="checkbox"/> Homicidal     |                                       |
| <input type="checkbox"/> Other _____   |                                       |

**Symptoms/Behaviors**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Eating Less          | <input type="checkbox"/> Acting Out Sexually    | <input type="checkbox"/> Socializing              |
| <input type="checkbox"/> Procrastinating      | <input type="checkbox"/> Acting Aggressively    | <input type="checkbox"/> Marital Relationships    |
| <input type="checkbox"/> Attempting Suicide   | <input type="checkbox"/> Disorganization        | <input type="checkbox"/> Parent/Child Conflicts   |
| <input type="checkbox"/> Poor Concentration   | <input type="checkbox"/> Impulsivity            | <input type="checkbox"/> Lack of Ambition/Goals   |
| <input type="checkbox"/> Crying               | <input type="checkbox"/> Recklessness           | <input type="checkbox"/> Poor Peer Relationships  |
| <input type="checkbox"/> Withdrawing Socially | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Night Mares              |
| <input type="checkbox"/> Skipping Classes     | <input type="checkbox"/> Passivity              | <input type="checkbox"/> Worries About Body Image |
| <input type="checkbox"/> Binge Drinking       | <input type="checkbox"/> Drug Use               | <input type="checkbox"/> Spiritual Problems       |
| <input type="checkbox"/> Injuring self        | <input type="checkbox"/> Alcohol Use            | <input type="checkbox"/> Dating Concerns          |
| <input type="checkbox"/> Compulsivity         | <input type="checkbox"/> Being Good to Yourself | <input type="checkbox"/> Finances                 |
| <input type="checkbox"/> Career/Major Choice  | <input type="checkbox"/> Sexual Problems        | <input type="checkbox"/> Other _____              |

**Physical Symptoms**

- Insomnia
- Tired
- Weight Gain or Loss
- Pain
- Headaches
- Tightness In Chest
- Dizziness or Light-headedness
- Numbness or Tingling
- Vomiting
- Rapid Heart Beat
- Dry Mouth
- Excessive Sleep
- Loss of Memory
- Eating Problems
- Other \_\_\_\_\_

Please describe any medical conditions you have:

Anything else you would like us to know about you:

