Nursing Intake Screen

Demographic Information

Current Address: _____

Phone number: _____ Is it OK to leave a message? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

Relationship: _____

Is your Emergency Contact aware of your addiction? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ Don't Know ☐ N/A

Are you taking Birth Control Pills? ☐ Yes ☐ No ☐ N/A

Drug Use History:

What are you currently using at this time?

☐ Heroin – Amount:

☐ Oxycontin – Amount:

☐ Methadone – Amount:

☐ Percocet, Vicodin, etc – Amount:

☐ Cocaine – Amount:

☐ Benzos (Klonopin, Xanax, Ativan, etc) – Amount:

☐ Alcohol – Amount:

☐ Other: _____ Amount:

☐ Nothing

Have you ever overdosed? ☐ Yes ☐ No

Number of lifetime overdoses _____

Have you ever been hospitalized due to an overdose? ☐ Yes ☐ No

If yes, were you kept overnight? ☐ Yes ☐ No

If yes, were you intubated? ☐ Yes ☐ No

Have you ever purchased opiates over the counter? ☐ Yes ☐ No

Substance Abuse Treatment History

Have you had any substance abuse treatment? ☐ Yes ☐ No

If yes, how many times to each type?

___ Detox Program

___ Residential (Rehab or Halfway House)

___ Outpatient Counseling

___ Buprenorphine/Suboxone maintenance

___ Methadone Maintenance

___ 12 Step Programs (NA, AA)

___ Acupuncture

___Other: _____

How many attempts have you made to get clean? _____

Do you attend: ☐ AA ☐ NA Other: _____

If so, how many meetings do you attend each week?

☐ 1-2 week

☐ 3-4 week

☐ 5-6 week

☐ Daily

☐ None

☐ Other: _____

Have you worked the steps and if so, what step are you on? _____

Do you have a sponsor? ☐ Yes ☐ No

How often do you have contact with your sponsor? _____

Do you have any history of any other addictive behaviors? ☐ Yes ☐ No

If yes:

☐ Gambling

☐ Sex

☐ Shopping

☐ Eating Disorder (Over eating, bulimia, anorexia)

☐ Other: _____

Criminal History:

Have you ever been arrested? ☐ Yes ☐ No

Have you ever been incarcerated? ☐ Yes ☐ No

How many times have you been incarcerated? _____

What is the longest period of time you spent in jail/prison? _____

Are you on probation? ☐ Yes ☐ No

Are you facing any potential jail time? ☐ Yes ☐ No

Do you have any outstanding legal issues? ☐ Yes ☐ No

If yes, can you tell us about them? _____

_____

_____

_____

_____

Clean Time History

What was the longest period of time that you have been clean? _____

When was this? _____

What has triggered relapse in the past? _____

Methadone History

Have you ever been on Methadone Maintenance? ☐ Yes ☐ No

When were you on Methadone Maintenance? _____

Where were you on Methadone Maintenance? _____

How long were you on Methadone Maintenance? _____

What was your dose? _____

Why did you stop Methadone Maintenance? _____

_____

Are you currently on Methadone Maintenance? ☐ Yes ☐ No

What is your dose? _____

Where are you receiving services for your Methadone Maintenance _____

What is the name of your counselor at your Methadone Clinic? _____

How long have you been in your current Methadone Maintenance Program?

_____

Are you receiving take homes? ☐ Yes ☐ No

If yes, How many? _____

What has your experience been like on Methadone?

☐ Extremely positive

☐ Positive

☐ Neutral

☐ Negative

☐ Extremely Negative

Suboxone History

Have you ever been prescribed Suboxone before? ☐ Yes ☐ No

If yes, when were you on Suboxone? _____

What was the dose? _____

Are you still on Suboxone? ☐ Yes ☐ No

If no, why did you stop taking Suboxone? _____

Have you ever tried Suboxone without a prescription? ☐ Yes ☐ No

Mental Health History

Have you ever been diagnosed with any mental health condition? ☐ Yes ☐ No

If yes, please specify:

☐ Depression ☐ Obsessive Compulsive Disorder (OCD)

☐ Anxiety ☐ Post Traumatic Stress Disorder (PTSD)

☐ Bipolar ☐ Attention Deficit Disorder (ADD)

☐ Schizophrenia ☐ Panic Attacks

☐ Other_____

Are you currently taking any medications for this/these problem(s)? ☐ Yes ☐ No

If yes, what medications are you taking?

_____

_____

Are you currently seeing a psychiatrist, psychologist or counselor for this/these problem(s)?

☐ Yes ☐ No

Where do you see your psychiatrist, psychologist or counselor?

_____

_____

What is this individuals name? _____

How often do you see them? _____

How many times have you seen this person in the last 6 months? _____ times

Will you sign a consent to release information so that we can communicate with your psychiatrist, psychologist or counselor about your treatment plan? ☐ Yes ☐ No

If you are not seeing a psychiatrist, psychologist or counselor, why not?

_____

_____

Have you ever been hospitalized for mental health issues? ☐ Yes ☐ No

Have you ever attempted to end your life or to hurt yourself? ☐ Yes ☐ No

How many times have you attempted to end your life or hurt yourself? _____

Have you ever attempted or thought about homicide (killing someone else) in the past?

☐ Yes ☐ No

Have you thought about how you would do it?

_____

_____

Have you been hurt physically, emotionally or verbally by anyone in the last year? ☐ Yes ☐ No

Have you ever been asked to perform sexual acts that you did not want to do? ☐ Yes ☐ No

Health Status

Have you ever been diagnosed with any other medical conditions? Mark all that apply.

☐ Diabetes (specify type) _____

☐ High Blood Pressure

☐ Heart Disease (Specify) _____

☐ Cancer (Specify) _____

☐ Asthma

☐ Hepatitis C If yes, have you been treated? ☐ Yes ☐ No

☐ Hepatitis A

☐ Hepatitis B

☐ HIV If yes, are you currently in care? ☐ Yes ☐ No

☐ Seizure disorder Are you on medications? ☐ Yes ☐ No

☐ Head Trauma/Injuries

☐ Pancreatic Problems

☐ Other (Specify) _____

☐ None

Are you taking any other medications? ☐ Yes ☐ No

If yes, what medications are you taking?

_____

_____

Have you been tested for HIV? ☐ Yes ☐ No

If yes, did you go back for the results? ☐ Yes ☐ No

If yes, when was the last time you were tested? _____

Have you ever had surgery? ☐ Yes ☐ No

If yes, what surgery and why did you have surgery?

_____

_____

Do you have any pending surgeries? ☐ Yes ☐ No

Pain

Do you have problems with pain? ☐ Yes ☐ No

Where is the pain located?

_____

_____

Has your pain lasted 3 months or longer? ☐ Yes ☐ No

If yes, tell us about your pain. (What it is from, how often do you experience it, how do you deal with it?)

_____

_____

_____

Rate your pain on a scale of 0-10 without any pain medications (prescribed or not prescribed)

_____

Have you been prescribed any medications for your pain? ☐ Yes ☐ No

Which medication gives you the most pain relief?

_____

_____

Have you tried other treatments that did not include medications for your pain? i.e Acupuncture, physical therapy, steroid injections, behavioral therapy etc. ☐ Yes ☐ No

Physician Information

Where do you get most of your health care? _____

When was the last time you saw a doctor?

☐ Last week
☐ Last month
☐ Within the last 3 months
☐ Within the last 6 months
☐ Within the last year
☐ More than 1 year ago

What is the name of your doctor? _____

What is his/her phone number? _____

Employment

Are you currently employed? ☐ Yes ☐ No

If yes, what do you do for work? _____

Are you working full or part time? _____

What days of the week do you work and how many hours per day?

_____

Are you satisfied with your job? ☐ Yes ☐ No

Social Support

What is your relationship status?

☐ Single (Skip to the next section)

☐ Married

☐ Long term relationship

☐ Divorced

☐ Other _____

Do you live with your partner/significant other? ☐ Yes ☐ No

Has your partner ever used drugs? ☐ Yes ☐ No ☐ Don't know

Is your partner currently in treatment? ☐ Yes ☐ No

If yes, what kind of treatment are they in?

☐ Suboxone

☐ Methadone

☐ Other _____

How satisfied are you with the support you get from your partner?

☐ Very Satisfied

☐ Satisfied

☐ Fairly Satisfied

☐ Not satisfied

Do you, or have you ever used at home? ☐ Yes ☐ No

If yes, who have you used with? _____

Is there someone whom you can turn to if you needed help in an emergency situation or got sick? ☐ Yes ☐ No

How is this person related to you?

☐ Partner/Spouse

☐ Friend

☐ Social Worker

☐ Other Family Member

☐ Other: _____

Does this person know about your history of substance abuse?

☐ Yes ☐ No ☐ Don't know

Overall, how satisfied are you with the support you get from your friends?

☐ Very Satisfied

☐ Satisfied

☐ Fairly Satisfied

☐ Not satisfied

☐ N/A _____

Family History

Do any of your family members have a history of substance use/abuse ☐ Yes ☐ No

If yes, which family members?

☐ Mother

☐ Father

☐ Sibling

☐ Grandparent

☐ Other _____

Are they currently using drugs or alcohol? ☐ Yes ☐ No

If yes, what are they using?

☐ Alcohol

☐ Heroin

☐ Cocaine

☐ Benzos

☐ Amphetamines/Methamphetamines

☐ Marijuana

☐ Other: _____

Overall, how satisfied are you with the support you receive from your family members?

☐ Very satisfied

☐ Satisfied

☐ Fairly satisfied

☐ Not satisfied

☐ N/A

Transportation

How do you get around?

☐ I drive Do you have your own car? ☐ Yes ☐ No

☐ Public transportation

☐ Walk

☐ I get a ride from family/friends

☐ Other _____

Do you have a drivers license? ☐ Yes ☐ No

How would you get to the office if you needed to get here?

☐ I would drive

☐ Public Transportation

☐ I would walk

☐ I would get a ride from family/friends

☐ Other _____

Would you be able to come into the office with 48 hours notice? ☐ Yes ☐ No

Housing

Have you spent one or more weeks on the street or in a shelter in the last 3 months?

☐ Yes ☐ No

What type of place are you living in now?

☐ A house or apartment that you own?

☐ A house or apartment that you rent?

☐ In a house or apartment owned or rented by family or friends?

☐ Hotel

☐ Drug or alcohol treatment program

☐ Shelter

☐ Street or car

☐ Other _____

How long have you been staying where you currently live? ____ Years _____ Months

Where were you living before this?

- [ ] A house or apartment that you own?
- [ ] A house or apartment that you rent?
- [ ] In a house or apartment owned or rented by family or friends?
- [ ] Hotel
- [ ] Drug or alcohol treatment program
- [ ] Shelter
- [ ] Street or car
- [ ] Other _____

How many different places have you lived in the last 12 months?

- [ ] One place only
- [ ] Two places
- [ ] Three places
- [ ] Four places
- [ ] Five or more places

What are your goals for this treatment?

_____
_____
_____
_____
_____
_____
_____