

Patient Intake Form

Date of Admission: _____

Methadone Maintenance Detoxification

Name (Last, First, Middle Initial) _____

Address/Apartment Number: _____

City/State/Zip Code: _____

Phone Number/Area Code: _____

Date of Birth (Month/Day/Year): ____ / ____ / ____ Social Security Number: _____

Sex: Male Female Race: _____

Do you currently have MediCal? Yes No Are you a Veteran? Yes No Type of Discharge: _____

Do you have a Drivers License? Yes No How will you get to the clinic? Own car Bus

Psychological

Marital Status

Married Never Married Single Separated Divorced Other

Religious Preference

Catholic Christian Baptist Jewish Protestant Other

Sexual Orientation

Heterosexual Bisexual Gay Lesbian Transsexual Do not wish to disclose.

Social Preference/Living Arrangements

Current number of people in your home: _____

Live alone Live w/others Live w/parents Live w/spouse & children Live w/children

Other: _____

Employment

Employed Full Time (35 or more hours/week) Employed part time (5-34 hours/week) Length of employment: ____

Average monthly income: up to \$3,500 \$3,500-\$3,700 \$3,700-\$3,900 \$3,900-\$4,100 \$4,100-\$4,300

\$4,300-\$4,500 \$4,500-\$4,700 over \$4,700

Other means of support: None Welfare (GR) Unemployment Ins. Disability Ins. Alimony

child support family friend other: _____

Date last employed: _____ Do you need employment referral assistance? Yes No

Unemployed, looking for work Not seeking employment Primary Care Giver/Homemaker Disabled

Retired Do you think you are eligible for unemployment assistance? Yes No

Educational/Vocational

Highest Grade in School Completed: _____

Did not complete High school Attended some College AA BA/BA Masters PhD

Vocational Training Other: _____

Legal Status

No legal problems Under Parole Supervision On Probation Summary Probation Case Pending

Have you ever been arrested for a drug related charge? Yes No

Do you have any court dates pending? Yes No If yes, what is your court date? _____

What is the charge? _____

List of probation or parole officer and department location: _____

Current Drug Use [Indicate primary drug (1), secondary drug (2)]

- Heroin Alcohol Barbiturates Other Sedatives or Hypnotics Methamphetamine Amphetamines
Cocaine/Crack Marijuana/Hashish PCP hallucinogens Tranquilizers Non-Prescription Methadone
Vicodin OxyContin Percocet Other prescription opioids (specify):_____ Inhalants
Over-the-Counter drugs Other (specify):_____

(1) Opiate Drug Use

Date of last use:_____ Amount used:_____ Time Used:_____ Average daily amount:_____ Length of use:_____
Usual routine of Admission: oral smoking inhalation injection

(2) Secondary Drug Use

Date of last use:_____ Amount used:_____ Time Used:_____ Average daily amount:_____ Length of use:_____
Usual routine of Admission: oral smoking inhalation injection

Drug Treatment History

Date of last Admission:_____ Date of last Discharge:_____ Number of Prior Admissions:_____

What was the type of treatment during your last admission? Detox MMTP

Outcome of last admission to treatment was: Completed Not Completed

Are you currently transferring from another methadone maintenance program? Yes No

If yes, list continuous treatment admission date on methadone maintenance: ____/____/____

If yes, do you have earned Take Homes? If yes, how many?_____

Name of former methadone clinic:_____

Clinic Contact Person_____ Phone#: _____

Have you received other types of drug treatment? Yes No

If yes, what type:_____

PATIENT ADVISED OF THE NATURE AND PURPOSE OF TREATMENT WHICH INCLUDES THE FOLLOWING INFORMATION:

1. I have read and understand, and have received copies of the Consent for Methadone Treatment and the Program Rules/Instructions and Orientation.
2. I authorize the Program to disclose information about my presence in treatment to the Department of Public Social Services and Medi Cal.

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| 21 CFR 291.505(d)(4)(I)(C) | Counseling on Transmission/Prevention of HIV and the Availability of HIV Testing |
| Section 10280 | Patient Acknowledgement of Program Orientation |
| Section 10290 | Consent to Treatment Form (FDA 2635) |
| Section 10170 | Patient Acknowledgement Receiving Program Rules/Instructions |
| Section 10285 | Acknowledge Orientation (female) |
| Section 10210 | Detection of Multiple Registration |
| Title 22 Section 50951, 50953 | Drug Medi-Cal Fair Hearing Rights |

Patient Signature _____ Date _____

Staff Signature _____ Date _____

Physician Assistant Signature _____ Date _____

Physician Signature _____ Date _____ NATA