Patient Intake Form

Date of Admission:________________________ ☐ Methadone Maintenance ☐ Detoxification

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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 opiods (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.

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

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