BrightView

# INTAKE FORM

**IMPORTANT: This information is confidential.**

**DEMOGRAPHIC INFORMATION:**

| | |
|---|---|
| Full Name: | Date of Birth: |
| Mailing Address: | |
| Social Security #: | Gender: ☐ Male ☐ Female<br>Race: ☐ White ☐ Hispanic ☐ Black ☐ Asian<br>☐ Other:_____ |
| Home/Mobile Phone: | Is it ok to leave a message? ☐ YES ☐ NO |
| Work Phone: | Is it ok to leave a message? ☐ YES ☐ NO |
| Preferred Contact Number:<br>☐ Home ☐ Mobile ☐ Work | Driver's License #: |
| E-mail Address: | |
| Emergency Contact Name: | Emergency Contact Phone: |
| Emergency Contact Relationship: | |
| Current Employer: | Position Title: |
| Current Occupational Status: ☐ F/T ☐ P/T ☐ Self-Employed ☐ Student ☐ Unemployed | |
| If employed, how long at your current job? ☐ 30 days ☐ 90 days ☐ 6 months ☐ 1 year ☐ >2 years | |
| If NO, why: ☐ Criminal Record ☐ Disability ☐ Education ☐ Lack Experience ☐ Other: | |
| Highest Education Level: ☐ G.E.D. ☐ High School ☐ Associates Degree ☐ Bachelor's Degree<br>☐ Other:_____ ☐ Master's Degree ☐ Doctorate<br>Have you been enrolled in school in the past 12 months? ☐ YES ☐ NO | |
| Military Background: ☐ Active Duty ☐ Reserves ☐ Veteran ☐ National Guard<br>If YES, which branch? ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy | |
| Relationship Status: ☐ Dating ☐ Divorced ☐ Married ☐ Single ☐ Other: | |

**INSURANCE INFORMATION:**

Name of Person Carrying Insurance: _____

☐ Self ☐ Parent ☐ Spouse ☐ Legal Guardian

Insurance Company Name: _____

Insurance Company Address: _____

_____

Policy #:_____ Group ID#:_____

Place of Employment (If specified other than Self):_____

In-Network Deductible: $_____ Out-of-Network Deductible: $_____ Co-pay Amount: $_____

**MENTAL HEALTH DATA:**

Have you ever been hospitalized for psychiatric/behavioral health problems? ☐ Yes ☐ No

If YES, please explain: _____

In the past 12 months, have you felt sad, down, depressed, etc…? ☐ Yes ☐ No

In the past 12 months, have you felt anxious or suffered a panic attack? ☐ Yes ☐ No

In the past 12 months, have you had suicidal thoughts? ☐ Yes ☐ No

In the past 12 months, have you attempted suicide? ☐ Yes ☐ No

Do you feel your mental health has negatively impacted your ability to complete your daily activities in the past 30 days? ☐ Yes ☐ No

**Behavior – Please Check Any of the Following Behaviors that Apply to You:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Can't Keep a Job | | Impulsive Reactions | | Odd Behavior | | Take Too Many Risks |
| | Compulsions | | Insomnia | | Overeat | | Vomiting |
| | Crying | | Lack of Motivation | | Procrastination | | Withdrawal |
| | Eating Problems | | Nervous Tics | | Sleep Disturbance | | Work Too Hard |

**PHYSICAL HEALTH DATA:**

**Please list ALL medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):**

_____

_____

Please list any allergies (including seasonal):

_____

Describe your physical health: Excellent: ☐ Good ☐ Average ☐ Poor

Are you currently under a doctor's care: ☐ Yes ☐ No

If YES, please provide the doctor's full name: _____

Reason for doctor's care: _____

Have you been hospitalized in the past? If YES, please describe:

_____

_____

Have you had any recent major illnesses or surgeries? If YES, please desribe:

_____

_____

Do you have any current concerns about your physical health? If YES, please specify:

_____

**Do you have or have you had any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| AIDS or HIV | ☐YES ☐NO | Epilepsy/Convulsions | ☐YES ☐NO | Liver Disease | ☐YES ☐NO |
| Anemia | ☐YES ☐NO | Fainting/Seizures | ☐YES ☐NO | Low Blood Pressure | ☐YES ☐NO |
| Angina | ☐YES ☐NO | Frequently Fatigued | ☐YES ☐NO | Mitral Valve Replacement | ☐YES ☐NO |
| Anorexia | ☐YES ☐NO | Glaucoma | ☐YES ☐NO | Obesity | ☐YES ☐NO |
| Arthritis | ☐YES ☐NO | Gonorrhea | ☐YES ☐NO | Radiation Therapy | ☐YES ☐NO |
| Asthma | ☐YES ☐NO | Hay Fever/Allergies | ☐YES ☐NO | Recent Weight Loss | ☐YES ☐NO |
| Bulimia | ☐YES ☐NO | Heart Attack | ☐YES ☐NO | Respiratory Problems | ☐YES ☐NO |
| Cancer | ☐YES ☐NO | Heart Disease | ☐YES ☐NO | Rheumatic Fever | ☐YES ☐NO |
| Cardiac Pacemaker | ☐YES ☐NO | Heart Murmur | ☐YES ☐NO | Stroke | ☐YES ☐NO |
| Chest Pain | ☐YES ☐NO | Hepatitis | ☐YES ☐NO | Swollen Ankles | ☐YES ☐NO |
| Chlamydia | ☐YES ☐NO | High Blood Pressure | ☐YES ☐NO | Syphilis | ☐YES ☐NO |
| Diabetes | ☐YES ☐NO | Joint Replacement | ☐YES ☐NO | Thyroid Problems | ☐YES ☐NO |
| Easily Winded | ☐YES ☐NO | Kidney Disease | ☐YES ☐NO | Tuberculosis | ☐YES ☐NO |
| Emphysema | ☐YES ☐NO | Leukemia | ☐YES ☐NO | Ulcer/Stomach Issues | ☐YES ☐NO |

**Physical – Please Check Any of the Following Symptoms that Apply to You:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Back Pain | | Don't Like Being Touched | | Headaches | | Palpitations | | Tingling |
| | Blackouts | | Dry Mouth | | Hearing Problems | | Rapid Heart Beat | | Tremors |
| | Bowel Disturbances | | Excessive Sweating | | Hearing Things | | Sexual Disturbances | | Twitches |
| | Burning or Itchy Skin | | Fainting Spells | | Muscle Spasms | | Skin Problems | | Unable to Relax |
| | Chest Pains | | Fatigue | | Nervous Tics | | Stomach Trouble | | Visual Disturbances |
| | Dizziness | | Flushes | | Numbness | | Tension | | Watery Eyes |

**SOCIAL HISTORY DATA:**

Your Marital Status:_____ # of marriages: _____Spouse's Name:_____

Living with a partner: ☐YES ☐NO For how long: _____Partner's Name:_____

**Children:**

1) ☐M ☐F Age_____ 2) ☐M ☐F Age_____ 3) ☐M ☐F Age_____ 4) ☐M ☐F Age_____ 5) ☐M ☐F Age_____

Were you adopted? ☐YES ☐NO If YES, your age at the time of adoption: Age_____

Were you ever in foster care or residential care? ☐YES ☐NO

**Siblings:** Circle your place in the family. If a sibling is deceased, put an X through the placement number.

1) ☐M ☐F Age_____ 2) ☐M ☐F Age_____ 3) ☐M ☐F Age_____ 4) ☐M ☐F Age_____ 5) ☐M ☐F Age_____

What is your current living situation? ☐Rent ☐Own ☐ Friend's home ☐Relative's home ☐Homeless Shelter

Do you feel that you live in a healthy and safe place? ☐YES ☐NO

Have you had difficulty meeting your basic needs in the last 12 months (rent, clothing, groceries, etc.)? ☐YES ☐NO

Do you collect disability income? ☐YES ☐NO

Are there any major stressors in your life? ☐ YES ☐ NO If YES, what are those stressors?

| Stressors | How Severe? | | | How Long? | |
|---|---|---|---|---|---|
| | Mild | Moderate | Severe | Recent | > 1 Year |
| Marriage/Relationship | | | | | |
| Friends/Social | | | | | |
| School-related | | | | | |
| Work-related | | | | | |
| Housing | | | | | |
| Financial | | | | | |
| Legal | | | | | |
| Death/Grief | | | | | |
| Health Problems | | | | | |

Do you currently smoke cigarettes or cigars? ☐ YES ☐ NO

If a former smoker when was your quit date? _____

Do you currently use smokeless tobacco products such as chew or snuff? ☐ YES ☐ NO

Have you ever had any D.T.'s? (Delirium tremens) ☐ YES ☐ NO

Have you experienced any blackouts from drugs or alcohol? ☐ YES ☐ NO

Have you ever injected drugs? ☐ YES ☐ NO

**Please complete the following chart:**

Please indicate substances currently used (over the past 12 months), how much at one time, how many times per day/week, age of first use, past use history & length of time used.

| | Drug of Choice? (Yes | Age of First Use | Route | How Much | How Often | Date/Time of Last Use |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Cocaine | | | | | | |
| Ecstasy | | | | | | |
| Heroin | | | | | | |
| Inhalants | | | | | | |
| LSD/PCP/ Hallucinogens | | | | | | |
| Marijuana | | | | | | |
| Methamphetamine | | | | | | |
| Other Prescription Drugs (Benzos, etc.) | | | | | | |
| Prescription Pain Killers | | | | | | |
| Prescript. Stimulants (Adderall, etc.) | | | | | | |
| Other | | | | | | |

**PREVIOUS CHEMICAL DEPENDENCY TREATMENT DATA:**

Have you ever been in treatment for Chemical Dependency/Addiction? ☐YES ☐NO

If YES, where:_____

Treatment was for what chemical(s): _____

Are you involved in a recovery program? ☐YES ☐NO Do you attend meetings? ☐YES ☐NO

Have you completed a 12-step program? ☐YES ☐NO If YES, when:_____

Do you have a sponsor? ☐YES ☐NO

**The following questions relate to the recovery support you currently have available to you.**

In the 30 days before you entered this program, how many times did you attend **AA, NA, MA or other self-help group meetings** (count # of meetings attended)? _____ Meetings ***(If ZERO, skip the next question)***

How many of those meetings were in religious or **faith affiliated** recovery self-help groups? _____ Meetings

Did you have contact with an AA, NA, MA or other sponsor in the 30 days before you entered this program?
☐YES ☐NO ☐DO NOT HAVE A SPONSOR

In the 30 days before you entered this program, did you have contact with family or friends who were supportive of your recovery? ☐YES ☐NO

In the 30 days before you entered this program, how many people could you count on for recovery support when you need it? _____ PEOPLE

How many people can you count on **now** for recovery support when you need it? _____ PEOPLE

Besides substance abuse treatment and opiate replacement medication, what are the next two most useful things you believe will help you in getting or staying off illicit drugs or alcohol?

| | SELECT TWO ANSWERS: | | |
|---|---|---|---|
| | Change in Environment (Staying Away from Certain People, Places) | | Staying Busy/Keeping Occupied |
| | Children (being responsible for dependents) | | Support from a Partner (boy/girlfriend, spouse) |
| | Counseling | | Support from Family |
| | Employment | | Support from Friends |
| | My Faith or Religion | | The Need to Stay Out of Jail or Prison |
| | Other People in Recovery | | Will Power |
| | Remembering the Past/Consequences | | Other, Please Specify: |

Based on what you know about yourself and your situation, how good are the chances that you can get off and stay off drugs and/or alcohol?

| | PROBABILITY |
|---|---|
| | Very Poor |
| | Moderately Poor |
| | Uncertain |
| | Moderately Good |
| | Very Good |

**FAMILY HISTORY DATA:**

Birthplace: _____

FATHER: Age now if living: _____Age at death: _____Cause of death: _____

MOTHER: Age now if living _____Age at death: _____Cause of death: _____

Do your parents live together? ☐YES ☐NO Are your parents divorced? ☐YES ☐NO

**Do You Have a Family History of Any of the Following:**

| | | | | | |
|---|---|---|---|---|---|
| AIDS or HIV | ☐YES ☐NO | Diabetes | ☐YES ☐NO | Leukemia | ☐YES ☐NO |
| Allergies | ☐YES ☐NO | Emphysema | ☐YES ☐NO | Liver Disease | ☐YES ☐NO |
| Anemia | ☐YES ☐NO | Epilepsy/Convulsions | ☐YES ☐NO | Low Blood Pressure | ☐YES ☐NO |
| Angina | ☐YES ☐NO | Fainting/Seizures | ☐YES ☐NO | Mitral Valve Replacement | ☐YES ☐NO |
| Anorexia | ☐YES ☐NO | Glaucoma | ☐YES ☐NO | Obesity | ☐YES ☐NO |
| Arthritis | ☐YES ☐NO | Heart Attack | ☐YES ☐NO | Respiratory Problems | ☐YES ☐NO |
| Asthma | ☐YES ☐NO | Heart Disease | ☐YES ☐NO | Rheumatic Fever | ☐YES ☐NO |
| Bulimia | ☐YES ☐NO | Heart Murmur | ☐YES ☐NO | Stroke | ☐YES ☐NO |
| Cancer | ☐YES ☐NO | Hepatitis | ☐YES ☐NO | Thyroid Problem | ☐YES ☐NO |
| Cardiac Pacemaker | ☐YES ☐NO | High Blood Pressure | ☐YES ☐NO | Tuberculosis | ☐YES ☐NO |
| Chest Pain | ☐YES ☐NO | Kidney Disease | ☐YES ☐NO | Ulcer/Stomach Issues | ☐YES ☐NO |

**LEGAL HISTORY DATA:**

In the past 12 months, have you been convicted? ☐YES ☐NO

If YES, was it a felony or misdemeanor? ☐Felony ☐Misdemeanor

Reason for conviction:_____

Have you ever had any drug or alcohol related arrests? ☐YES ☐NO

Have you ever been convicted of any of the following crimes?

Homicide/Murder: ☐YES ☐NO

Attempted Murder: ☐YES ☐NO

Rape/Sexual Assault: ☐YES ☐NO

Arson: ☐YES ☐NO

Have you ever had a DWI (Driving While Intoxicated)? ☐YES ☐NO How Many:_____

Are you currently on probation? ☐YES ☐NO Explain:_____

Do you have any current pending charges? ☐YES ☐NO Explain:_____