

Staff use only
Date received: _____
Staff initials: _____



Please do not leave any question blank. If question does not apply to you please indicate by NA.

Applicant Name _____ Date: _____

Services Requested: _____ Substance Use Assessment
_____ Residential Treatment

Reason why services are being requested:

Who referred you to this program:

Have you had a Substance Use Assessment in the last 90 days?

___ Yes ___ No

Where did you have this Assessment done _____

What were its recommendations _____

****If you are requesting this Assessment be used to support your need for treatment, we must have a copy of the Assessment and a signed Release of Information allowing us to contact the agency who did this Assessment.

Ethnicity / Gender Status information is optional:

Race/Ethnicity: _____ Male ___ Female ___

Date of Birth: _____ Social Security Number: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Children: ___ Yes ___ No How many? _____

Where do they currently reside: _____

Have you ever had any Office of Children Services (OCS) involvement:

Please explain in detail these OCS situations:

Application for Services

Applicant Name _____ Date: _____

Mailing Address: _____

Phone Number: _____

Message Phone: _____

Employer: _____ Phone Number: _____

Length of Time Employed: _____

Educational Information:

Highest Grade Completed: _____ Diploma _____ GED _____

Vocational School: _____

Last employed: _____

Legal Information:

Name of Attorney: _____

Phone Number: _____

Are you currently on Probation: _____ Yes _____ No

Probation Officer: _____ Phone Number: _____

Do you have any current charges, if so please list them:

Past criminal charges, if so, please list- what was the outcome/result:

Medical Information:

Current Physician's Name: _____

Address: _____

Phone Number: _____

Current Medical Conditions / and or Allergies:

List Current Prescribed Medications:

Type of Medication	Reason why you take this medication
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Application for Services

Applicant Name _____ Date: _____

Do you have a disability that might affect your treatment need? Yes No
 Please explain:

Substance Use History: Do you now or have you ever used or tried any of the following substances?

Substances	Age first Use	Age Last Use	How Often Used	How much did you Use.	Date last Used	How Used: (Oral, IV, Smoke, Snort, etc
Amphetamine						
Speed, Uppers						
Amyl Nitrate						
Barbiturates						
Benzodiazepine						
Cocaine/Crack						
Codeine						
Heroin						
Inhalants						
LSD (ACID)						
Marijuana/Weed						
Opium						
PCP/Angel Dust						
Percodan						
Peyote						
Quaaludes						
Spice						
Suboxone						
Other Stimulates						
Tobacco						
Alcohol						

Have you experienced any blackouts/ overdosing/or negative physical conditions due to your use of substances within the last 12 months?

Application for Services

Applicant Name _____ Date: _____

Physical or medical problems:

- Increased tolerance Hangovers Liver disease
- Stomach ailments
- Experiences withdrawal symptoms
- Heart ailments
- Blackouts Other medical problems

Previous or Current Substance Use Treatment:

<u>Where</u>	<u>Dates:</u>
_____	_____
_____	_____
_____	_____

Previous or Current Mental Health Treatment:

<u>Where</u>	<u>Dates:</u>
_____	_____
_____	_____
_____	_____

Previous or Current Substance Use Treatment:

<u>Where</u>	<u>Dates:</u>
_____	_____
_____	_____
_____	_____

Financial Information: Payment is required at the time of appointment

How will you be paying for your services: _____ Cash
_____ Medicaid
_____ Other-Please explain

Name of Insurance Company: _____

Medicaid Number: _____

Additional Information you would like to include in this application:

Applicant Printed Name _____ Date _____

Applicant Signature _____