West Pines
BEHAVIORAL HEALTH | SCL Health

VS / For internal use only:

POX _____
BP _____
P _____
R _____
T _____
BAL _____
LU _____

Admission-Intake Form

Welcome to West Pines. Please complete this form. It is very important that you be as honest and detailed as possible. This information will help our team give you the best possible care and help us in our efforts to get authorization for payment from your insurance company if you are using benefits. It will also help our medical team to have a comprehensive record of your medical history and current medical needs. Thank you.

Name: _____ Age: _____ Date: _____

How were you referred to West Pines?

- ☐ Internet search
- ☐ Insurance
- ☐ I am a former patient
- ☐ I heard about it from a former patient
- ☐ My doctor _____
- ☐ Other provider/program _____
- ☐ Hospital /Emergency Room
- ☐ Therapist/Case Manager _____
- ☐ Work/EAP
- ☐ Other _____

HISTORY OF SUBSTANCE ABUSE

Why are you seeking treatment today?

- ☐ Family/Friend Intervention
- ☐ Job Loss
- ☐ Legal Issues
- ☐ Child Custody Issues
- ☐ Occupational/Educational Concerns
- ☐ Financial Issues
- ☐ Medical Concerns
- ☐ Grief/Loss/Crisis
- ☐ Other _____

What substance(s) do you want to quit using?

- ☐ Alcohol: What kind, how much and for how long have you been drinking at this level? _____
- ☐ Heroin: How many grams daily? _____
- ☐ Prescription Opiates (i.e. Oxycodone, Vicodin): What kind and how many milligrams daily? _____
- ☐ Benzodiazepines (i.e. Xanax, Klonopin, Ativan): What kind and how many milligrams daily? _____
- ☐ Other: What and how much daily? _____

How do you use the substance(s) you are addicted to (i.e. smoke, IV, snort, oral)? _____

When was the first time you used the substance(s) you are addicted to? _____

When was the last time you used the substance(s) you are addicted to? _____

When, and for how long, is the longest time you have been sober? _____

☐ Do you use tobacco? ☐ Smoke ☐ Chew If so, how much per day? _____ When did you start? _____

Have you been treated for your substance abuse before? ☐ Yes ☐ No

Emergency Room Visit: Date(s) _____ Where: _____

Medical Detoxification: Date(s) _____ Where: _____

Intensive Outpatient Program: Date(s) _____ Where: _____

Residential Treatment: Date(s) _____ Where: _____

MEDICAL HISTORY

List any medical problems you have: _____

_____

_____

Allergies

Are you allergic to any medications or latex? _____

SURGICAL HISTORY

List any surgeries you have had: _____

_____

_____

INFECTIOUS DISEASES

Have you been screened for ☐ HIV ☐ Hepatitis ☐ Tuberculosis ? Would you like screening while here? ☐ Yes ☐ No

MEDICATIONS

Please list any medications you take regularly:

Name:	Dose:	Frequency:

MENTAL HEALTH

Do you have any other Mental Health Diagnoses? ☐ Yes ☐ No

If yes, what are they? _____

Does anyone in your family have a history of mental illness or addictions? ☐ Yes ☐ No

If yes, who and what? _____

REVIEW OF SYSTEMS

Do you CURRENTLY suffer from any of the following?

Headaches	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Memory Problems	☐ Yes ☐ No
Confusion	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Tremors	☐ Yes ☐ No	Recent falls	☐ Yes ☐ No

Hallucinations during withdrawal (hearing voices or seeing/feeling things that are not there) ☐ Yes ☐ No
If yes, please describe: _____

History of seizures during withdrawal? ☐ Yes ☐ No
If yes, last occurrence? _____

Weakness of arms or legs? ☐ Yes ☐ No
If yes, which ones are weak and when? _____

History of stroke or blood clots? ☐ Yes ☐ No
If yes, when, and are you on blood thinners? _____

History of Diabetes in your family? If yes, who? _____

Chest pain or palpitations?	☐ Yes ☐ No	Heart attack? If yes, when? _____	☐ Yes ☐ No
Swelling of legs?	☐ Yes ☐ No	Ear, nose, throat pain or problems?	☐ Yes ☐ No
Difficulty breathing or lung problems?			☐ Yes ☐ No
If yes, please describe: _____			
Constipation?	☐ Yes ☐ No	Abdominal pain or cramping?	☐ Yes ☐ No
Diarrhea?	☐ Yes ☐ No	Hemorrhoids?	☐ Yes ☐ No
Nausea or vomiting?	☐ Yes ☐ No	History of reflux?	☐ Yes ☐ No
History of ulcers or bleeding?	☐ Yes ☐ No	History of pancreatitis?	☐ Yes ☐ No
Liver problems?	☐ Yes ☐ No	Urinary problems or infections?	☐ Yes ☐ No
If female, when was your last period? _____ MM / DD / YY		If female, could you be pregnant?	☐ Yes ☐ No

Chronic pain? ☐ Yes ☐ No
If yes, please describe the type and location of pain: _____

Current pain? ☐ Yes ☐ No
If so, please describe and rate on scale of 1-10 (1 is low): _____

Skin lesions or rashes? ☐ Yes ☐ No
If yes, please describe: _____