

Instructions: Please complete every page included in this packet. Do not leave any blanks. Please indicate "N/A" if a question does not apply to you.

Name			Date of Birth			Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Current Address			How long? Yrs./Mos.			County	
City/State/ Zip			Is this clinic convenient for you?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is there a child-proof storage area in the home?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Spiritual Preference			Do you have medical insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have Medicare/ Medicaid?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does anyone contribute the majority of your support?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many people depend on you for the majority of their food, shelter, etc?			Are any of your children currently in foster care?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

List everyone who lives at your current residence:

Name	Relation to you	Their age	Name	Relation to you	Their age
1.			3.		
2.			4.		

Check one in each category:

Sexual Orientation	Ethnicity	Marital Status	Living Situation	Income	Current Employment Status
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> White	<input type="checkbox"/> Never married	<input type="checkbox"/> Live alone	<input type="checkbox"/> None	<input type="checkbox"/> Part-time
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Black	<input type="checkbox"/> 1st time married	<input type="checkbox"/> Live with spouse/common	<input type="checkbox"/> Salary	<input type="checkbox"/> Full-time
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Remarried	<input type="checkbox"/> A family member	<input type="checkbox"/> Public Assist	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Gay	<input type="checkbox"/> Asian	<input type="checkbox"/> Widowed	<input type="checkbox"/> With a friend	<input type="checkbox"/> Retirement	<input type="checkbox"/> Homemaker
<input type="checkbox"/> Transgender	<input type="checkbox"/> Native Am	<input type="checkbox"/> Cohabiting	<input type="checkbox"/> A group	<input type="checkbox"/> Disability	<input type="checkbox"/> Student
<input type="checkbox"/> Other	<input type="checkbox"/> Multiethnic	<input type="checkbox"/> Divorced	<input type="checkbox"/> Homeless	<input type="checkbox"/> Family/Friends	<input type="checkbox"/> Retired
Gender Expression	<input type="checkbox"/> Other	<input type="checkbox"/> No Children	<input type="checkbox"/> Other relatives	<input type="checkbox"/> Illegal Gains	<input type="checkbox"/> Disabled
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X			<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

What are your cultural influences & background? _____

What has been your usual employment pattern over the past 3 years?

<input type="checkbox"/> Full-time (35+ hours per week)	<input type="checkbox"/> Military Service
<input type="checkbox"/> Part-time (regular hours)	<input type="checkbox"/> Retired/disability
<input type="checkbox"/> Part-time (Irregular hours)	<input type="checkbox"/> Not in workforce
<input type="checkbox"/> Student	<input type="checkbox"/> In controlled environment

What is the highest education level you have completed?

<input type="checkbox"/> 10 th grade or less	<input type="checkbox"/> Associates Degree
<input type="checkbox"/> 11 th grade	<input type="checkbox"/> 3+ yrs in college
<input type="checkbox"/> 12 th grade / GED	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> 1 yr. of college	<input type="checkbox"/> Post-bachelor's

Were you in the military? NO YES If "Yes": Branch _____ Years _____ Discharge _____

How well do you feel you read & write? Not at all Below Average Average Above Average Very Well

Do you require special accommodations or assistive technologies? NO YES IF "Yes", what type: _____

What is your usual occupation? _____ How long was your longest full-time job? _____

What are your career goals? _____

What do you hope to gain from methadone maintenance treatment?

<input type="checkbox"/> Stop using opiates and/or other drugs.	<input type="checkbox"/> Improve my current educational/vocational situation.	<input type="checkbox"/> Improve my economic/financial situation.
<input type="checkbox"/> Improve my current employment situation.	<input type="checkbox"/> Improve my medical/psychological well being.	<input type="checkbox"/> Improve my current legal status.
<input type="checkbox"/> Improve my relationships.	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

FAMILY/SOCIAL HISTORY

Have you had significant periods in which you have experienced serious problems getting along with the following:

	PAST 30 DAYS	PAST 60 DAYS	IN LIFE TIME
Mother	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Father	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sister/Brother	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sexual Partner/Spouse	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Children	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Significant Family Member	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Close Friends	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neighbors	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Co-Workers	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Have you experienced or witnessed any of the following?

	PAST 6 MONTHS	PAST YEAR	IN LIFE TIME
Abuse (verbal or emotional)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neglect	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Violence	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sexual Assault	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

With whom do you usually spend your free time?		How many friends are opiate users?		How many friends are on methadone?		
Is there a history of family addiction?	<input type="checkbox"/> YES <input type="checkbox"/> NO	What is the relation to you?		For what drug type?		
Did they get help for their problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO					
What is your birth order in your family?	<input type="checkbox"/> Only child	<input type="checkbox"/> 1st Born	<input type="checkbox"/> 2nd Born	<input type="checkbox"/> 3rd Born	<input type="checkbox"/> 4th Born	<input type="checkbox"/> 5th Born
Why did you leave home?		Total Siblings				

PSYCHOLOGICAL HISTORY/STATUS

In the last 2-4 weeks, have you had a significant period (not a direct result of drug/alcohol use), in which you have experienced:

<input type="checkbox"/> Serious Depression	<input type="checkbox"/> Preoccupation w/ sex	<input type="checkbox"/> Attempted suicide
<input type="checkbox"/> Serious Anxiety or tension	<input type="checkbox"/> Engaged in compulsive behaviors	<input type="checkbox"/> Serious thoughts of self-harming behavior
<input type="checkbox"/> Trouble understanding, concentrating or remembering	<input type="checkbox"/> Trouble controlling violent behavior	<input type="checkbox"/> Engaged in self-harming behavior
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Engaged in pleasurable activities with high potential for painful consequences.

How many times have you been treated for any psychological or emotional problems?	Hospital	Out-patient	Do you receive a pension for a psychiatric disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Current Diagnosis:	Physician's Name & Phone #			
Are you currently on medication(s) for this disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you willing/does your physician know you are seeking methadone treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
How many days in the last 30 have you been affected by your disabilities and/or disorders psychologically & socially?				
If affected, how does it affect you?				
What day of the week is it?	Who is the President of the United States?			
What city are you in?	Current month and year?			

Do you currently have serious thoughts or plans to:	Harm yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Harm someone else?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the patient appear to need a Behavioral Management Treatment Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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SUBSTANCE ABUSE HISTORY

TRANSFER-IN

Print Name _____

Date of Birth _____

Have you been using opiates/ heroin for more than one year?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How long?		Have you used opiates in the last 24 hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you or recently have been enrolled in methadone program?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How long?		Where?	

	# of days in past 30 Days	How much	Lifetime Use (Years)	Age at First Use	Route of Administration						
					Oral	Nasal	Smoking	IV Use	Non-IV	Other	No use
Heroin					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street Methadone (non-treatment)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Opiates/Analgesics (Opium/Demerol/Morphine/ Hydrocodone & Oxycodone)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypnotics/ Sedatives/ Anxiolytics					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis (marijuana/hashish)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines/ Methamphetamines					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens (LSD/Psychedelics/ PCP/Mushrooms/Peyote)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO NOT LEAVE ANY BLANKS:

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Regarding heroin and/or use of other opiates, in the past 12 months have you:	Y	N	Regarding heroin and/or use of other opiates, in the past 12 months have you:	Y	N
Taken opioids in larger amounts or for longer periods of time than intended?	<input type="checkbox"/>	<input type="checkbox"/>	Found yourself using the drug again to relieve or avoid withdrawal symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Found you're not successful in your efforts to cut-down or control use?	<input type="checkbox"/>	<input type="checkbox"/>	Please answer the following questions:		
Found yourself spending more time in trying to obtain and/or trying to recover from the effects of using it?	<input type="checkbox"/>	<input type="checkbox"/>	How many times in your life have you been treated for substance abuse?		
Had cravings or strong urges to use opioids?	<input type="checkbox"/>	<input type="checkbox"/>	Approximate date of last time you were in treatment:		
Been unable to fulfill major role obligations because of opioid use?	<input type="checkbox"/>	<input type="checkbox"/>	Location of treatment center:		
Continued use of opioids despite it causing problems with family & friends?	<input type="checkbox"/>	<input type="checkbox"/>	How many of these were for detox only?		
Given up or reduced important social, occupational, or recreational activities because of drug use?	<input type="checkbox"/>	<input type="checkbox"/>	How many times have you overdosed?		
Used opioids in situations where it was physically hazardous?	<input type="checkbox"/>	<input type="checkbox"/>	List the prescription drugs or over-the-counter medications you are currently taking.		
Used opioids even though it made a physical or psychological problem worse?	<input type="checkbox"/>	<input type="checkbox"/>			
Found a need for increased amounts to achieve the desired effect?	<input type="checkbox"/>	<input type="checkbox"/>			

What issues have caused you to seek treatment today? _____

I acknowledge that the information provided is accurate and true.

Patient Signature

TDL/ID #

Date

LEGAL STATUS/HISTORY

Information will be kept confidential.

Type of Offense	Total arrests	Type of Offense	Total arrests	Type of Offense	Total arrests
Public Intoxication	<input type="checkbox"/>	Gambling/bookmaking	<input type="checkbox"/>	Arson/weapons	<input type="checkbox"/>
DWI	<input type="checkbox"/>	Prostitution/pimping	<input type="checkbox"/>	Vandalism/vagrancy/ loitering	<input type="checkbox"/>
Use of Illegal Drugs	<input type="checkbox"/>	Burglary or auto theft	<input type="checkbox"/>	Sex offenses	<input type="checkbox"/>
Sale/distribution/manufacturing	<input type="checkbox"/>	Other theft	<input type="checkbox"/>	Probation/Parole Violations	<input type="checkbox"/>
Forgery/Fraud	<input type="checkbox"/>	Robbery	<input type="checkbox"/>	Other	<input type="checkbox"/>
Buying/receiving stolen property	<input type="checkbox"/>	Assault	<input type="checkbox"/>		

Do you have a suspended driver's license?	<input type="checkbox"/> YES <input type="checkbox"/> NO	For what reason?			
Do you need to complete an offender education course to get your license back?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Name/Address/Telephone of Supervision Officer:			
What is your current legal status?	<input type="checkbox"/> Clear	<input type="checkbox"/> Warrants out		<input type="checkbox"/> Awaiting trial or sentencing	
<input type="checkbox"/> Probation	<input type="checkbox"/> Parole	<input type="checkbox"/> Work-release		<input type="checkbox"/> Other	
For which offense?		When does your current parole/ probation end?			

What are your treatment preferences?

Check appropriately: one choice only	YES	NO	DOESN'T MATTER	Check appropriately:	YES	NO	DOESN'T MATTER
This location is convenient for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I prefer a female Counselor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I require special accommodations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I prefer family involvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.M. clinic hours are ok.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I don't mind written/reading assignments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I prefer outpatient over in-patient treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I don't mind going to 12-Step meeting such as NA/AA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I prefer a male counselor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I prefer controlled use of drugs over freedom from all drugs use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STANDARD COURSE OF TREATMENT

The following outlines the course of treatment. I understand I am to ask questions if I do not understand.

- If you are new to methadone maintenance treatment or beginning a new treatment experience with Counseling And Recovery Services you will be involved in the titration phase of treatment whereby you will be medically monitored to ensure you become stabilized on methadone. Your input is very important during this process.
- Upon stabilization you will begin to meet with your assigned counselor on a regular basis to begin developing a Treatment Plan whereby you and your counselor will determine how, based on your strengths, needs, abilities, and preferences, will accomplish the goals you set for yourself while in treatment.
- You will be encouraged to refrain from all illicit or unapproved drug use so that when you complete at least 30 days in treatment you may progress to the next level in the treatment process and receive take-home medication for the weekend. Until then, you will be required to attend the clinic daily, except for Sunday. All take-out schedules are determined by time in treatment and other important criteria. You may become eligible for additional take-home medication as you transition from one phase of treatment to the next.
- Should you not transition or progress through the treatment process as expected, you may be required to attend specialty groups and/or increase the number of counseling sessions you are required to have with your counselor.
- If at anytime you choose to voluntarily terminate your treatment with Counseling And Recovery Services, or discharged during the course of treatment for any reason, the staff at Counseling And Recovery Services will assist you with a transfer to another methadone maintenance clinic, a detoxification center, and/or help you become familiar with community resources (such as Narcotics Anonymous & Relapse Prevention Groups) to help you continue your recovery from opiate addiction.

Patient Signature

Date

Intake Counselor Signature

Date