



To be complete by patient:

Name _____ Today's Date _____ Phone # _____

Address _____ City/State/Zip _____

Email _____ Date of Birth _____

Driver's License # _____ Social Security # _____

Central Registry # _____ Height _____ Weight _____
(See below to formulate #)

Name of Emergency Contact _____
Name Relation Telephone #

Choose one: Are you under the age of 18? YES NO
Are you pregnant? YES NO
Have you recently been institutionalized/incarcerated? YES NO
Have you ever received drug treatment before? YES NO

Age at which you first began to use opiates? _____ Which drug type? _____

Did you ingest/snort/IV use this drug? YES NO Have you shared needles? YES NO

Approximate date of your last physical examination? _____

Approximate date of your last TB test? _____

Approximate date of your last HIV/AIDS tests? _____

Do you require special accommodation because of a disability? YES NO

Type of accommodations needed: _____

Are you currently enrolled in another maintenance treatment program? YES NO

Why are you transferring? _____

Were you required to pay a \$25.00 transfer fee at this clinic? YES NO NOT SURE

Have you ever been a patient at Counseling And Recovery Services? YES NO

Approximate Date? _____ Which location: _____

How did you hear of our clinic? _____

To be completed by Program Staff

Patient No. _____ Date of Admission _____

Central Registry #:

I. First Initial: _____ IV. Race: White⁽¹⁾ Black⁽²⁾ Hispanic⁽³⁾ Other⁽⁴⁾

II. Date of Birth: _____ V. Last 4 of SS#: _____

III. Gender: Male⁽¹⁾ Female⁽²⁾

Previous Patient? YES NO Chart # _____ Admission Date _____ Anniversary Date _____

Length Time in Program _____ Dosage @ Discharge _____ Level at Discharge _____

Discharge Date _____ Reason for Discharge _____

Is the patient eligible for re-admission? YES NO Did patient complete the detox process? YES NO