Today's Date: ______________________

Client Name: ____ Date of Birth: _____________________

Address: ____Phone: _______________

Race: __________________Social Security: ______________________ Gender identification: ___________

Legal citizen: ☐ YES ☐ NO Place of birth: ___________________________Marital Status: ___________

Health Insurance: ☐ YES ☐ NO List: ________________________________

MEDICAID Verification/Eligibility:

Status :☐ ACTIVE ☐ INACTIVE NJFamilyCare Application Completed? ☐ YES ☐ NO

SSI/SSD: ☐ YES ☐ NO Amount:$______ Currently employed: ☐ YES ☐ NO Weekly wage: $_______

Welfare: ☐ YES ☐ NO Food stamps: ☐ YES ☐ NO County: _______________

If unemployed, how are you supported/who/how much/how often? __________________________________

____

D1: Intoxication / Withdrawal:

1. Substance of choice: ______________________ ☐ Nasal ☐ IV ☐ Oral ☐ Smoke ☐ IVmuscular

Frequency: ________ Amount used: _________________ Last use date: _________________

2. Substance of choice: ______________________ ☐ Nasal ☐ IV ☐ Oral ☐ Smoke ☐ IVmuscular

Frequency: ________ Amount used: _________________ Last use date: _________________

Tobacco Use: ☐ YES ☐ NO type: _____ amount: __________ Desire to stop: ☐ Yes ☐ No

Methadone/Suboxone maintenance: ☐ YES ☐ NO TAPER dose: _____________

Last dose date: ___________Clinic name/phone: ____________________________________

No limit methadone dose; Suboxone up to 24 mg per day mornings only. All methadone admissions must arrive with* ***dosing record* *and* ***letter*** *from clinic stating they are able to return if discharged including non-successful completion.*

D2: Biomedical Conditions:

Seizures?: ☐ YES ☐ NO Date of last seizure: __________Open wounds? ☐ YES ☐ NO

list:_____________

Are you an Insulin Dependent diabetic? ☐ Yes ☐ No Flex Pen or Needles?

Are you currently pregnant? ☐ Yes ☐ No Due: _________ Given birth within the past month? ☐ Yes ☐ No

Able to walk up/down stairs with no issue: ☐ YES ☐ NO

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Cardiac issues? (Heart Disease, High/Low Blood Pressure, etc.) ☐ YES ☐ NO

Explain: ____

Currently under the care of a specialist? (Cancer, HepC, HIV, Chronic Pain, etc) ☐ YES ☐ NO

Explain: ____

Current **physical health** medications (list w/dosage):

____________________ ____________________ ____________________

Date last PPD test: _________Positive / Negative Chest x-ray :☐ YES ☐ NO

If the TB test is/was positive, we are in need of the chest x-ray results and documentation of treatment.

<u>D3: Emotional/Behavioral Conditions:</u>

Mental health diagnosis? ☐ YES ☐ NO list: ______________________________

Suicide attempts? ☐ YES ☐ NO dates: __________Do you hear voices or hallucinate?☐ YES ☐ NO

Self-harm? ☐ YES ☐ NO (cutting/burning, etc.)list:______________________________

Current **mental health** medications (list w/dosage):

____________________ ____________________ ____________________

<u>D4: Stage of Change:</u>

Why are you interest in Integrity House? ______________________________

<u>D5: Relapse Risk Potential:</u>

Treatment History/Dates:______________________________

Current Facility: ______________________Anticipated Discharge Date: ______________

If not on Medication Assisted Treatment are you interested in MAT? ☐ YES ☐ NO

<u>D6: Recovery Environment:</u>

Probation: ☐ YES ☐ NO Cases pending: ☐ YES ☐ NO Incarcerated: ☐ YES ☐ NO

Sexual assault: ☐ Yes ☐ No Child Abuse: ☐ Yes ☐ No Arson: ☐ Yes ☐ No

Murder/Homicide/Manslaughter ☐ Yes ☐ No Arrest history:______________________________

Case worker/officer contact:______________________________

Currently enrolled in school: ☐ YES ☐ NO Highest Grade Completed: ______________

<u>Anticipated Level of Care:</u>* Short Term Residential * Long Term Residential *Halfway House* Outpatient *

Counselor Completing Screen (Print) ______________________________

Please fax to:973-642-5919 or Please scan to: zcrichlow@integrityhouse.org

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COVID-19 Appendix 1:

Do you have a fever? **Yes** **No**
and
Are you experiencing coughing, sneezing, shortness of breath? **Yes** **No**
(Yes = please refer to Primary Care Physician)

Is anyone in your household sick? **Yes** **No**
(Yes = please reschedule appointment for 14 days)

Have you been in contact with anyone CoVid-19 positive? **Yes** **No**
(Yes = please reschedule appointment for 14 days)

Have you traveled abroad in the last 30days? **Yes** **No**
(Yes = please reschedule appointment for 14 days)

Have you traveled outside the State of New Jersey within the last 14 days? **Yes** **No**
(Yes = please see most recent governor issued "hot spot" travel list and reschedule appointment for 14 days if applicable)

Have you experienced any recent change in taste? **Yes** **No**
(Yes = please refer to Primary Care Physician)