INTEGRITY HOUSE

Today's Date: _____

Client Name:_____ Date of Birth: _____Age:_____

Address:_____Phone: _____

Race: _____Social Security: _____ Gender identification: _____

Legal citizen: ☐ YES ☐ NO Place of birth: _____Marital Status: _____

Insurance Verification/Eligibility:
Health Insurance (Medicaid): ☐ YES ☐ NO List: _____ Special Pop? ☐ YES ☐ NO

SSI/SSD: ☐ YES ☐ NO Amount:$_____ Reason: _____

D1: Intoxication / Withdrawal:
1. Substance of choice: _____ ☐ Nasal ☐ IV ☐ Oral ☐ Smoke

Frequency: _____ Amount used: _____ Last use date: _____

2. Substance of choice: _____ ☐ Nasal ☐ IV ☐ Oral ☐ Smoke

Frequency: _____ Amount used: _____ Last use date: _____

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

Methadone/Suboxone/Vivitrol/Sublocade maintenance: ☐ YES ☐ NO 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.*

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

D2: Biomedical Conditions:
Seizures?: ☐ YES ☐ NO Date of last seizure: _____Open wounds? ☐ YES ☐ NO list:_____

Are you a 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

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

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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.

D3: Emotional/Behavioral Conditions:
Mental health diagnosis? ☐ YES ☐ NO list: _____

Suicide attempts? ☐ YES ☐ NO dates: _____ Self-harm? ☐ YES ☐ NO
list:_____

Do you hear voices or hallucinate? ☐ YES ☐ NO Please Explain: _____

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

_____ _____ _____

D4: Stage of Change:
Why are you interest in Integrity House? _____

D5: Relapse Risk Potential:
Treatment History/Dates:_____

Current Facility: _____Anticipated Discharge Date: _____

D6: Recovery Environment:
Probation/Parole/Case Pending: ☐ YES ☐ NO _____ Incarcerated: ☐ YES ☐ NO

Sexual assault: ☐ Yes ☐ No Arson: ☐ Yes ☐ No Arrest history:_____

Legal Contact:_____

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

Currently employed: ☐ YES ☐ NO Weekly wage: $_____

Anticipated Level of Care:* Short Term Residential * Long Term Residential *Halfway House* Outpatient *

Are you interested in Interim Services? : ☐ YES ☐ NO

Counselor Completing Screen (Print) _____

Please fax to:973-642-5919 or Please scan to: CentralAdmissions@IntegrityHouse.org

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Additional Notes:
How did you hear about us?

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)

COVID-19 Vaccine Appendix 2:

Have you had your first dose of COVID-19 Vaccine? **Yes** **No**

(Yes= When/Where is your next dose scheduled: _____)

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