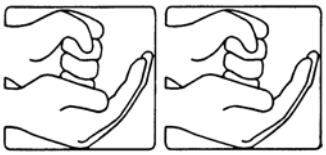
MINNESOTA CHEMICAL DEPENDENCY PROGRAM
FOR DEAF AND HARD OF HEARING INDIVIDUALS
University of Minnesota Medical Center, Fairview Riverside



Intake Worksheet

Date ____/____/____

Potential Client's Name: _____ M ☐ F ☐

Address: _____

_____

Phone/TTY/Video phone:_____ Email: _____

What is the best way to contact you? _____ S.S.#: _____

D.O.B.: ____/____/____ Age: _____ Fairview MR# (if known) _____

Single ☐ Married ☐ Partnered ☐ Divorced ☐ Legally Separated ☐ Widowed ☐

What method(s) of communication do you prefer? Please circle: *written English* *spoken English*

American Sign Language *Signed Exact English* *Pidgin Signed English* *Cued speech*

Lip/speech reading *other* _____

Do you use assisted listening devices? _____ Type: _____

Referral Source: _____

Address: _____

_____

Phone: _____ Email: _____

How did you learn about our program? _____

Emergency Contact: _____ Relationship: _____

Address: _____

_____

Phone: (Home) _____ (Other) _____

E-Mail: _____

Primary Insurance

Insurance Company: _____

Policy holder: _____ DOB: ____/____/_____

SS/ID/Policy #: _____ Group Number: _____

Payer's phone number/contact information: _____

Secondary Insurance (if applicable)

Insurance Company: _____

Policy holder: _____ DOB: ____/____/_____

SS/ID/Policy #: _____ Group Number: _____

Payer's phone number/contact information: _____

Primary Care Physician

Name _____

Address_____

_____

Phone_____

Secondary Physician/Psychiatrist

Name _____

Address_____

_____

Phone_____

You are encouraged to provide Fairview with any relevant medical records.

In order for this worksheet to be processed, it **must** be accompanied by a copy of your insurance, Medicare, and/or Medicaid cards.

Prior chemical dependency or mental health treatment:

Name of facility	Inpatient	Outpatient	Dates attended

History of alcohol and other drug use

First, please tell us what substances you are CURRENTLY using:

Type of substance	Amount typically used	How often/how many times a week	Date of last use	How long you have used

Please also tell us what substances you have used IN THE PAST:

Type of substance	Amount typically used	How often/how many times a week	Date of last use	How long you used

How old were you when you got drunk or used drugs for the first time? _____

Why have you used these drugs? _____

_____

Any prescription drugs or over-the-counter medications currently being used: _____

_____

Do you use tobacco or nicotine? If so, type and frequency of use: _____

_____

Psychological history:

Previous or current diagnoses: _____

_____

Behavioral issues, such as suicide attempts, aggression, etc.

_____

_____

Medical conditions and concerns:

Physical concerns, such as diabetes, seizures, chronic pain, vision or mobility barriers, etc.

_____

_____

Are you independent in all activities of daily living? If not, please explain the type of assistance needed:

_____

_____

Legal consequences:

Legal history, such as arrests, DUI/DWI, probation, parole, assaults, property damage, theft, etc.

_____

_____

Do you have a parole/probation officer? If so, name: _____

County and state: _____ Phone: _____ Email: _____

Family consequences and concerns:

Issues such as arguments, fights, domestic violence, abuse, etc. _____

_____

_____

Any children/dependents? Please list: _____

Financial consequences and concerns:

Issues such as unpaid bills, large debt, borrowing money from others, etc. _____

_____

_____

Work or school consequences and concerns:

Issues such as poor performance, absenteeism, terminations, etc. _____

_____

_____

Patient's Occupation: _____

Employer: _____ Phone: _____

In the past 30 days:

Have you been arrested and if so, how many times? _____

How many of these arrests have been alcohol or drug related? _____

How many nights have you spent in jail? _____

How many days have you used alcohol in the past 30 days? _____

On how many of those occasions did you use 5 or more drinks in one setting?

_____

How many drinking occasions were four drinks or fewer in one setting?

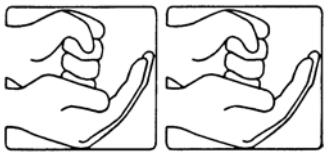
_____

For professional referral source (social worker, counselor, etc.) use only: Are there options to support sobriety after treatment is completed? Include ideas for outpatient treatment, sober housing, and changes in living arrangements, etc. _____

_____

_____

When this form is completed,
please submit it to our Intake Coordinator by fax, email, or mail.
If you have questions about this form or need assistance filling it our,
please contact us and we will be happy to help.



Minnesota Chemical Dependency Program
for Deaf and Hard of Hearing Individuals
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Minneapolis MN 55454

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(612) 273-4516 (fax)
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Visit our website at www.mncddeaf.org
Learn more about our company at www.fairview.org
Learn more about our facility at www.uofmmedicalcenter.org