Turning Point Counseling & Consulting

Intake Questionnaire

Patient Name: ____

Date: ____

(The following questions are to assist us in the design and implementation of your treatment plan)

1) What is the best time of day and day of the week for clinic visits?

____

2) Are there any months out of the year when you may have difficulty making it in for appointments?

____

3) Is there any problem that makes it hard for you to give urine specimen?

____

4) Do you have any disabilities that make it hard for you to read prescription labels or count pills?

____

5) What are your reasons for interest in a Medically-Assisted Treatment program?

____

6) What “triggers” do you know that put you in danger of a relapse?

____

7) What coping methods have you developed to deal with these “triggers” to relapse?

____

8) What plans do you have for the coming year for work or home?

____

9) Is anyone in your home addicted to drugs or alcohol?

____

10) What are the major sources of stress in your life?

Patient Name: ____

11) What family or significant other will be supportive of you during your treatment?

12) Would you be willing to sign a release so that the persons identified above can be spoken to regarding your treatment?

13) Have you ever been treated for a psychiatric problem or mental illness or prescribed psychiatric medications?

Signature *Date*