JOHNSTON RECOVERY SERVICES - CASE PRESENTATION –

Date_____________________________ Medicaid # _________________________ JRS #___________

Name____ SS#_______________________

Address ____

City_________________________ County ________________________________Zip_______________

Miles traveled to the clinic (one-way) _____ How long have you lived at the above address? __________

Is this your permanent residence? ☐ Yes ☐ No Temporary residence? ☐ Yes ☐ No

Telephone Numbers (Please provide only numbers at which you give me permission to call you):

Cell/Home:______________________________ May we leave a detailed message? ☐ Yes ☐ No

Cell Carrier:_____________________________ May we leave a detailed message? ☐ Yes ☐ No

Email Address:____

D.O.B. ____/____/________ Age_______ Sex________ Height________ Weight_______

Living With (Name and Relationship)____

Race_____________ Relationship Status__________________ Children____________Ages__________

Emergency Contact: _________________________Relationship:_________Phone:__________________

Are you Employed? ☐ Yes ☐ No

Occupation____________________Employer______________________________

Are you receiving unemployment benefits? ☐ Yes ☐ No Disability benefits? ☐ Yes ☐ No

Are you a Student? ☐ Yes ☐ No Military status: ☐ N/A ☐ Active

College attending:_________________________ ☐ Vetern

Highest Level of Education Completed:______________

Age of First Opiate Use___________ Date/Time/Amount of Last Use___________________________

Drug of Choice_______________________ Route of Administration____________________________

2nd Drug of Choice____________________ Route of Administration____________________________

Other Drugs Used_________________________________

Any Current Legal Involvement? ☐ Yes ☐ No

How many arrests in the last year? _______Charges?____

How did you hear about our services? ____

What would you like to gain from working with Johnston Recovery Services? What are your goals?

____

____

____

NAME:____ **JRS ID:** ______________

MEDICAL HISTORY:

Primary Care Physician:______________________________________Telephone:_________________

When was your last physical?________________________

List any medical problems:

____

____

____

Please list **ALL** mediations you are currently taking, indicate whether they are **RX** prescribed to you or **OTC** over the counter. *(You will need to register all medications with the nurse – this is for your safety.)*

____

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____

Allergies:____

Have you ever been enrolled in an Opioid Treatment Program? ☐ Yes ☐ No

When and where:____

Hospitalizations (When? Where? Include Medical, Psychiatric & Substance Abuse):

____

____

____

Family history of:			
	Mental illness?	☐ Yes	☐ No
	Substance abuse?	☐ Yes	☐ No
	Suicide?	☐ Yes	☐ No
	Violent behavior?	☐ Yes	☐ No

How often do you?					
	Smoke	____never	_____monthly	_____weekly	_____daily
	Drink alcohol	____never	_____monthly	_____weekly	_____daily
	Use drugs	____never	_____monthly	_____weekly	_____daily

INSURANCE:

Do you have Medicaid? ☐ No ☐ Yes

Do you have other Health Insurance? ☐ No ☐ Yes -- Carrier:_________________________________