24-Hour Admission Screening

Name: _____ Social Security #: _____ DOB: _____

Address: _____

Gender: ☐ Male ☐ Female Telephone #:_____Date of Screening_____

Staff Initials _____ Time: _____ Referral Source _____

Race:	☐ White	☐ American Indian/Alaskan Native	☐ Black/African American	☐ Asian
	☐ Latin/Spanish	☐ Native Hawaiian/Other Pacific Islander	☐ Not Available	

1. Do you have insurance? ☐ Yes ☐ No Type of Insurance and #:_____
2. Highest level of school completed _____
3. Attended School or College within past 3 months? ☐ Yes ☐ No
4. Employment Status _____ Are you a military veteran? ☐ Yes ☐ No
5. Do you receive SSI or SSDI? ☐ Yes ☐ No
6. Do you any physical or mental disabilities? _____
7. Do you have any health concerns that you feel a need to address? ☐ Yes ☐ No
   If yes, please explain _____
8. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
9. Have you ever been a client a 4 2 Restore before? ☐ Yes ☐ No When: _____

Contact Clinical Supervisor or Program Director for Approval

10. Do you know anyone who is currently in, or about to be admitted to 4 2 Restore? ☐ Yes ☐ No
11. # of lifetime admissions of treatment? _____
12. # of times in a self-help group in the past 30 days (AA/NA) _____
13. Have you ever been convicted of a Sexual Offense, Child Abuse, or Arson? ☐ Yes ☐ No
14. # of arrest in the past 12-months _____ Are you on parole or probation? ☐ Yes ☐ No
    Is treatment a condition of your parole/probation? ☐ Yes ☐ No
15. Do you have any upcoming Court dates/Open warrants, Doctor's appointment or any other outside appointments within the next 35 days? ☐ Yes ☐ No Dates: _____
16. What substances are you using? Primary_____ Method of use? _____
    How often? _____ When was the last time you used? _____
    Current Length of Use _____ Age of first use _____ Total yrs. of use _____
17. Secondary Substance _____ Method of use? _____
    How often? _____ When was the last time you used? _____
    Current Length of Use _____ Age of first use_____ Total yrs. of use _____
18. Are you currently experiencing withdrawal symptoms? ☐ None ☐ Nausea ☐ Vomiting
    ☐ Cramping ☐ Sweating ☐ Agitation ☐ Tremors ☐ Blackouts ☐ Current DT's
    ☐ Past DT's ☐ Current DT's ☐ Current Seizures ☐ Past Seizures
19. Have you ever experienced an opiate overdose? ☐ Yes ☐ No How many times have you experienced an opiate overdose in your lifetime _____ Within the past 30 days _____

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20. Number of dependent children _____ (*Females Only)* Are you pregnant? ☐ Yes ☐ No
    Are you being seen for prenatal care? ☐ Yes ☐ No
    If, so which clinic? _____
    When is your next personal care appointment? _____
21. Have you been victim of domestic violence of previous abuse? ☐ Yes ☐ No If yes, explain _____
    _____
22. Do you have any medical conditions? ☐ Yes ☐ No What is the condition(s) _____
    Does your medical condition require medication? ☐ Yes ☐ No
    Medication(s) _____
23. Do you have any psychiatric conditions? ☐ Yes ☐ No What is the condition(s)? _____
    _____
    Does psychiatric condition require medication? ☐ Yes ☐ No
    Are you taking medications as prescribed? ☐ Yes ☐ No
24. Have you ever attempted suicide? ☐ Yes ☐ No When was the most recent attempt? _____
    What did you do? _____ Were you hospitalized? ☐ Yes ☐ No
25. Do you have or had any ideations, intent or plans to harm yourself? ☐ Yes ☐ No
26. Are currently experiencing any auditory or visual hallucinations? ☐ Yes ☐ No
27. Have you been diagnosed with Tuberculosis? ☐ Yes ☐ No
28. Have you used tobacco products 30 days prior to admissions? ☐ Yes ☐ No
29. Are you on Methadone or Suboxone? ☐ Yes ☐ No
    If yes, who is your provider: _____
30. Have you ever taken Lithium, Valproic Acid, Synthroid, Dilantin, or Blood Thinners? ☐ Yes ☐ No
31. Do you have any previous Hospitalization with Substance Use? ☐ Yes ☐ No If yes, _____
    _____
32. Do you have a gambling problem, or have you ever been diagnosed with a gambling disorder?
    ☐ Yes ☐ No
33. Do you have difficulties with reading and/or writing? ☐ Yes ☐ No
34. What is your Primary Language? _____
35. Are you a Hurricane victim? ☐ Yes ☐ No
36. Vitals Signs: Blood Pressure _____ Pulse Rate: _____ Temp: _____ Heart Rate: _____
37. Urinalysis results: Primary _____ Secondary _____
    Tertiary _____ Poly Use _____