Patient Intake Questionnaire

24/7 RECOVERY HOUSE CENTER

Please complete the form and submit in confidence to manager@therecoverycompany.com

Name of person completing form:_____
Relationship to Patient:_____

YOUR CONTACT INFORMATION

Phone #: _____
Alternate Phone #: _____
Fax:_____ Email: _____
Mailing Address:_____

How did you hear about "The Recovery Company - 24/7 Recovery House"?_____

If you were referred by a physician, therapist or interventionist or other, we would appreciate you providing their contact information:

Name: _____
Address:_ _____
Phone Number:_____
May we contact your referral source? Yes No

CLIENT INFORMATION:

Name:_____
DOB: _____ Age: _____ Social Security #:_____
Marital Status: ____ Gender: ____
Address: _____
Telephone #:_____ Alternate Telephone #: _____
Why do you want to enter "24/7 Recovery House Program/Center? _____
_____Continue on attached page if needed.
Are you ready to commit to 6 months or longer to the Program?_____, If Not Explain._____

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Employer Name: _____
(We will not contact your employer without a signed consent from you)

Emergency Contact Name: _____Telephone #: _____

If necessary, may we contact your Emergency Contact? Yes No
Will this be your first treatment program? Yes No

What do you consider to be your primary addiction? Please list that first in the sections below, to the best of your ability. Please include alcohol, addictive prescription medications and street drugs. Please be sure to include all prescription narcotic and benzodiazepine medications:

Name of Drug	Quantity/Usage per Day	How Long	Last Use

Are there any other issues you need help with? Yes No If yes, please describe:

_____

Please list any prior treatment programs you have attended, including outpatient treatment programs.

This includes alcohol, drug and/or psychiatric treatment programs over the past 10 years:

Name of Program	Date	Purpose of Treatment

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What is your longest period of (clean and sober) sobriety?_____
What helped you remain sober?_____
_____
Do you have a family history of addiction? Yes No
If yes, please describe:_____
Do you have any current legal problems? Yes No
If yes, please describe:_____
Do you have any current medical problems? Yes No
If yes, please describe: _____
_____
_____
Are you currently, or have you been in a Pain Management Program? Yes No
If yes, please describe:_____
_____
Name of program : _____
Telephone #:_____
Is the Program Narcotic/Opioid Free/Medication-Free (Physical Therapy)…? Yes No
May we contact them? Yes No

Please list any other medications you take that are not listed in the substance abuse questionnaire above. Include name of medication, dosage, what frequency and the name of the prescribing doctor:

_____

_____

Have you ever experienced any of the following when you attempted to stop drinking or using or while drinking and/or using? Please check where apply.

	Seizures		Loss of Consciousness
	Tremors		Hot/Cold sweats
	Nausea and Vomiting		Blackouts
	Hallucinations (DT's)		Falls

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Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? May we contact them?

Name:_____Telephone #: _____
Name:_____Telephone #: _____
Name:_____Telephone #: _____
Name:_____Telephone #: _____

Have you ever thought about, planned or attempted suicide? Yes No If yes, please explain:

_____
_____

Are you currently suicidal? Yes No
If yes, please explain:

_____
_____

Are you currently taking any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia or other psychiatric illnesses? Yes No If yes, please describe:

_____
_____

You do understand that you will Not be working, for any outside employment while in the residential Center/Program.r. However you will be asked to perform household chores, OTJ training, work,.. Etc as participation in the Program. Do you have any physical limitations, barring any type of activity, and/or exercise? ** This means Doctor Diagnosed Medical Issues.

_____
_____

Is there any other important information you would like to provide at this time? Yes No

_____
_____
_____
_____

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Health Insurance Information:

Please provide the following from your health insurance card
Subscriber Name (if other than patient):_____
DOB:_____ SSN#:_____
Name of Insurance:_____
Identification #: _____
Employer Group Name: _____
Insurance Provider Service Telephone#: _____
Customer Service Telephone #: _ _____
If applicable, Mental Health/Substance Abuse Telephone #: _____
If there is a secondary insurance please provide the same information as above
Subscriber Name (if other than patient):_____
DOB:_____ SSN#:_____
Name of Insurance:_____
Identification #: _____
Employer Group Name: _____
Employer or Insurance Group #:_____
Insurance Provider Service Telephone #:_____
Customer Service Telephone #: _____
If applicable, Mental Health/Substance Abuse Telephone #:_____
If you have Medicare insurance please provide the following:
Name, as it appears on card:_____
Medicare ID#: (include letters after the number): _____
Effective Date: _____
Do you have any other specific questions or requests?_____

Assistance Benefit Information:

Are you currently enrolled in or receive any State or Federally funded Housing or Assistance Programs?

Yes No

Please list them and expiration date for benefits. Include amounts.

Name of Agency:_____Expiration Date _____ Type of Benefit_____ Amount_____
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You will be required to apply for Housing Assistance Benefits, If required, Do you understand this? Any bar to receiving benefits? Yes No If yes, please explain:

_____
_____

Are you currently Homeless? Yes No
If yes, please explain:

_____

_____

The Recovery Company, 24/7 Recovery House, insist of a client's strict adherence to some simple rules.To you, some may seem frivolous or burdensome, perhaps even limiting your personal freedom of expression or choice in Recovery. We mandate attendance at All house meetings, and activities, as well as, AA/NA Meetings. (We do NOT count any CR or other fellowship groups as fulfilling your meeting attendance requirements). You can review all rules and conditions in Your Client Handbook or ask the House Manager, or your Intake contact.

Do you have any issue/concern with the above statement? Yes No If, so, explain freely here._____
Will you be able to abide by ALL rules and conditions? Yes No If, "No" Your application is complete… Seek another center, and we can assist you with referral.

Thank you very much for the time you have taken to complete this questionnaire. We will respond to your inquiry in a timely manner and look forward to working with you!

Sincerely,

Intake Staff at 24/7 Recovery House Center
1-800-296-7108
http://www.therecoverycompany.com