

Prescreen Template

Are you looking for services? Yes/No

May I ask you a few questions that may be a little sensitive so it will allow me to better assist you? Yes/No

Personal Stats

Name: _____ Sex: _____

Date: _____ Time: _____ Phone: _____ Msg.phone: _____

DOB: _____ Social security number: _____ County: _____

****Are you a registered sex offender? Yes or No (If yes, notify client we are unable to provide services, due to the location of our facility) ****

Address: _____

Last date admitted: _____ Veteran: Yes No What branch? _____

Highest level of education: _____ Currently in school or training: Yes No

Insurance: _____ PCP (Enter under "External Providers" in Credible): _____

How did you hear about CCMH (Enter under "referral source" in Credible): _____

Are you looking for inpatient treatment at Pathways in addition to detox? (Yes/No) _____

Currently: Single Living as married Married Divorced Widowed Separated

SO/Spouse Name: _____ Phone: _____

Emergency Contact (Must enter into Credible separately)

Name: _____ Relationship: _____ Phone: _____

Do you have any children: Yes No Ages: _____

Any Mandates: Yes No Who: _____

Currently Employed: Yes No Where: _____

Current Living arrangements: _____

Currently pregnant:	Yes	No	Diabetic/insulin dependent:	Yes	No
Currently on methadone:	Yes	No	Currently taking benzodiazepines:	Yes	No
Liver disease:	Yes	No	Acute/possible infection:	Yes	No
Unstable cardiopulmonary conditions:	Yes	No			
Able to perform all self-care without assistance?	Yes	No			

Do you smoke or use tobacco products: Yes No **(Notify client facility is non-smoking)**

How many times in the past year have you had 5(for men) or 4 (for women and all adults older than 65 years) or more drinks in one day?

- 2 or less instances
- 3 or more instances

Substance Abuse History

Substance	Amount/Frequency	Age of first use	Last use/amount	Route
“What are you detoxing from?”	“How much/often do you use?”	“When is the first time you remember using (substance).”	“When was the last time you used/drank (substance)? How much did you use/drink?”	“Do you smoke, use IV, drink?”

How long have you been using? _____

What is the longest time that you have been clean and sober, and when was that? _____

Medical Data

Are you experiencing or have you experienced any of the following symptoms:

- Tremors: Yes No Dts: Yes No Vomiting: Yes No
- Diarrhea: Yes No Fever: Yes No Hallucinations: Yes No
- Seizures: Yes No

If yes to seizures and/or hallucinations give dates of most recent and types of seizures and whether seizures are withdrawal-related or seizure disorders: (type of hallucinations are audio, visual, and tactile):

Possible Admit

Do you currently have any of the following medical conditions that need attention?

Asthma: Yes No Surgeries: Yes No Liver problems: Yes No

Epilepsy: Yes No Shortness of breath: Yes No Open wounds: Yes No

Broken Bones: Yes No Abscesses: Yes No Injuries/accidents: Yes No

Heart conditions: Yes No Chest or abdominal pain: Yes No

Have you had any recent injuries, accidents, or hospitalizations? Yes No

Have you ever been told that you had TB? Yes No

Do you have any other current medical issues?: _____

Are you on any prescribed medications: Yes No Are they in the bottles they came in: Yes No

Notify client that they must bring in their medications with them on admit and they must be in their original bottles with their name, correct medication, and be current (not expired).

Notify client that if they do not meet these requirements that the medications will be disposed of on admit.

Name of Medication: Dose: Route: Frequency: Diagnosis:

Allergies and reaction *(Must be entered into Credible separately, or check "NKDA" box under allergies tab):*

Special diet modifications/restrictions: _____

Psychiatric Data

Do you have any history of mental health symptoms? (Depression, anxiety, bipolar, etc.) _____

Have you ever experienced any psychotic symptoms (felt disconnected from reality); If yes, describe thoughts/behaviors:

Current suicidal ideations: Yes No If yes do you have a plan _____

Are you currently on or have you ever been on mental health medications: _____

Do you have a history of violent/homicidal thoughts or behaviors: Yes No; if yes, describe thought/behaviors

Legal Charges

Do you have any current legal issues?

Have you been arrested in the past? If so, what were you arrested for?

Notify client that we are a non-smoking facility

Notify client that our goal is to help our clients obtain sobriety in a quiet, relaxed environment

Intoxication Level

Mild

Moderate

Extreme

Does client qualify for medical detoxification? (Alcohol or opiates?): Yes/No

Does the client qualify for clinical detox? (Meth): Yes/No