Eosis Recovery

Patient ID#: **Patient Name:** Date of Birth:

Initial Screening / Demographic

Potential Patient Information

Address:
City: State: Zip:
Phone #: Mobile #: Work Phone #:

Mailing Address
Address:
City: State: Zip:

What are the precipitating events that have led you to seek inpatient treatment as this time?

Who are you currently living with?
Are they sober? ☐ Yes ☐ No
Who are your sober supports?
Do you have an interest in changing your current living situation? ☐ Yes ☐ No

Drug of Choice	Frequency	Quantity	Age of First Use	Last Use	Route of Ingestion

Previous Substance Abuse Treatment

Previous Outpatient Treatment: *Treatment Facility* *Date*
Previous Inpatient/Residential Treatment: *Treatment Facility* *Date*
Previous Detox Treatment: *Treatment Facility* *Date*

Medical History

Are you currently pregnant? ☐ Yes ☐ No ☐ N/A
Due Date:
What is the health of the unborn child:
Current involvement in prenatal care:
Doctor's Name:

Do you have a history of seizures? ☐ Yes ☐ No
Are they related to substance use? ☐ Yes ☐ No
Notes:

Medication allergies: ☐ Yes ☐ No

Please list medication allergies:

Food/substance allergies: ☐ Yes ☐ No

Please list food/substance allergies:

Please describe your eating habits:

Please describe your current sleep pattern:

Current medical issues? ☐ Yes ☐ No

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Please describe medical issues:

Any medical diagnosis? ☐ Yes ☐ No

Please describe medical diagnosis:

Are you currently taking any of the following:

		Dosage	*Prescribing Doctor*	*Phone Number*
Methadone:	☐ Yes ☐ No			
Suboxone:	☐ Yes ☐ No			
Buprenorphine:	☐ Yes ☐ No			
Subutex:	☐ Yes ☐ No			

Current Prescribed Medications:

Frequency: *Dosage:*

Not Prescribed Medications:

Frequency: *Dosage:*

Mental Health/Psychiatric History

Current MH Issues? ☐ Yes ☐ No

Please describe:

Treating agency:

Diagnosis:

Current/Previous Mental Health Treatment "Outpatient":

Current/Previous Mental Health "Inpatient": ☐ Yes ☐ No

Previous Inpatient History: *Facility:* *Dates:*

Current Prescribed Medications:

Frequency: *Dosage:*

Any history of the following:

Hallucinations:	☐ Yes ☐ No
Suicide Ideation:	☐ Yes ☐ No
Suicide Plan:	☐ Yes ☐ No
Suicide Attempt:	☐ Yes ☐ No
Eating Disorder:	☐ Yes ☐ No
Violence:	☐ Yes ☐ No
Fire Setting:	☐ Yes ☐ No
Sexual Assault:	☐ Yes ☐ No
Cutting Burning:	☐ Yes ☐ No

Please describe any risky behaviors that you are currently engaged in:

Legal History

Charges pending? ☐ Yes ☐ No

Describe pending charges:

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Past Legal History? ☐ Yes ☐ No
Describe past legal history:

Number of days patient has been arrested in past 30 days:

Past or present incarcerations? ☐ Yes ☐ No
Date of Incarceration:

Do you have a Probation/Parole Officer? ☐ Yes ☐ No

Probation/Parole Officer Name: Phone:
Address: Fax:
City: State: Zip:

Mandated to Treatment? ☐ Yes ☐ No By when?

Payer Information

Payer Source:

Primary	**Secondary**
Insurance:	Insurance:
Group #:	Group #:
ID #:	ID #:
Phone #:	Phone #:
Subscriber Name:	Subscriber Name:
Relationship:	Relationship:

Requested Admission Date:

Signatures