

APPLICATION FOR TREATMENT - SUBSTANCE ABUSE TREATMENT UNIT

NAME: _____ DOB (M/D/YYYY) _____

SSN: _____ AGE: _____

Home Address: _____

Telephone Number: __ (____) _____ - _____

Insurance: Yes No Type of Insurance: _____

Referral Source:

Name: _____

Address: _____

Phone Number: __ (____) _____ - _____

Subjective Information – Chief Complaint:

Social (Housing/Family/Martial):

Drug/Alcohol History:

Substance:	Amount	Frequency	Route	Last Use/Duration
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Drug/Alcohol Treatment/Response/Relapse:

Legal History and Issues:



Medical History

- | | | |
|--------------------------|------------------------------|-----------------------------|
| History of Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DTs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blackouts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Allergies: _____

Current Medical Conditions – Medications – Dose:

Where does veteran currently receive their medical care?

Females: Currently pregnant /any possibility of pregnancy: Yes No

Pregnancy in the past 12 months: Yes No

If yes, please explain:

Psychiatric History:

Current Psychiatric Medication:

Suicidal Thoughts Yes No - If yes please explain: _____

Suicidal Attempts Yes No - Date and method: _____

Homicidal Thoughts Yes No - If yes please explain: _____

History of Violence Yes No - Describe: _____

A/V Hallucinations Yes No - Describe _____

Do you have any fears or phobias Yes No - If yes please explain:
