|  |  |
| --- | --- |
| **Client First/Last Name:**  |  |
| **Best Contact Number:** |  |
| **Date of Birth:** |  |
| **Funding Source:** |  |
| **Member ID No. & HMO:** |  |
| **Scheduled Intake Date:** |  |

| **Questions** | **Notes** |
| --- | --- |
| **Where is the client coming from and what does their living situation look like?** |  |
| **Support system / emergency contact information?** | First/last name:Address:Phone Number:Alt/Phone number:Relationship to client:\*Any toxic or no-contact individuals? |
| **What is the primary language spoken in the home?** | [ ]  English[ ]  Spanish[ ]  Hmong[ ]  Other (indicate here): |
| **Do you need assistance with communicating in English?** | **[ ]** Yes [ ] No |
| **What is your race?** | **[ ]** Asian[ ]  Black or African-American[ ]  Middle Eastern[ ]  Native American/Alaska Native[ ]  Native Hawaiian or other Pacific Islander[ ]  White[ ]  Other (indicate here):  |
| **Are you Hispanic/Latinx?** | [ ]  Yes [ ]  No |
| **How do you identify your gender?****How do you identify your gender? (cont’d).** | [ ]  Female[ ]  Trans-woman (male-to-female)[ ]  Trans-man (female-to-male)[ ]  Gender queer[ ]  Gender non-conforming[ ]  Something else (indicate here):What are your preferred pronouns? (indicate here): |
| **Brief Substance Use History** |
| **Question** | **Notes** |
| **Have you misused substances, including alcohol, marijuana, and other drugs or misused prescriptions, in the past year?**  |   [ ]  Yes [ ]  No [ ]  Don’t know |
| **Drug of Choice? (Indicate here):** |     |
| **Route? (Indicate here):** |  |
| **Date of last use & DOC? (Indicate here):** |  |
| **Is the client currently prescribed medication?** |  [ ]  Yes [ ]  No |
| **MAT? Prescriber? (Indicate here):** |  |
| **Please list all other medications & prescriber (Indicate here):** |  |
| **Meta House provides all medication assisted treatment on-site except for Methadone. Meta House provides transportation daily to the following Methadone clinics: Community Medical Services (CMS) and Addiction Services and Pharmacotherapy (ASAP). Residents that are current patients at other Methadone clinics will be required to transfer to CMS or ASAP.** **\* Does the client understand this requirement?** | [ ]  Yes [ ]  No |
| **History of use (how much? how often? age it became an issue?):** |  |
| **Brief mental health history** |
| **Questions** | **Notes** |
| **Does client have any current mental health diagnosis?**  | [ ]  Yes [ ]  No**(Indicate here):** |
| **Has client experienced a history of suicidal ideation?**  | [ ]  Yes [ ]  No |
| **Has client experienced any suicide attempts?** | [ ]  Yes [ ]  No |
| **Date of last attempt:** **Means:** | **(Indicate here):****(Indicate here):** |
| **Do you have any upcoming appointments related to your mental health, for example with an RSC?** | **(Indicate here):** |
| **Brief Medical History** |
| **Questions** | **Notes** |
| **Any Allergies to Food or Medication** | [ ]  Yes [ ]  No |
| **Vegetarian or Cultural Food Accommodations** | [ ]  Yes [ ]  No |
| **Recent Hospitalizations (within two weeks w/o follow-up at):** | [ ]  Yes [ ]  No |
| **Cardiac issues (heart attack, abnormal rhythm):** | [ ]  Yes [ ]  No |
| **Strokes or Seizures:** | [ ]  Yes [ ]  No |
| **Blood clots:** | [ ]  Yes [ ]  No |
| **Uncontrolled blood pressure:** | [ ]  Yes [ ]  No |
| **Diabetes:** | [ ]  Yes [ ]  No |
| **Deaf, hard of hearing, blind, or visually impaired** | [ ]  Yes [ ]  No |
| **Is the client ambulatory? (not in need of physical assistive devices ie: cane)** | [ ]  Yes [ ]  No |
| **Is this client pregnant:** | [ ]  Yes [ ]  No |
| **How many weeks?** |  |
| **Is she receiving prenatal care?** | [ ]  Yes [ ]  No |
| **Please list the name, clinic, and telephone number for the attending physician** | Physician name:Clinic:Physician’s phone number: |
| **Do you have any upcoming DR. – Prenatal – Ultrasound appointments?** | Date:Date:Date:Date:Date: |
| **Family** |
| **Questions** | **Notes** |
| **Does the Client have children?** | [ ]  Yes [ ]  No |
| **Please list the name(s)m date(s) of birth, and gender(s) of children:****Please list the name(s)m date(s) of birth, and gender(s) of children (cont’d):** |  |
| **Are these children currently in the care of their mother?**  | [ ]  Yes [ ]  No |
| **If “NO" where/who will they be residing with while mother is in treatment?** |  |
| **Is there child welfare involvement?** | [ ]  Yes [ ]  No |
| **If “YES” which agency is overseeing the case and caseworker’s info?**  |  |
| **Will the client be bringing children with her to treatment?** | [ ]  Yes [ ]  No |
| **IF YES, PLEASE GIVE BACK UP CONTACT CARE FOR CHILD Name Relationship & Phone number:**  |
| **Does the child have special needs?** | [ ]  Yes [ ]  No |
| **If yes, please indicate:** |  |
| **Does the child have dietary restrictions?** | [ ]  Yes [ ]  No |
| **If yes, please indicate:** |  |
| **Is the child currently prescribed medication?** | [ ]  Yes [ ]  No |
| **If yes, please indicate:** |  |
| **Is the father involved?** | [ ]  Yes [ ]  No |
|  **Reviewed with Client** |
| **Questions** | **Notes** |
| **Meta House is a smoke free treatment program. Clients will have access to non-smoking aids including patches, lozenges, and gum. Smoking violations can result in discharge. Does the client understand the potential consequences of smoking while enrolled in the Meta House residential treatment program?** | [ ]  Yes [ ]  No |
| **Meta House is a safe sleep partner no co sleeping with children allowed** |  |
| **Clients should bring two weeks’ worth of clothing to residential treatment. Will you need clothing to get started?** | [ ]  Yes [ ]  No |
| **If so, what sizes?** |  |
| **Bring ID & insurance card if available** |  |
| **Client Complies with information given?** | [ ]  Yes [ ]  No |
| **Is there anything you can tell us about the client’s personality and how they feel about coming to treatment? (cont’d).** |  |
| **Cancellation List** |
| **Questions** | **Notes** |
| **Would your client be interested in being added to our cancellation list? Those interested in being on the cancellation list would like to be contacted if a client scheduled for admission is unable to make it on their scheduled date. When contacted, we would offer a bed the same day or the next day. The first individual we are able to make contact with will be given the bed.** | [ ]  Yes [ ]  No |
| ***TO BE COMPLETED BY THE ASSESSOR:*** |
| **How was the above interview conducted?** | [ ]  In person  [ ]  By phone [ ]  Probation Officer[ ]  Other: |
| **If the interview was not completed in person, identify why:** | [ ]  Incarcerated [ ]  Out of County [ ]  Transportation Barriers |
| **The following question is for staff only – DO NOT ask client to answer!****Is client a sex offender? Look up here:** <https://www.nsopw.gov> | [ ]  Yes (do not schedule appointment) [ ]  No, verified not on the registry |