

IS THIS FORM BEING COMPLETED AS PART OF A FAMILY/EMPLOYER INTERVENTION? YES NO
If YES, Please provide name, relationship to prospective patient, phone number, and e-mail address of person completing this intake:

Patient's Legal Name (**First, Middle, Last**): _____ Nick Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____
(#, Street) (City) (County) (State) (Zip)

E-Mail Address: _____ Present Marital Status: _____

Date of Birth: _____ AGE: _____ SEX: _____ SS#: _____

How Many People Live In Your Home **Including You**: _____?

Dependent Children/Step (Names, Ages): _____

Emergency Contact Name/Next of Kin: _____ Relationship: _____

Address: _____
(#, Street) (City) (County) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

REFERRAL SOURCE

How Did You First Hear About Seabrook House?

1) Name of Therapist/Counselor/Professional or Family that Referred You: _____

Address: _____
(#, Street) (City) (County) (State) (Zip)

Phone #: _____ Cell Phone: _____

SOCIAL HISTORY

Current/Past Legal Problems: _____ DWI -When? _____

Lawyer Name & Phone: _____

Current Health (High BP, ulcers, diabetes, allergies etc.) _____

Primary Doctor Name & Phone: _____

Current Medications-Name/Dosage Amount/Why Prescribed: _____

Present or Past Alcohol/Drug/Psychiatric Treatment or Hospitalization in Past 5 years: _____ Dates: _____ How Many Days: _____ Did You Complete: _____
 _____ NO YES
 _____ NO YES

<u>ALCOHOL/DRUG USE</u>	<u>DATE LAST USED</u>	<u>HOW MUCH ON THAT DATE?</u>	<u>AVERAGE FREQUENCY/AVERAGE AMOUNT</u>
Primary Substance	_____	_____	_____
Secondary Substance	_____	_____	_____
Third Substance	_____	_____	_____

HEALTH INSURANCE INFORMATION (Patient is the Subscriber)

Employer Name: _____ Employer Phone & Contact: _____
 Address: _____
 (#, Street) (City) (County) (State) (Zip)
 Occupation: _____ How Many Years/Months at Present Employer? _____

PATIENT HEALTH INSURANCE: _____
 (Name) (ID #) (Group #)

Please List **All** Telephone/800 #'s On Your Insurance ID Card: _____

IF APPLICABLE, SECONDARY INSURANCE - Select Subscriber Relationship to Patient:

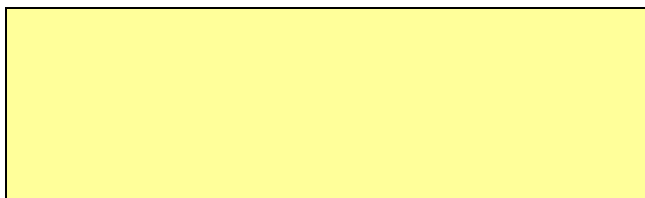
Name of Subscriber: _____ DOB: _____ SS#: _____
 Employer: _____
 (Name) (Address) (Phone)

OTHER HEALTH INSURANCE: _____
 (Name) (ID #) (Group #)

Please List **All** Telephone/800 #'s On Your Insurance ID Card: _____

ANY COMMENTS/QUESTIONS FROM PERSON COMPLETING THIS FORM:

E-MAIL Address of Person Completing this Form: _____



CONFIDENTIALITY NOTICE:

All intake information is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without written consent unless otherwise provided for in the regulations. The Federal rules prohibit any further disclosure of this information unless a written consent is obtained from the person to whom it pertains. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.