TEEN FOCUS RECOVERY CENTER

Preliminary Initial Intake Sheet

Intake Date: _____ Intake Coordinator: _____

Date & Time of appointment: _____ Client #: _____

Client Information

Client Name: _____

Address: _____

City, State, Zip: _____

Telephone number: _____

DOB: _____ SS#: _____ Gender: _____

Referent

Referred By: _____ Phone: _____

Referral Agency: _____

Address: _____

City, State, Zip _____

Funding Information

Health Care Insurance: ☐
ID# _____ Group# _____

Self Pay: ☐

Consolidated Funding: ☐

Current Substance Use

Drug of Choice: _____ Date of Last Use: _____
Frequency of use: _____

Has this client attended a treatment program before? _____ If yes where & when: _____

Current medical or mental health issues: _____

Current medications: _____