

Wilbur D. Mills

PRELIMINARY SCREENING FORM *SMOKE FREE FACILITY*
ADVISE PERSON BEING SCREENED THAT THE RESULTS ARE CONFIDENTIAL AND
IF THE RESULTS ARE TO BE PROVIDED ELSEWHERE, A RELEASE OF
INFORMATION WILL BE NEEDED.

Date: _____ In Person _____ By Phone _____
INS _____ ID # _____ Group# _____ Medicaid _____
Medicare _____

Name: _____ DOB: ___ / ___ / ___ SSN: ___ / ___ / ___

Address: _____ Zip Code: _____

City: _____ County: _____ Phone: _____ - _____ - _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Grant Funds Are Available Based on Income YOU MUST BRING YOUR PROOF OF INCOME
WITH YOU OR YOU WILL BE CHARGED FULL FEE - (CHECK STUB OR LATEST W-2)
ANCILLARY FEES: RES. 500.00, Day Treatment 300.00, OP 200.00

Can you pay all or part of this at admission? _____ How Much? _____

Do you have any income? ___ If so, How Much? \$ _____ Are you currently drawing food stamps? _____

Number of Dependents _____ Are you paying child support? ___ IF so how much? _____

This can be deducted from your total income, however you must bring proof of what you pay.

Do you own your home or in process of buying a home? ___ If so, bring payment coupon or proof. What type of work

do you do? _____ Why are you seeking treatment? _____

Are you on any type of probation or parole? _____ Who is your Parole/Probation Officer? _____

Are you Court Referred? _____ Court/Judges Name _____

Do you have any upcoming court dates? _____ Child Custody? _____ Support Hearings _____

If "yes" to any, what dates will you have to be in court? _____

Who Referred you? _____ Phone # _____

Do you have minor children? ___ If Yes, who will keep them while you are in treatment? _____

Have you ever been in treatment before? ___ If so, where? _____

Did you complete treatment? _____ If answer is NO, Please explain:

What is your DOC? Primary: _____ Secondary: _____,
_____, _____

Are you an Intravenous or Intramuscular drug user? _____

Frequency and amount of Use: Primary _____ Secondary

Date and amount of Last Drink / Drug Use: Primary _____ Secondary _____ -

Have you ever been seen by a Mental Health Therapist? _____ Suicidal History:

Are you currently seeing a Physician ? _____, Psychologist ? _____, Mental Health Counselor ?
_____ Who: _____

Are you taking any prescribed medications? _____ If Yes, What are they and how long
have you been taking
them?: _____

Do you have high blood pressure?: _____ Any other medical problems? _____ If
yes, then what? _____ Do you have any physical problems: _____ If
Yes, Please explain: _____ Are you
pregnant? _____

THIS IS A SMOKE FREE FACILITY.

Screener's Signature _____

To be filled out by Administrative Team and Intake Coordinator

Date Staffed:

Modality to be admitted to? Residential _____ Detox _____ Out-Patient _____ Day Tx _____ No.
of Tx. Days _____

Accepted _____ Rejected _____ Reason for Denial

Client referred to another clinic? _____ If yes, Where? _____

Time Scheduled for admission:

Revised 12/31/05
