Medical Screen Form:

FILE #: _____ Intake Date: _____

Client Information:

Full Name: _____ Phone Number: _____

Address: _____

DOB: _____ PHN: _____

Detox location: _____ Days Detoxed: _____

Substance(s) in Treatment for: _____

Length of time using above substance(s): _____

Method used to ingest substance(s): _____

Number of days since last use: _____

Amount of daily use: _____

Medical History:

Physician: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

Allergies: _____

Medical Conditions: _____

Mental Health concerns: _____

History of Suicide Attempts: _____

Current Suicide Risk: _____

Current Medications/Dosage: _____

TB test: Negative: _____ Positive: _____

Is client medically stable at this time? _____

Comments: _____

_____

_____

Physician's Name: _____

Physician's Signature: _____

Date: _____

Office Stamp