Connecticut Behavioral Health Associates, P. C.

SPECIALIZED SERVICES INTAKE FORM

Client Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Contact Phone Number: _____ ☐ Male ☐ Female

Primary Ins & ID#: _____ Secondary Ins & ID#: _____

Is the client pregnant or breast feeding? ☐ YES ☐ NO Could they be? ☐ YES ☐ NO

Is the client currently employed? ☐ YES ☐ NO Occupation: _____

Does the client have peer support/recovery coach? ☐ YES ☐ NO If yes, please sign and attach ROI.

Contact Name: _____ Relationship: _____ Phone: _____

Is the treatment court ordered? ☐ YES ☐ NO

MEDICATION HISTORY

Please list all prescriptions and any OTC medications that the client is currently prescribed or is taking.							
Medication	**Dosage**	**Directions**	**Prescriber**	**Medication**	**Dosage**	**Directions**	**Prescriber**
Please list all controlled substances that the client has been prescribed in the last 12 months?							
Medication	**Dosage**	**Directions**	**Prescriber**	**Medication**	**Dosage**	**Directions**	**Prescriber**

SUBSTANCE ABUSE TREATMENT HISTORY

Please list any substance abuse treatment that the client has received in the last 12-24 months?			
Treatment Center Name or Provider	**Approximate Date & Duration**	**Reason for Treatment**	**Outcome**

SUBSTANCE ABUSE HISTORY

Please list below which substance(s) the client uses or has used in the past and provide the approx dosage, duration, & date of last use:

☐ Opioids ☐ Heroin ☐ Methadone ☐ Benzodiazepines ☐ Stimulants ☐ Cocaine ☐ Marijuana ☐ Alcohol

☐ Other: _____

_____

_____

DISCHARGE INFORMATON: _____

_____

_____

Coordinator Name: _____ **Phone Number:** _____

Signature: _____ **Date:** _____