

**Mission Unity Treatment Services
BRIEF SCREENING FORM**

Date: _____ Time: _____ Contact: Phone __ Internet__ Walk-in__

Client information:

Name: _____ Relationship to client: _____

Phone Number: _____ Email: _____

Comments:

Prospective Client information:

WHY is patient seeking treatment today? _____

Drug(s) of Addiction: 1 _____ 2 _____ 3 _____

1 Duration of use: _____ Amounts: _____

2 Duration of use: _____ Amounts: _____

3 Duration of use: _____ Amounts: _____

Does Patient need Detox now? _____ Is PT in Detox at present: _____

Last Detox: _____ Where: _____

Last Treatment: _____ Where: _____

Prior IP or OP treatment: _____

Longest clean time: _____ When: _____

Medical Issues: _____

Seizure D/O _____

DTS _____

Respiratory _____

Blackouts _____

Ambulatory _____

Hallucinations _____

Diabetes _____

Heart condition _____

Hypertension _____

Patient Name:

Medications: _____

Psychiatric Conditions: _____

Have you lost your job as a result of your addiction: _____

Previous MH admissions: _____ DX: _____

Suicide Attempts: _____ When and how many: _____

Methods used: _____

Present Suicide Intent? _____ Plan: _____ Present Homicide Intent? _____

Hx of Eating D/O _____ Hx of Gambling D/O _____ Sexual Addiction: _____

Legal Issues: _____

Past DUI: _____

Client and/ or Family Member advised of cost of program: _____

Program cost: _____ Money for PT acct: _____

Financial Party: _____ Method of payment: _____

Amount due upon admission: _____

Screener Name: _____

Date: _____

Marketer: _____

Date: _____

Comments or additional information:

Date of Admission: _____ Mode of Travel: _____

Time expected: _____ Needs pick-up: _____

Location of Pick up: _____
