Harbor House Chemical Dependency Services

Referral Form

All questions contained in the questionnaire are strictly confidential and will become part of your medical record.

Name:	DOB: AGE:
Sex:	Social Security#:
Address:	Phone-1:
	Phone-2:
Email:	Referred by:

PERSONAL HEALTH HISTORY				
Pregnant: YES ◯ NO ◯ If yes, # of months: Nursing: YES ◯ NO ◯				
List current physical problems:				
List current mental health problems:				
Have you been hospitalized in the past 30 days? YES ◯ NO ◯ If yes, explain:				
DRUG(S) OF CHOICE & USAGE HISTORY				
Name of Drug:	Age of first use:	Date of last use:	How much/often?	Method of use:
ALCOHOL/DRUG TREATMENT HISTORY				
Date of Treatment:	Facility:	Type of treatment (residential, outpatient, etc.)	Did you complete the treatment program?	
LIST ANY CURRENT LEGAL ISSUES (PENDING CASES, DRUG COURT, PROBATION, PAROLE, ETC.):				
MOTHERS ONLY: WILL YOU BE ENTERING AS A PPW CLIENT? YES ◯ NO ◯				
IF YES, PLEASE ANSWER THE FOLLOWING:				
1. AGE OF CHILD:				
2. NAME OF CPS CASEWORKER:				

3. COUNTY OF CPS CASE:
4. CPS PHONE NUMBER AND EMAIL:
DO YOU WANT TO BE ASSESSED FOR MEDICALLY ASSISTED TREATMENT (MAT) PROGRAM?
YES ◯ NO ◯
WILL YOU REQUIRE DETOX PRIOR TO ADMISSION TO HARBOR HOUSE?
YES ◯ NO ◯
If yes, please explain:

MEDICAL QUESTIONNAIRE

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS WHICH YOU ARE CURRENTLY EXPERIENCING:

Depression ☐	Sexual Dysfunction ☐	Sleep Problems ☐	Gambling ☐	Obsessive thoughts ☐
Anxiety ☐	Eating Disorder ☐	Negative thoughts ☐	Compulsive behavior ☐	Work problems ☐
Panic attacks ☐	Mood Swings ☐	Traumatic stress ☐	Family problems ☐	School problems ☐
Mood swings ☐	Poor concentration ☐	Voices/Visions ☐	Marital problems ☐	Financial problems ☐
Suicidal thoughts ☐	Substance abuse ☐	Poor memory ☐	Sleep problems ☐	Anger outbursts ☐

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL AND MENTAL HEALTH CONDITIONS WHICH APPLY TO YOU AND LIST ANY MEDICATION YOU HAVE BEEN PRESCRIBED FOR CONDITIONS YOU HAVE CHECKED:

CONDITION (check if applicable to you):	**MEDICATION (if applicable):**
Depression ☐	
Bipolar Disorder ☐	
Anxiety Disorder ☐	
Obsessive Compulsive Disorder ☐	
Schizophrenia or Paranoia ☐	
Attention Deficit Disorder ☐	
Autism Spectrum Disorder ☐	
Suicidal thoughts/attempts ☐	
Alcohol/Drug Abuse ☐	
Eating Disorder ☐	

Epilepsy/Seizure Disorder	☐	
Migraines	☐	
Lupus	☐	
Arthritis	☐	
High Blood Pressure	☐	
Heart Attack	☐	
Stroke	☐	
Cancer	☐	
Diabetes	☐	
Hepatitis	☐	
Sexually Transmitted Disease	☐	
Other (please specify):	☐	

CURRENT MEDICATIONS

Name of Medication:	Dosage:	Prescribing Doctor:	Reason for Medication:

Are you currently under the care of a mental health professional (psychiatrist, psychologist, licensed counselor)? YES ◯ NO ◯ If yes, who are you currently seeing and why?

Have you ever attempted suicide? YES ◯ NO ◯ If yes, when? _____

Have you experienced any severe psychological trauma? YES ◯ NO ◯

What type?

Abuse ☐	Terrorism ☐	Crime Victim ☐	Natural Disaster ☐
Witness to violence ☐	Witness to death ☐	Combat ☐	Accident ☐
Other: ☐			

Are you currently employed? YES ◯ NO ◯				
If yes, where?				
How do plan to pay for treatment?				
Cash ◯	Check ◯	Credit card ◯	Insurance ◯	Unknown ◯

REFERRAL SOURCE
How did you hear about our facility?

ADDITIONAL INFORMATION
Is there any additional information you wish to provide which may help us serve you better?