

Edgewater Recovery Center and Blue Sky Recovery Center

Phone: 606-462-3001 Fax: 606-328-0065

Email: intake@edgewaterrecovery.com

Date: _____ Completed By: _____

General Information

Name: _____ DOB: _____ Phone: _____

Address: _____ City/State: _____

SSN: _____ Marital Status: _____

Sex: _____ Pregnant: _____

Race: _____

Do you have Dependent Children? Yes No Ages: _____

Who currently has custody: _____

Employer: _____ What was the last grade of school completed: _____

Do you receive disability income (Mental or Physical)? _____

Referral Source: _____ Phone: _____

Currently in Residential Facility? Yes No Facility Name: _____

Does client have transportation to treatment: Yes No

What are those arrangements: _____

Medical Coverage

Private Insurance _____ KY Medicaid _____ Other _____

Insurance Provider: _____ Insurance Phone: _____

Policy or Medicaid MCO Number: _____ Group Number: _____

Primary Insured Name: _____ Relationship to Primary

Insured: _____

Judicial Information

Incarcerated, if so what facility: _____ Date of Arrest: _____

Court Order: Yes No If So, How Long?: _____ Active Warrants: _____

Pending Charges _____

Casey's Law: Sex Offender Registry: Current DUI:

Attorney: _____ Phone: _____ Email: _____

Probation or Parole: _____ Officer Name: _____ Phone: _____

History (or current) violent offenses: Yes No Explain:

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Medical Information

Drugs of Choice: _____

Last Date of use: _____ Substance(s) Used: _____

How long have you attempted to abstain from use: _____

When you cease use do you experience any of these symptoms:

Headache nausea tremors anxiety elevated blood pressure
agitation restlessness mind cloudiness/disorientation hallucinations seizures

Have you ever been to Detox? Yes No When & Where _____

Mental Health Diagnosis: Anxiety Depression Bipolar Schizophrenia PTSD

Other: _____

Mental Health Medications: _____

Is Client Stable? Yes No

Abuse: Physical Mental Sexual

Suicidal/Homicidal Thoughts? Yes No When? _____

Suicide Attempts Yes No Dates: _____

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- 1) Has the client had two or more episodes of inpatient care for mental illness within the past 12 months? _____
 - 2) Has the client had continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months? _____
 - 3) Has the client been treated by a crisis team two or more times within the past 24 months?

 - 4) Has the client been committed by the court as a mentally ill individual in the last three years? _____
 - 5) Has the client had a legal guardian that made or makes financial decisions for the recipient? _____
 - 6) Has the client been prescribed psychotropic medications but is not stable on or compliant with medication? _____

Previous Treatment (where): _____ Type: _____

Completion or Discharge; Why? _____

Are you currently a MAT client: Yes No If so, what type:

Buprenorphine (Suboxone or Subutex)

Naltrexone (Vivitrol)

Methadone

Do you wish to continue this treatment? Yes No Health Conditions: _____

Bleeding disorder:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hep A	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing/Vision Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hep B	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gastro-intestinal	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hep C	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mobility Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>	Climb Stairs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tuberculosis Open	Yes <input type="checkbox"/> No <input type="checkbox"/>	Walk 1 Mile (Unassisted)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Wounds/MRSA	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fall Risk	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Seizure History	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Last Seizure: _____	

Have you received Hep A or Hep B Vaccination? Yes No Which One? _____
Specialty Medical Treatments or Devices _____
Allergies: _____ **Bring EPIPEN if needed.**
Can said person walk up to 1 mile unassisted? _____
Other Prescribed Medications _____

ASAM CRITERIA

Dimension # 1: Acute Intoxication/Withdraw Potential: Have you ever had life threatening withdrawal signs or symptoms? (Have you currently or in the past been in detox, hospitalized or had an OD?) (0.5) Yes _____ No _____

If Yes, are you currently having similar withdrawal symptoms? (0.5) Yes _____ No _____
Please note any signs or symptoms you have ever had:

Dimension # 2: Biomedical Conditions and Complications: Do you have any current, untreated severe physical problems? (i.e. high blood pressure, chest pains, stomach issues, hepatitis, etc.) (1) Yes _____ No _____

Are you an IV drug user: Yes ___ No ___ Have you seen a Dr. in the past year Yes ___ No ___

Dimension # 3: Emotional/Behavioral Conditions & Complications: Do you feel that you are in imminent danger of harming yourself or others? (0.5) Yes _____ No _____

Have you been diagnosed with a mental health diagnosis, such as depression, anxiety, Post traumatic stress disorder, schizophrenia, etc.? (0.5) Yes _____ No _____

If Yes, please note any diagnosis: _____

Dimension # 4: Treatment Acceptance/Resistance: Do you feel that you are in immediate need of alcohol/drug treatment? (0.5) Yes _____ No _____

Have you been referred or required to have an assessment and/or treatment by the criminal justice system, health or social services, work, or family/significant other? (0.5) Yes ____ No ____

If so, who referred you? _____

Dimension # 5: Relapse/Continued Use Potential: Are you currently under the influence? (0.5) Yes _____ No _____

Are you likely to continue using alcohol/drugs or relapse? (0.5) Yes _____ No _____

Dimension # 6: Recovery Environment: Are there any dangerous/using family, significant others, and/or living/working situations threatening your safety, immediate well-being and/or recovery? (0.5) Yes _____ No _____

Are you homeless? Yes ____ No ____ Are there any toxic relationships? Yes ____ No ____

Total ASAM Score: _____
