



## Alcohol or Drug Abuse Request for Services Form

What type of treatment are you seeking?

Residential     Day Treatment     Outpatient Treatment     Suboxone

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address:

Street \_\_\_\_\_

City \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Gender:  Male  Female    DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    SSN: \_\_\_\_\_

Ethnicity:  Caucasian     African American     Asian  
 Hispanic     Native American     Other: \_\_\_\_\_

Language:  English     Spanish     American Sign     Other: \_\_\_\_\_

Marital Status: Never Married\_\_\_ Married\_\_\_ Separated\_\_\_ Divorced\_\_\_ Widowed\_\_\_

Education/Highest Grade Attended: \_\_\_\_\_

In your own words, answer the following questions:

1. What led you to contact us and seek treatment at this time?
2. Tell us about your current and past alcohol or drug use.

| Substance? | How often? | How much? | Using how long? | Date of last use? |
|------------|------------|-----------|-----------------|-------------------|
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|            |            |           |                 |                   |
|            |            |           |                 |                   |
|            |            |           |                 |                   |

3. Have you received any treatment (Detox, Residential, Day Treatment, Outpatient) in the past? If so, when and where?
4. Have you had periods of abstinence and/or sobriety? If so, when and for how long?
5. Are there any mental health or emotional issues that are troubling you right now? Please specify.
6. Have you had any help with these mental health or emotional issues in the past? If so, what type of help did you receive? Where did you receive help?
8. Do you currently, or have you ever, had a prescription for medications for your mental health or emotional condition? Please specify.
9. Who is your mental health provider? Psychiatrist and/or counselor?
10. Are you currently having suicidal thoughts? If yes, please explain.
11. Have you ever attempted suicide? If yes, when did this happen? Please explain.
12. Have you ever been hospitalized for psychiatric reasons, including suicidal thoughts or attempts? If yes, when and where? Please provide month and year of last hospitalization.
13. Do you have any current or chronic physical health problems? If yes, please specify.
14. Who is your primary care physician? What clinic do you go to for physical health?
15. Are you currently taking medications for your physical health problems? Please specify. (Include over the counter medications.)

16. Do you have any current or past legal problems? Please specify.
17. Are you on probation, parole, a civil commitment, or some other legal restriction? Please specify.
18. How much contact do you have with your family? Is it generally positive or negative?
19. Where do you live and with whom?
20. Is your living situation supportive of your recovery efforts? Yes \_\_\_\_\_  
 No \_\_\_\_\_  
 If no, please explain:
21. Where do you plan to be living when you finish treatment? Will you need assistance securing housing?
22. Are you currently employed or in school? (Full time? Part time?) Please Specify.
23. What is your current or usual occupation?
24. Is your income enough to meet the basic needs of you and your family? (food, shelter, clothing, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_
25. Do you receive any government assistance?
26. What type of insurance or funding do you have?
- | Name of Insurance Carrier: | Member ID: | Customer Service Number (usually on back of card): |
|----------------------------|------------|----------------------------------------------------|
|                            |            |                                                    |
27. How did you hear about Tellurian?