Southwestern Behavioral Healthcare, Inc.

INQUIRY FOR SERVICE

Date of Call: _____ Time of Call: _____ Staff: _____ Email: _____

First Name Middle Name Last Name Date of Birth

Maiden Name:_____ Previous Name(s): _____

Address City/County/State Zip Code

☐ Male ☐ Female Marital Status: _____ Social Security Number: _____

Home Phone: _____ Work: _____ Message: _____ Cell: _____

Referral Source Phone Number

If referral source is self/family/friend, how did caller hear about Southwestern?

☐ Billboard ☐ Bus Ad ☐ Bus Bench ☐ Family
☐ Friend ☐ Magazine ☐ Newspaper ☐ Online/Search Engine
☐ Phonebook ☐ Radio ☐ Self ☐ TV
☐ Website

Name of Caller (If Other Than Patient) Phone Number

Employer/School: _____ Does patient/spouse have EAP? ☐ Yes ☐ No

****

INSURANCE

Company: _____ Company Phone: _____ Group ID: _____

Policy Holder: Name _____ DOB _____ SSN _____

Employer_____ ID Number _____

Precertification required? ☐ Yes ☐ No If yes, phone number? _____

INFORM PROOF OF INCOME REQUIRED TO BE ON SLIDING SCALE.

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I. Presenting Problem

_____

_____

_____

_____

_____

II. Substance Use

Substance	Amount (Be specific: grams, color of pill, etc.)	Frequency (How often do you use this?)	How long have you been using this way?	Date of Last Use

Are you an IV drug user in **past 90 days**? ☐ Yes ☐ No Which substances? _____

Do you use tobacco? ☐ Yes ☐ No If yes, inform of our tobacco-free environment and encourage Nicotine Replacement Patches (Either bring some or bring a co-payment up to $10. We will enroll in HIP if eligible.)

Type (cigarettes, chew, vape)	Amount	Frequency (How often do you use this)	How long have you been using this way?	Date of Last Use

III. Current and/or Previous Mental Health Treatment

Are you currently receiving or have you had treatment for Substance Abuse in the past month? ☐ Yes ☐ No

If yes, describe/dates:_____ Check if attending: ☐ AA ☐ NA

Are you currently receiving or have you had any treatment for psychiatric illness in the past? ☐ Yes ☐ No

If yes, describe what diagnosis/where/when: _____

_____

First Name Middle Name Last Name

IV. Medical Information

Family Doctor/Healthcare Provider: _____
Pregnant? ☐ Yes ☐ No ☐ Unsure ☐ N/A
IF PREGNANT: How many weeks? _____ Due Date: _____
Do you have an OB Doctor? ☐ Yes ☐ No
If YES, give NAME of MD and DATE of last appt and next appt: _____
Do you have a Pediatrician? ☐ Yes ☐ No Name: _____
Asthma? ☐ Yes ☐ No
High Blood Pressure? ☐ Yes ☐ No
Heart Disease? ☐ Yes ☐ No
Diabetes? ☐ Yes ☐ No
Recent Surgery (Type and Date): _____
Other Medical Problems (Describe or Write "None"): _____

Current Prescribed Medication:

Medication	Reason/Prescribed By	Dose	Times Per Day	Currently have this medication?	Taking as prescribed?

V. Risk Assessment

Suicidal thoughts? ☐ Yes ☐ No (IF YES, CONTACT A MANAGER.)
Homicidal thoughts? ☐ Yes ☐ No
History of hallucinations? ☐ Yes ☐ No

Hospital Referrals ONLY:
Hospital: _____ Contact: _____ Phone Number: _____
If in hospital, admission date: _____ Discharge Date: _____

VI. Legal Involvement

Any current legal charges? ☐ Yes ☐ No If yes, describe: _____
Any current history of Felony Charges? ☐ Yes ☐ No
Registered sex offender? ☐ Yes ☐ No
Probation Officer: _____ County: _____
Court Dates? _____ Outstanding warrants? (Stepping Stone Only) _____
Current DCS involvement (DCS referral)? ☐ Yes ☐ No
DCS Caseworker: _____ County: _____
Appling for Disability? _____

VII. Detox History (Stepping Stone Residential Only)

In past month, have you gone 3-5 days with NO ALCOHOL OR BENZO (Xanax, Klonopin, etc.) use? ☐ Yes ☐ No
If YES, what withdrawal symptoms did you have? _____
Have you ever had a seizure? ☐ Yes ☐ No
Ever been diagnosed with or treated for seizures? _____
DT (Alcohol Only)? ☐ Yes ☐ No
Prior detox in hospital? ☐ Yes ☐ No When? _____ Where? _____

First Name Middle Name Last Name

VIII. Priority Status (Stepping Stone Residential Only) – CHECK ALL THAT APPLY

☐ Pregnant ☐ Woman with Dependent Children ☐ IV Drug Use ☐ Active Case ☐ Lives in Vanderburgh/Gibson/ Warrick/Posey County

Are you a veteran and NOT receiving services through the VA? (Yes answer is a priority.) ☐ Yes ☐ No

Do you currently have a safe living environment absent of substance use or violence? ☐ Yes ☐ No

Do you have sober individuals in your life that support you? ☐ Yes ☐ No

Have you ever tried treatment or classes before for substance use? ☐ Yes ☐ No

Stepping Forward referral? ☐ Yes ☐ No

Living Arrangement: ☐ House ☐ Homeless ☐ In Jail ☐ In Hospital

Children's Current Living Situation: _____

Desire Arrival Date: _____

Additional Comments: