SECOND CHANCES
ADDICTION RECOVERY CENTER

INTAKE FORM

Date_____ Name_____ DOB_____
Sex_____ SSN_____ Phone #_____
Address_____ City_____ State____ Zip_____
Referral Source_____ Referral Phone #_____

INSURANCE

Medicaid Y / N
Type_____
Medicaid #_____

Other Insurance Y / N
Type_____
Policy #_____
Group #_____

SUBSTANCE Hx

Substance	Amount / Method	Frequency	Last Use

PRIOR Tx

Facility	Month / Year

CURRENT MEDICATION

Name	Dosage	Frequency

Please list any **trauma/abuse**, **legal issues**, or **diagnosis** our team should be aware of for treatment.

_____
_____
_____
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