

Pacific Coast Recovery Center

Please complete and submit on-line or to Confidential Fax # 949-499-7651

Name of Person Completing Form: _____

Relationship to Patient: _____

Your contact information

Phone #: _____

Alternate Phone #: _____

Fax: _____

Email: _____

Mailing Address: _____

May we contact you at any or all of the above? If not, be specific, please:

How did you hear about Pacific Recovery Center? _____

If you were referred by a physician, therapist or interventionist or other, we would appreciate you providing their contact information:

Name: _____

Address: _____

Phone Number: _____

May we contact your referral source? Yes _____ No _____

Patient Information:

Name: _____

DOB _____ Age _____ Social Security # _____

Marital Status _____ Gender _____

Address _____

Telephone #: _____

Alternate Telephone #: _____

Employer Name: _____
(We will not contact your employer without a signed consent from you)

Emergency Contact Name: _____

Telephone #: _____

If necessary, may we contact your Emergency Contact? Yes ___ No ___

Will this be your first treatment program? Yes ___ No ___

What do you consider to be your primary addiction? Please list that first in the sections below, to the best of your ability. Please include alcohol, addictive prescription medications and street drugs. For the chronic pain patient please be sure to include all prescription narcotic and benzodiazepine medications:

Name of Drug	Quantity/Dosage Day	How long?	Last Use?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any non-substance addictions you need help with? ___Yes ___No

If yes, please describe

Please list any prior treatment programs you have attended, including outpatient treatment programs. This includes alcohol, drug and/or psychiatric treatment programs over the past 10 years:

Name of Program	Dates	Purpose of treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your longest period of (clean and sober) sobriety? _____
What helped you remain sober? _____

Do you have a family history of addiction? _____
If yes, please describe: _____

Do you have any current legal problems? _____
If yes, please describe: _____

Do you have any current medical problems?
If yes, please describe: _____

Are you currently in a Pain Management Program?
If yes, please describe: _____

Name of program : _____
Telephone #: _____
May we contact them? Yes _____ No _____

Please list any other medications you take that are not listed in the substance abuse questionnaire above. Include name of medication, dosage, what frequency and the name of the prescribing doctor:

Have you ever experienced any of the following when you attempted to stop drinking or using or while drinking and/or using?

Seizures _____ Tremors _____ Nausea and Vomiting _____ Hallucinations
(DT's) _____
Loss of Consciousness _____ Hot/Cold sweats _____ Blackouts _____ Falls _____

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? May we contact them?

Name: _____	Telephone #: _____
Name: _____	Telephone #: _____
Name: _____	Telephone #: _____
Name: _____	Telephone #: _____

Have you ever thought about, planned or attempted suicide?

If yes, please explain:

Are you currently suicidal?

If yes, please explain:

Are you currently taking any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia or other psychiatric illnesses?

If yes, please describe:

Have you ever been treated for or do you need treatment for an Eating Disorder?

If yes, please explain:

Is there any other important information you would like to provide at this time?

Health Insurance Information:

Please provide the following from your health insurance card:

Subscriber Name (if other than patient): _____

DOB _____ SSN# _____

Name of Insurance _____

Identification #: _____

Employer Group Name: _____

Employer or Insurance Group #: _____

Insurance Provider Service Telephone#: _____

Customer Service Telephone #: _____

If applicable, Mental Health/Substance Abuse Telephone: # _____

If there is a secondary insurance please provide the same information as above:

Subscriber Name: _____

DOB: _____ SSN#: _____

Name of Insurance: _____

Identification: # _____

Employer Group Name: _____

Employer or Insurance Group #: _____

Insurance Provider Service Telephone: # _____

Customer Service Telephone # : _____

If applicable, Mental Health/Substance Abuse Telephone #: _____

If you have Medicare insurance please provide the following:

Name, as it appears on card: _____

Medicare ID#: (include letters after the number) _____

Effective Date: _____

Do you have any other specific questions or requests? _____

Thank you very much for the time you have taken to complete this Questionnaire. We will respond to your inquiry in a timely manner and look forward to working with you!

Sincerely,
Intake Staff at Pacific Coast Recovery Center

Confidentiality Notice:

All intake information is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR Pts 160 and 164 and cannot be disclosed without written consent unless otherwise provided for in the regulations. The Federal rules prohibit any further disclosure of this information unless a written consent is obtained from the person to whom it pertains. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.