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

Home #: _____ Work#: _____ Message: _____ Cell #: _____

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

Sexual Orientation: _____ Pronoun: _____ Gender Identity: _____

_____

Referral Source Phone Number

☐ Clergy	☐ Family/Friend	☐ Military	☐ Residential
☐ Correctional/Legal	☐ Medical	☐ New Choices	☐ Self
☐ Education	☐ Mental Health	☐ Other	☐ Shelter
☐ Employer/EAP	☐ Social or Community	☐ SUD	

_____

Name of Caller (if other than client) Phone number

Employee/School: _____ Does client/spouse have EAP? ☐ Yes ☐ No

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INSURANCE

Company _____ Company phone # _____ Group ID _____

Policy Holder Name _____ DOB _____ SSN _____

Employer _____ ID number _____

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

INFORM INDIVIDUAL PROOF OF INCOME REQUIRED TO BE ON SLIDING SCALE

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I. Presenting Problem

_____

_____

_____

_____

_____

II. Substance Use

Substance	Amount (be specific: gram, 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 or vape)	Amount	Frequency (how often do you use this)	How long have you been using this way?	Date of last use

First Name Middle Name Last Name

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: _____

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 "name"): _____
Dentist name: _____
Current prescribed medications:

Medication(s)	Reason/prescribed by	Dose	Times per day	Currently have this medication?	Taking as prescribed?

V. Risk Assessment

Suicidal thoughts? ☐ Yes ☐ No (If YES. During office hours (Mon – Fri 8 to 5) contact Stepping Stone Clinical Mgr
If after hours, weekend or holiday, forward call to Crisis Line at (812) 422-1100)
Homicidal thoughts? ☐ Yes ☐ No
History of hallucinations? ☐ Yes ☐ No

Hospital Referrals ONLY:
Hospital: _____ Contact: _____ Phone #: _____
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: _____
Applying for Disability? _____

First Name Middle Name Last Name

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? _____

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 arrangements: ☐ house ☐ homeless ☐ In jail ☐ In hospital

Children's current living situation: _____

Desired arrival date: _____

Additional comments: