CIRCLE PROGRAM
ADMISSION QUESTIONNAIRE
PLEASE PRINT LEGIBLY

Client Name: _____ Today's Date: _____
(First Name) (Middle Name) (Last Name)

Date of Birth: _____ **Social Security Number:** _____ ( ) declined/reason _____

Phone: circle one - Cell/Home (_____) _____ Ok to Leave Message: ( ) YES ( ) NO

Phone: Message (_____) _____ Ok to Leave Message: ( ) YES ( ) NO

Phone: Emergency Contact (_____) _____ Ok to Leave Message: ( ) YES ( ) NO

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

( ) **Male** ( ) **Female** **Race** (circle): Alaskan Native American Indian Asian Black Hawaiian/Pacific Islander White Decline

Additional Race(s): Alaskan Native American Indian Asian Black Hawaiian/Pacific Islander White

Ethnicity (circle): Not Hispanic Hispanic/Mexican Hispanic/Puerto Rican Hispanic/Cuban Other Hispanic Decline

Living Status (circle):

Correctional Facility/Jail Inpatient	Sober Living	Residential Treatment: _____
Independent	Nursing Home	Residential Facility: _____
Homeless (no fixed address/includes shelters	Group Home	ATU: _____
Halfway House	Boarding Home	Other: _____

Marital Status (circle): Single (never married) Married Widowed Separated Divorced

Tobacco Use: Yes No Decline **Packs per Day:** _____ **Chewing Tobacco:** Yes No

Primary Language: _____ **Need Interpreter?** Yes No **Military:** Yes No

Referred By: _____

Employment Status: _____ **Occupation:** _____

Number of Days Worked in the Last 30 Days: _____ **Highest Level of Education Completed:** _____

Source of Income: Wages Public Assistance Retirement/Pension Disability Other None

Annual Income: _____ **Number of People in Household:** _____ **How Many Under 18:** _____

Medicaid ID: _____

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Psychiatric diagnoses (use official DSM V Diagnoses) ***Attach a psychiatric evaluation done in the last 12 months***	**What medications?**	**Taking now?**
Axis I:		
Axis II:		
Axis III:		

Medical Information:

Please list any past or current medical conditions: _____

_____

Please list any medical durable equipment such as: Oxygen, C-PAP, Glucometer, etc:

_____

List all current medication(s) and dosages: _____

_____

Is client pregnant? Y / N N/A

Special accommodations for physical activities? Y/N If yes, specify: _____

_____

Legal Information	**No**	**Yes**	**If yes, explain:**
Probation, *if yes*, include copy of terms & conditions and police reports of crime.			
Parole, *if yes*, include copy of terms & conditions and police reports of crime.			
Hold orders			
Duty to warn			
Restraining order			
Pending charges			
Will serve jail/prison time after treatment at Circle			

Treatment plans	**Name of provider, agency, address, phone number**
Who will be providing substance abuse treatment while person is awaiting admission to Circle?	
Who will be providing mental health services while person is awaiting admission to Circle?	

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illness requires medical monitoring but not hospitalization?			
l. Has moderate to severe risk of behaviors endangering self or others including while intoxicated or under the influence?			
m. Personality disorders lead to dysfunctional behaviors that require continuous "boundary setting" intervention?			
n. Person recognizes substance use is excessive but has been unable to reduce or control it when substances are available in their environment?			

Please attach a hand written letter from client explaining why they want to enroll in the Circle Program. (REQUIRED)

Use this space for any information you may want to include or did not have room for:_____

Please note:

1. ***Remember to attach a copy of the most recent psychiatric evaluation.***
2. **Please fill out questionnaire completely.**
3. **Please feel free to add additional paperwork you consider necessary.**
4. **Return of the signed client agreement is necessary to receive a bed date.**

ANY MISREPRESENTATION OF INFORMATION MAY RESULT IN DENIAL OF ADMISSION

_____ _____

Prospective Client's Signature *Date*

_____ _____

Referral Source's Signature *Date*

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