WITS Admission Form

Agency: _____
Facility: _____

Client Profile Information

Last Name _____ First Name _____ Gender M F

D.O.B _____ SSN: _____ Consent Decree? (Class Member) YES NO

Ethnicity *(Please Check Only One)*

- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Specific Hispanic
- ☐ Hispanic – Specific Origin Not Specified

Race *(Please Check Only One)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other ____Unknown

Veteran? YES NO County of Residence: _____

Clinic Use Only

Client Intake Profile

Source of Referral: _____ *(See Table for Code)* Intake Staff: _____

Initial Contact Date *(Date of First Phone Call)* _____ Intake Date *(First Face to Face)* _____

Pregnant? YES NO If Yes, Due Date? _____ HIV Positive YES NO UNKNOWN

Hep C Positive YES NO UNKNOWN

Injection Drug User ___NEVER ____IN LAST 6 MONTHS ___IN LAST 5 YEARS ____ PRIOR TO LAST 5 YEARS

Problem Area _____ SUBSTANCE ABUSE ____ EVALUATION ____ AFFECTED/CO-DEPENDENT

Client Admission Profile

Admission Type ____ADMISSION ___SHELTER/DETOX Admission Staff _____

Admission Date *(Date of First Treatment)* _____

MH/MR Diagnosis: None____ Diagnosed Mental Illness/Disorder____ Mental Retardation____ Unknown____

(Please indicate the number of admissions/times attended for each within the specified time frame)

Prior Substance Abuse Treatment ____
Substance Abuse Hospitalization in Past 6 Months ____
Prior Mental Health Treatment in Past 12 Months ____
Prior Mental Health Hospitalizations past 2 Years ____
Medical Treatment Physician/clinic past 12 months____
Hospital Emergency Room Past 12 months ____
Medical Hospital Inpatient Past 12 months ____
Self-Help Attendance (Includes AA, NA, ETC) ____

In your lifetime, how many times have you gambled (bet) with money or possessions? ____

Has the money or time that you have spent on gambling let to financial problems or problems in your family, work, school or personal life? YES NO

Highest Grade Completed: _____ or Check Applicable

- ☐ Senior in High School/GED
- ☐ Freshman College
- ☐ Sophomore College
- ☐ Junior College
- ☐ Senior College
- ☐ Masters 1
- ☐ Masters 2
- ☐ PHD 1
- ☐ PHD 2
- ☐ Self-contained special education class

Are you a domestic violence survivor? YES NO

Financial/Household Information *(Select Applicable)*

Employment Status

- ☐ Full Time (>35 Hours)
- ☐ Part Time (17-34 Hours)
- ☐ Irregular (<17 Hours)
- ☐ Unemployed (Have Sought Work)
- ☐ Unemployed (Have Not Sought Work)
- ☐ Student
- ☐ Homemaker
- ☐ Retired
- ☐ Inmate of Institution
- ☐ Unable to Work Due to Physical or Psychological Reasons
- ☐ Seasonal Worker
- ☐ Temporary Layoff
- ☐ Unable Due to skills/resources
- ☐ Unable due to program requirements
- ☐ Volunteer: (Full Time____ Part Time____ Irregular____)

Expected Payment Source *(Please Check Only One)*

- ☐ None
- ☐ SAMHSH
- ☐ Human Services (Other than adult/child protective)
- ☐ Corrections
- ☐ Human Services (adult/child protective)
- ☐ Self-Pay
- ☐ MaineCare (Medicaid)
- ☐ Medicare
- ☐ Blue Cross Blue Shield
- ☐ Health Maintenance Organization (HMO)
- ☐ Other Private Health Insurance
- ☐ Town Assistance
- ☐ Worker's Compensation
- ☐ Veteran's Administration

Insurance Type *(Please Check Only One)*

- ☐ Private Insurance
- ☐ Blue Cross Blue Shield
- ☐ Medicare
- ☐ MaineCare (Medicaid)
- ☐ Health Maintenance Organization (HMO)
- ☐ Other (e.g. TRICARE)

Living Arrangements *(Please Check Only One)*

- ☐ Independent Living (Alone)
- ☐ Independent Living (With Others)
- ☐ Dependent Living (With Others)
- ☐ Homeless
- ☐ Local Jail or Correctional Facility
- ☐ State Correctional Facility

Marital Status *(Please Check Only One)*

- ☐ Never Married (Single)
- ☐ Married / Cohabitating
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Number of Dependents by Age Group

____ 0-12 Months
____13-35 Months
____3-5 Years
____6-12 Years
____13-17 Years

If the client has dependent children, where are the children while the client is in treatment?

- ☐ With the Client
- ☐ Spouse/Other Parent
- ☐ Grandparent/Relatives
- ☐ Friend(s)
- ☐ Temporary Foster Care
- ☐ Other

Clinic Use Only

Substance Abuse

Primary Substance _____ Frequency _____ Method _____ Detailed Drug Code _____ Age of First Use _____

Secondary Substance _____ Frequency _____ Method _____ Detailed Drug Code _____ Age of First Use _____

Tertiary Substance _____ Frequency _____ Method _____ Detailed Drug Code _____ Age of First Use _____

Medication Assisted Treatment *(See Table for Codes)* _____

Tobacco

Do you currently use tobacco? YES NO If yes, age of first use _____

In the past 30 days, how often did you use tobacco products per day?

____ No Use ____ ½ pack ____ 1 pack ____ 1 ½ packs ____ 2 packs ____ More than 2 packs

Route of Administration ____SMOKING ____CHEWING TOBACCO/DIP/ORAL

Clinic Use Only

Legal History

Legal Status _____ *(See Table for Code)* Domestic Violence Offender YES NO

Arrests in Past 12 Months ____ Arrests in Past 30 Days ____ OUI Arrests Past 12 months ____

Will Client Use Treatment or Evaluation to Satisfy DEEP Requirements? YES NO

If yes, DEEP Status ____First Offender ____Multiple Offender ____Youth Offender

Program Enrollment Profile

Program Name *(Primary Service)* Start Date *(First Treatment Date)* _____

REHABILITATION/RESIDENTIAL

- ☐ Hospital (Other than Detoxification)
- ☐ Short Term (30 days or less)
- ☐ Extended Care
- ☐ Halfway House
- ☐ Adolescent Res. Rehab. Transitional
- ☐ Consumer Run Residence

AMBULATORY

- ☐ Non-Intensive Outpatient
- ☐ Intensive Outpatient
- ☐ Detoxification
- ☐ Evaluation
- ☐ Adolescent Outpatient
- ☐ Adolescent Intensive Outpatient
- ☐ Opioid Replacement Therapy