

## Livengrin Foundation, Inc. Pre-Admission Intake

### DEMOGRAPHIC INFORMATION

Patient's Legal Name		Nick Name	
Home phone #	Work #	Cell #	
Address			
City, State, Zip			
Email Address			
Social Security Number		Sex    M    F	Marital Status
Date of Birth	Age	Race	
Emergency Contact Name		Relationship to Pt.	Contact #
Name of Referral (How did you first hear about Livengrin?)			Telephone #
Address		City, State, Zip	
Referral's recommendation:			
Patient's reason for seeking treatment:			

### SUBSTANCE USE (please list in order of preferred use)

Substance Amount/Type	How often	How long at current amount	Age of First Use	Last Use	Amount

Are you experiencing any of the following withdrawal symptoms?						
<b>Presently</b>	Uncontrollable shaking/tremors <input type="checkbox"/>	Hallucinations <input type="checkbox"/>	Seizures <input type="checkbox"/>	Nausea/Vomiting <input type="checkbox"/>	Severe Cramps <input type="checkbox"/>	Other
<b>Ever</b>	Uncontrollable shaking/tremors <input type="checkbox"/>	Hallucinations <input type="checkbox"/>	Seizures <input type="checkbox"/>	Nausea/Vomiting <input type="checkbox"/>	Severe Cramps <input type="checkbox"/>	Other

## MEDICAL ASSESSMENT

History			Prescribed medications	Do you take the medication as it is prescribed?	
	Y	N	Name, dosage	Y	N
Asthma					
Seizures					
Hypertension/Heart Condition					
Diabetes					
TB					
Chronic Pain History					
Other Physical					
Allergies (food, drug or environmentally)					
Mental Health Diagnosis					
Special Needs (e.g. physical/mental disability)					
Primary Care Physician Name			Telephone Number		
Address					
City, State, Zip					

## SOCIAL HISTORY

Current legal issues		DUI?
Attorney Name	Telephone Number	
Address		
City, State, Zip		

**HEALTH INSURANCE INFORMATION**

<b>PRIMARY (Patient is Subscriber)</b>		
Patient's employer		
Employer's address		
City, State, Zip		
# years/months employed		
Union Affiliation		
Insurance Plan Name		
Insurance Phone #		
ID#		
Group #		
Insurance Mailing address		
<b>SECONDARY (Someone other than patient is subscriber)</b>		
Subscriber's Name	Subscriber DOB	SS #
Employer Name		
Employer's address		
City, State, Zip		
Insurance Plan Name		
Insurance Phone #		
ID#		
Group #		