Jamestown Healing Clinic Intake Questionnaire

Name: _____ **DOB:** _____ **Date:** _____

1. What is your reason for seeking care at Jamestown Healing Clinic?

   _____

2. Are you currently using any illicit substances or alcohol? ☐ Yes ☐ No

If yes, which substance(s) (mark all that apply)?
☐ Opioids ☐ Methamphetamine ☐ Cocaine ☐ Alcohol ☐ Other: _____

3. Are you currently receiving medication treatment for opioid or alcohol use from another provider or treatment program? ☐ Yes ☐ No

If yes, please provide medication name**:** _____
Provider or treatment program: _____

If no, have you received any medication treatment for opioids or alcohol in the last 30 days? ☐ Yes ☐ No

If yes, please provide medication name**:** _____
Provider or treatment program**:** _____

4. Are you seeking medication for opioid or alcohol use? ☐ Yes ☐ No

If yes, what medication are you requesting?

_____

5. Have you experienced an overdose within the last 30 days? ☐ Yes ☐ No
6. Have you received medical care related to substance use within the last 30 days, such as emergency room, urgent care, or other treatment? ☐ Yes ☐ No
7. Please provide any additional information about your substance use, treatment, or recent medical care

   _____

8. Were you referred to Jamestown Healing Clinic because of a DUI? ☐ Yes ☐ No

If yes, do you have your abstract with you? ☐ Yes ☐ No

If not, please contact your lawyer to get copy. It is required for the completion of an assessment.

9. Are you currently involved in the legal system? ☐ Yes ☐ No If yes, check or identify all that apply:

☐ Department of Corrections (DOC)
☐ Child Protective Services (CPS)
☐ Department of Children, Youth, and Families (DCYF)
☐ LIFT Court
☐ Drug Court
☐ Mental Health Court
☐ Other:
_____

10. Do you currently have a primary care provider? ☐ Yes ☐ No
    If yes, provider's name: _____

Jamestown Healing Clinic has primary care services available. If you would like more information about becoming a primary care patient, please speak with the medical provider during your medical evaluation.

11. Do you have any long-term physical or mental health conditions? ☐ Yes ☐ No

If yes, please list: _____

12. Do you see any specialists? ☐ Yes ☐ No

If yes, please list the specialist(s) and reason for care:

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13. Are you currently taking any medications, supplements, or over-the-counter products? ☐ Yes ☐ No

If yes, please ask the medical team for a Medication Registration Form. All outside medications must be registered.

14. Are you currently pregnant? ☐ Yes ☐ No ☐ Not applicable ☐ Unsure

If you have urgent dental needs, such as broken teeth or an active infection, please inform the medical provider during your assessment.

15. Are you currently engaged in any community based supportive services such as the REAL Team, Case Management, Community Behavioral Health Support? ☐ Yes ☐ No
    If yes, please list the type and name of the support you are receiving.

Examples may include a case manager through a specialist's office, Peninsula Behavioral Health, First Step, or Rediscovery.

Type of support: _____
Agency: _____

If you would like your case manager involved in your care, request a Release of Information form from your counselor.

16. Are you an enrolled member of a federally recognized tribe?
    ☐ Yes ☐ No If yes, tribe name: _____

    If no, are you a descendant of a federally recognized tribe?
    ☐ Yes ☐ No If yes, tribe name: _____

Admin use only: ☐ Reviewed by Counselor ☐ Reviewed by Medical Provider