**Returning Consumer:  Yes  No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consumer Information ONLY**

|  |  |
| --- | --- |
| Consumer Name: | Date of Birth: |
| SS#: | MA#: |
| Gender Assigned at Birth: | Gender Identity: |
| Sexual Orientation: | Phone Number: |
| Message OK?  Yes  NO | Email Address: |
| Living Situation: | Address: |
| City: | State/Zip code: |
| School/Grade (if applicable): | Address of School: |
| Preferred Method of Contact:  Phone  Text  Email | Best Time to Call: |
| Are you Employed?  Yes  No | If yes,  Supportive Employment  PT  FT |

**Referral Source Information**

|  |  |
| --- | --- |
| Name: | Agency (if applicable): |
| Phone Number: | Fax Number: |
| Email Address: | Relationship to Consumer: |

**Parent/Guardian Information:**

|  |  |
| --- | --- |
| Name of Parent/Guardian: | Relationship: |
| Address: | Contact Number: |

**\*A LEGAL DOCUMENT MUST BE PRESENTED TO SHOW GUARDIANSHIP\***

**\*COURT ORDER/LEGAL DOCUMENTATION\***

**Please answer the following:**

|  |  |
| --- | --- |
| Is the consumer of Hispanic, Latino, or Spanish origin? | Yes  No  Unavailable |
| Race: | White  Asian  Black/African American  American Indian/Alaskan Native  Native Hawaiian  Other Pacific Islander  Not Available |
| How well does the consumer speak English? | Well  Not so well  Not at all |
| Does the consumer speak another language other than English at home? | Yes  No |
| If Yes, what is the language? | Spanish  French  Arabic  Greek  Other |
| Number of arrests in the past 30 days? | None  1-99 |
| Is the consumer deaf or do they have hearing difficulty? | Yes  No  Unknown |
| Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses? | Yes  No  Unknown |

**REASON FOR REFERRAL/Primary Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SUBSTANCES USE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Substance** | **Age at First Use** | **Route of Transmission** | **Frequency of Use** | **Date of Last Use** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| Currently Receiving Medication Assisted Treatment?  Yes  No | Clinic Name/Phone Number of MAT: |
| Mental Health Diagnosis: | Current Therapy/Treatment Supports: |