**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:  |