



IOP INTAKE FORM

Date of Intake: _____

Initial Screening Completed By: _____

Personal Information

Full Name: _____

Date of Birth: _____

Social Security #: _____

Gender: _____

Race: _____

Address: _____

Phone Number: _____ Email: _____

Emergency Contact Name: _____ Relation: _____

Number: _____ Email: _____

Referral Information

Referred By (if applicable): _____

Contact Information of Referrer: _____

Reason for Referral: _____

Vitals

Blood Pressure: _____ Height: _____

Pulse Ox: _____ Heart Rate: _____

Weight: _____

Urine Drug Screen (UDS)

Details: _____



Substance Use History

Substance(s) of Use: _____

(include alcohol, illicit drug, non-prescribed meds)

Primary Substance(s) of Use: _____

Frequency and Quantity of Use: _____

Age of First Use: _____

Date of Last Use: _____

Route of Administer: _____

Previous Attempts to Reduce or Quit (if any): _____

Current Medications for Substance Use (if any): _____

Overdose History: _____

Number of Overdoses: _____

Dates of Overdoses: _____

Have you ever experienced withdrawal symptoms in the past?:

Yes No

If yes, describe the symptoms you experienced:

Nausea/Vomiting

Shakes/Tremors

Sweating

Anxiety

Insomnia

Hallucinations

Seizures

Delirium Tremens (DTs)

Other: _____

Impact of Substance Use on Physical Health

1. Do you believe your substance use has affected your physical health?

Yes No

If yes, please explain: _____

2. Have any medical professionals expressed concerns about how substance use may be impacting your health?

Yes No

If yes, please explain: _____

3. Do you experience withdrawal symptoms that cause medical concerns (e.g., seizures, dehydration, heart issues)?

Yes No

If yes, please explain: _____



DX for Substance use:

Alcohol Use Disorder (AUD):

- F10.10 - Alcohol Use Disorder, mild
- F10.20 - Alcohol Use Disorder, moderate
- F10.20 - Alcohol Use Disorder, severe

Opioid Use Disorder (OUD):

- F11.10 - Opioid Use Disorder, mild
- F11.20 - Opioid Use Disorder, moderate
- F11.20 - Opioid Use Disorder, severe

Cannabis Use Disorder:

- F12.10 - Cannabis Use Disorder, mild
- F12.20 - Cannabis Use Disorder, moderate
- F12.20 - Cannabis Use Disorder, severe

Sedative, Hypnotic, or Anxiolytic Use Disorder:

- F13.10 - Sedative, Hypnotic, or Anxiolytic Use Disorder, mild
- F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, moderate
- F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, severe

Stimulant Use Disorder (e.g., cocaine, methamphetamines):

- F15.10 - Amphetamine-type substance, Mild
- F14.10 - Cocaine, Mild
- F15.20 - Amphetamine-type substance, Moderate/Severe
- F14.20 - Cocaine, Moderate/Severe

Phencyclidine Use Disorder (e.g., PCP)

- F16.10 - Phencyclidine Use Disorder, mild
- F16.20 - Phencyclidine Use Disorder, moderate
- F16.20 - Phencyclidine Use Disorder, severe

Other Hallucinogen Use Disorder (e.g., LSD, Psilocybin, Ketamine, Salvia)

- F16.10 - Other Hallucinogen Use Disorder, mild
- F16.20 - Other Hallucinogen Use Disorder, moderate
- F16.20 - Other Hallucinogen Use Disorder, severe

Inhalant Use Disorder

- F18.10 - Inhalant Use Disorder, mild
- F18.20 - Inhalant Use Disorder, moderate
- F18.20 - Inhalant Use Disorder, severe



Mental Health Information

1. Have you ever been diagnosed with a mental health condition? Yes No

If yes, when and where? _____

2. Are you interested in meeting with a therapist to discuss your mental health? Yes No

3. Which symptoms have you experienced in the LAST 2 WEEKS? (check all that apply):

- NONE Depression Anxiety Mood Swings Hallucinations/Delusions Suicidal Thoughts Anger/Irritability Poor Concentration Impulsivity Self-Harming Behaviors Trouble Sleeping Decreased energy/Fatigue Increased Energy Panic/Fear

4. Do you believe your mental health has contributed to past substance use or relapses?

Yes No

If yes, please explain: _____

5. Current Psychiatric Medications: _____

6. Prescribing Provider: _____

7. Date of Last Psychiatric Evaluation: _____

8. Have you ever been hospitalized for mental health? Yes No

If yes, when and where? _____

Physical Health Information

1. Primary Care Physician: _____

2. Last physical Exam: _____

3. Do you need a referral to see a physician for a physical? Yes No

4. Do you have any current medical conditions? Yes No

If yes, please list? _____

5. Current Medications: _____

6. Are you currently able to afford your medications and medical care? Yes No

If no, please explain: _____

7. Allergies: _____

- **Other:** _____



Housing and Transportation:

1. Outside of treatment or detox facilities, where do you live?
 Homeless
 Living with Family/Friends
 Own/Rent Housing
 Other (please specify): _____
2. Do you have consistent access to transportation? Yes No

Employment Status

1. Are you currently employed? Yes No
If yes, what type of job? _____
If yes, what is your schedule? _____

Education

1. Highest Level of Education Achieved: _____
2. Are you currently in school? Yes No
If yes, where? _____
3. Can you read/write in English and/or your native language? Yes No

Family and Social History

1. Describe your current family dynamic: _____ 2.
2. Do you have a support system? Yes No
If yes, who? _____
3. Are you currently in a relationship? Yes No
If yes, (check all that apply):
 Supportive Stressful Involved in Substance Use Abusive Other: _____
4. Do you have children? Yes No
If yes, are you the primary caretaker? Yes No
5. Have you experienced physical violence from a loved one? Yes No
6. Have you experienced a loved one causing you emotional/psychological harm? Yes No
7. As a child, were your caregivers ever unable to supply sufficient food/shelter/clothing?
 Yes No

Legal History

1. Have you ever been arrested? Yes No
If yes, please explain: _____
2. Have you ever been convicted of a crime? Yes No
If yes, what were the charges: _____
3. Have you ever been incarcerated? Yes No
If yes, when, for how long, and for what charges: _____
4. Are you currently on probation or parole? Yes No
• Probation/Parole Officer Name & Phone: _____



Strength and Goals

1. List 3 personal strengths: _____

2. What are your goals for treatment? _____

3. What do you hope to achieve by participating in services? _____

Physical Health Status

1. How would you rate your overall physical health?

- Excellent
- Good
- Fair
- Poor

2. How motivated are you to improve or manage your physical health?

- Not at all
- Somewhat motivated
- Moderately motivated
- Very motivated

3. Do you have any current medical conditions?

- Yes No

If yes, please list all diagnosed conditions: _____

4. Have you had any recent hospitalizations, surgeries, or ER visits?

- Yes No

If yes, provide dates and reasons: _____

5. Do you experience any of the following on a regular basis? (*Check all that apply*)

- Chronic pain
- Headaches or migraines
- Breathing difficulties
- Heart issue
- Gastrointestinal issues
- Fatigue or weakness
- Seizures



6. Do you have any disabilities or chronic illnesses that affect your daily functioning?

Yes No

If yes, please explain: _____

7. Do you have difficulty remembering things or making decisions? Yes No

8. Do you have any developmental disabilities or history of brain injury? Yes No

If yes, please describe: _____

9. Do you require any of the following to assist with mobility or care? Yes No

Wheelchair or walker

Personal care assistant

Home health nurse

Medical equipment (e.g., oxygen, CPAP)

Other: _

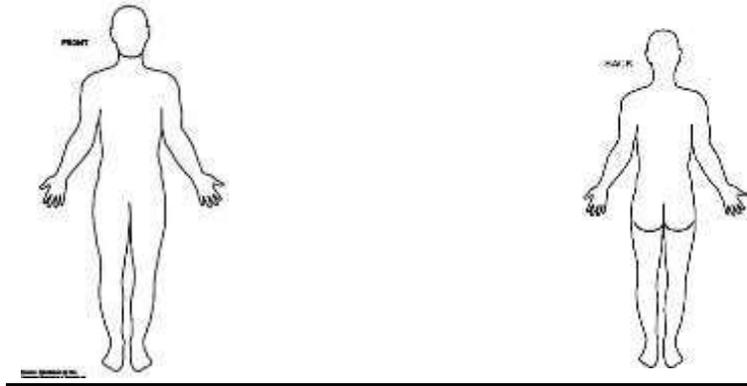
10. Do you have any untreated or undiagnosed physical health symptoms or conditions that you are concerned about? Yes No

If yes, describe: _____



Pain Assessment Tool

Pain location



- Head
- Neck
- Shoulders
- Arms
- Hands
- Groin
- Hips
- Legs
- Foot

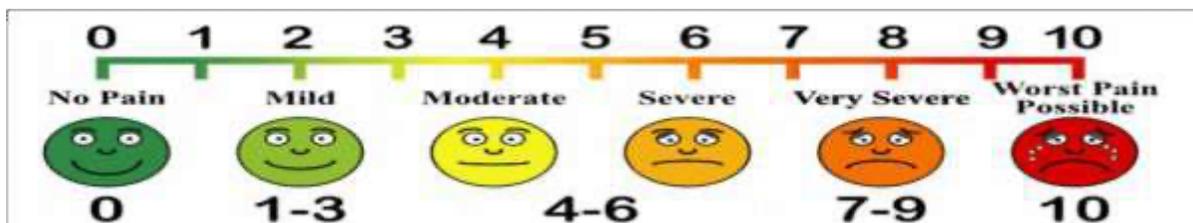
Description of pain

- Morning Afternoon Evening Night

Patient Description of Pain- Check all that apply

- Sharp Tingles Throbbing
Dull Stings Burning
Ache Tender Other

- Does the pain radiate? Patient Unable to describe/respond



Pain Rating Score-



Nutrition Assessment

1. Food Allergies (Confirmed or suspected) Please list:

2. Have you lost or gained 10 pounds or more in the last 3 months? Yes No
If yes, how much? _____

3. Have you had a decrease in food intake and/or appetite? Yes No

4. Do you have any dental problems? Yes No

5. Do you have any of the following eating habits or behaviors?

- Bingeing
- Inducing vomiting/purging
- Misuse of laxatives

6. Do you avoid family dinners and social events involving food? Yes No

Suicide Screening

1. In the past TWO weeks, have you wished you were dead? Yes No

2. In the past TWO weeks, have you felt that you or your family would be better off if you were dead? Yes No

3. In the past week, have you been having thoughts about killing yourself? Yes No

4. Have you ever tried to kill yourself? Yes No

If yes, when and what means did you use? _____

If the client answers yes to any of the above, ask the following question:

5. Are you having thoughts of killing yourself right now? Yes No

6. Do you have a plan for how you would end your life? Yes No

If yes, what is that plan? _____

7. Do you have access to the means (weapon/pills/etc.) to end your life? Yes No