

Intake form

General Information										
NAME AND SURNAME						SEX	M	F	AGE	
I.D. NUMBER				D.O.B.		NATIONALITY				
RACE		PHYSICAL ADDRESS			CODE					
POSTAL ADDRESS						CODE				
TEL NO			CELL		E-MAIL					
Next of kin										
NAME				RELATION						
PHYSICAL ADDRESS						CODE				
POSTAL ADDRESS						CODE				
TEL(W)			TEL (H)		CELL					
E-MAIL										
Emergency Contact										
NAME				RELATION						
TEL(H)			TEL(W)		CELL					
NAME				RELATION						
TEL(H)			TEL(W)		CELL					
Dependency/s										
DEPENDENCY /S (INCL. CIGARETTES etc.)										
MAIN DEPENDENCY					DURATION OF USE					
DATE OF LAST USAGE					DOSAGE (per day/week)					
Medical Information										
CHRONIC MEDICATION (From Age)					DOSAGE					
CHRONIC MEDICATION (From Age)					DOSAGE					
CHRONIC MEDICATION (From Age)					DOSAGE					
ALLERGIES					DISORDERS (INCL. SUICIDAL IDEATION)					
IMPLANTS / PROSTHETICS										
INJURIES ON ADMITTANCE										
MEDICAL HISTORY (SHORT ACCOUNT OF ALL HOSPITALISATION, REHABILITATION CENTRES, PSYCHIATRIC CENTRES, OPERATIONS ETC. INCLUDING AGE AND DATE OF SAID)										
Background										
HIGHEST LEVEL OF EDUCATION										
CRIMINAL RECORD (Please supply details) (Please indicate if time served in prison)										
SPECIAL OR ADVANCED SKILLS										
DATE AND TIME OF ARRIVAL			DATE		TIME					
DATE AND TIME OF DEPARTURE			DATE		TIME					
I, _____ declare that I have supplied the above information completely and truthfully. I understand that if found that any details have been omitted or supplied falsely I may be asked to leave the recovery centre.										
NAME				SIGNATURE						
DATE										
PARENTS / GUARDIAN										
NAME				SIGNATURE		DATE				
FIRST PHONE CALL										
FIRST VISIT										