www.CANAM INTERVENTIONS.com

Date: ______________________________

Client: ______________________________

Counselor: ______________________________

Case Management Intake Assessment

Name:	DOB:
Address:	Bill to:
Cell Phone:	Home Phone:
Allergies:	Current List of Medications:
Late date of use:	Substances abused:
Special Dietary Requirements:	

PREVIOUS TREATMENT STAYS

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Facility	Date/LOS	Reason for admission

LENGTHS OF SOBRIETY

Dates	Lengths of Sobriety	12 Step Work

ADDICTIVE BEHAVIORS

OTHER ADDICTIVE BEHAVIOR

UNDERLYING ISSUES PREVENTING SOBRIETY

TRAUMA/ABUSE HISTORY

MENTAL HEALTH ISSUES

CURRENT MEDICATIONS (& OTC)

Prescription Name	Dosage/Freq	Date Prescribed	Prescribed by

MEDICATIONS WITHIN THE LAST 6 MONTHS

Prescription Name	Dosage/Freq	Date Prescribed	Prescribed by

HISTORY OF SUICIDE ATTEMPTS

HISTORY OF SELF-HARM

MEDICAL ISSUES/LAST MEDICAL CHECKUP

HISTORY OF SEIZURES

ALLERGIES/SPECIAL DIETARY NEEDS

HISTORY OF LEGAL ISSUES

COMMENTS