

**First Step Services, LLC-Initial Intake Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
First Middle Last

**Address:** \_\_\_\_\_  
Street City State Zip Code

**Contact Info:** Home \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Referral Source:** \_\_\_\_\_ **Reason for referral:** \_\_\_\_\_

\* Payment is required at the time of services, \$25 fee for returned checks or credit card payments. If paying by check, assessment results will not be forwarded until the check clears. Please consider using cash or credit card for assessment or initial payments.

**How will you pay for 1<sup>st</sup> visit?**  Cash  Check  Visa or Mastercard  Other \_\_\_\_\_

EAP (Please specify name of company) \_\_\_\_\_

**Health Insurance:**  Yes (Please specify) \_\_\_\_\_  No

\*If using health insurance, please complete the red & white insurance claim form.

**Gender:**  Male  Female  Other (Please specify) \_\_\_\_\_

**Racial/Ethnic Group:**  American Indian or Alaskan Native  African American or Black  Asian  
 Native Hawaiian or Pacific Islander  Caucasian  Other (Please specify) \_\_\_\_\_

**Relationship Status:**  Married  Separated  Divorced  Single  Dating  Never Married  
 Other \_\_\_\_\_

**Employment Status:**  Full Time  Part Time  Unemployed  Full or Part Time Student

**DWI, Court Ordered, Pre-Trial, or Probation Referrals Only:**

**List any pending legal charges:** \_\_\_\_\_

**Attorney or PO Contact Info:** Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
Street City State Zip Code

**Do you need a letter for your attorney or PO?**  Yes  No

**DWI cases, can you provide copies of your BAC, ticket, and driving record?**

Yes  No (Please specify why) \_\_\_\_\_

**DO NOT WRITE IN THIS BOX, STAFF ONLY**

Axis I: \_\_\_\_\_ Axis II: \_\_\_\_\_ Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_ Axis V: \_\_\_\_\_ ASAM: \_\_\_\_\_

Tx: \_\_\_\_\_ Time Started: \_\_\_\_\_ Time Finished: \_\_\_\_\_

Staff Assisted: \_\_\_\_\_  Raleigh  Garner  Durham

**First Step Services, LLC-Health History**

**Personal Physician & Office Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Physician Address:** \_\_\_\_\_  
Street City State Zip Code

Was your last visit within the last 12 months?  Yes, date of last visit: \_\_\_\_\_  No

**Psychiatrist:** \_\_\_\_\_ **Psychologist:** \_\_\_\_\_ **Therapist:** \_\_\_\_\_

Have you injected drugs within the past 24 hours?  Yes  No Within the past 10 years?  Yes  No

Have you had a TB Skin Test?  Yes, Date & Results \_\_\_\_\_  No

Have you taken medication to prevent or treat TB?  Yes  No

Have you ever been diagnosed, treated for, or have a history of any of the following (*check all that apply*)

- Seizures  Diabetes  Hypoglycemia  High Blood Pressure  Heart Disease  Bipolar  Depression  Bowel Problems
- Schizophrenia  Ulcers  Hepatitis  Cirrhosis  Chest Pain  Cancer  Shortness of Breath  Infectious Diseases
- Liver Problems  Kidney Problems  Lung Problems  Abscess  Serious Infections  Pancreatitis  Head Injury  Surgery
- Broken Bones  HIV  STDs  Psychiatric Hospitalization  Suicide Attempts  Addictions  Eating Disorders
- Visual Impairment  Hearing Impairment  Speech Impairment
- Threatened/Harmed others  Other: \_\_\_\_\_

Comments on any of the above (dates of diagnoses & treatments): \_\_\_\_\_

Would you like to receive additional information on HIV education or testing locations?  Yes  No

Is a special diet required by your doctor?  Yes  No Eating Habits:  Poor  Fair  Good  Excellent

Do you have any current physical limitations/concerns?  Yes (*specify*) \_\_\_\_\_  No

Do you verify there are no physical limitations that will prohibit you being safe at First Step?

Yes  No (*please specify*) \_\_\_\_\_

Are you currently involved in high-risk behaviors that compromise safety/health?  Yes  No  
(Such as: unprotected sex, criminal behavior, needle sharing, excessive use of alcohol or drugs)

Please specify \_\_\_\_\_

Current treatments & medications: \_\_\_\_\_

**Emergency Contact Information**

**Contact's Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
Street City State Zip Code

**Nearest Relative:** \_\_\_\_\_ **Preferred Hospital:** \_\_\_\_\_  
Name Address Phone

*I hereby certify that the health information I have given to be true to the best of my knowledge.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **First Step Services, LLC- Confidentiality of Patients Records**

The confidentiality of mental health, alcohol and other drug abuse patient records maintained by this organization is protected by Federal Law and regulations. Generally, the program may not say to a person outside the program that the person served attends the program or disclose any information identifying the person served as an alcohol or drug abuser UNLESS:

1. The person served consents in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency.
4. The disclosure is required when the person served is in danger to himself/herself or threatens harm to another person and appropriate authorities must be notified.
5. The disclosure is made to the NC Department of Health and Human Services or local area authority personnel for audit or program evaluation and statistical reports required by the NC Department of Health and Human Services DWI Services Division.
  - a. Information regarding the race, sex, age, etc. of the below named person served may be used for statistical reports or other studies conducted and that such information will not include details such as the identity of the person served, which would constitute a violation of confidentiality.
6. The disclosure is made to appropriate agencies for collection of past due fees, non-payment, or to recover payment for returned checks. Violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by the person served either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. A complete explanation of your rights to confidentiality is available upon request.

***I, the undersigned, fully understand all of the above information as I have read it or had it explained to me.***

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**First Step Services, LLC-Referral Source Form**

***How did you hear about First Step Services?***

Dear First Step Customer,

Thank you for coming to First Step. It is very helpful for us to know how you first heard about us. Please check the box below that corresponds with how you heard about us. Please include the name of the person or company who first told you about us if possible.

I really appreciate your assistance with this. I hope your experience with First Step is as beneficial for you as possible.

Thank you,

Henry Tarkington, MSW, LCSW, LCAS, CCS  
Executive Director

*I first heard about First Step Services, LLC from:*

- First Step Services Website
- Yellow Pages or Phone Book
- Letter or Brochure in the mail
- Internet Site other than First Step's website: \_\_\_\_\_
- Family or Friend: (Name) \_\_\_\_\_
- Treatment Center: (Name) \_\_\_\_\_
- Attorney: (Name) \_\_\_\_\_
- School or College: (Name) \_\_\_\_\_
- Doctor or Therapist: (Name) \_\_\_\_\_
- Probation Officer: (Name) \_\_\_\_\_
- Court or Magistrate: (County) \_\_\_\_\_
- Other Assessment or Counseling Program: (Name) \_\_\_\_\_
- Other Person or Company: (Name) \_\_\_\_\_

Today's Date: \_\_\_\_\_

-----DO NOT WRITE BELOW THIS LINE-----

TYPE OF APPOINTMENT: \_\_\_\_\_ COMMENTS: \_\_\_\_\_