

**PROGRAM:**

Residential Tx: \_\_\_\_; Outpatient Tx. \_\_\_\_; Transitional Living \_\_\_\_

Assigned Counselor \_\_\_\_\_

Date and time to enter treatment: \_\_\_\_\_

Will pay \_\_\_\_\_ Intake Fee/Put on waiting List

**QUALITY LIVING CENTER**

**SCREENING FORM**

3925 ASHER AVENUE

LITTLE ROCK, ARKANSAS 72204

Screening Date: \_\_\_\_\_ Screener Name: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: street: \_\_\_\_\_ city: \_\_\_\_\_ state: \_\_\_\_ zip: \_\_\_\_\_

Phone #'s: (H) \_\_\_\_\_ message: \_\_\_\_\_

SS#: \_\_\_\_\_ Referral: \_\_\_\_\_

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**FAMILY INFORMATION**

Marital status: \_\_single; \_\_married; \_\_divorced; \_\_separated; \_\_widowed

Children: \_\_ Yes; \_\_ No; How many \_\_\_\_ Ages: \_\_, \_\_, \_\_, \_\_, \_\_, \_\_

Pregnant: \_\_Yes, No

With whom do they live? \_\_\_\_\_

Household: \_\_ Live alone; \_\_ Live w/partner and/or children; \_\_ Live w/parents/other family member; \_\_ Homeless; \_\_ Live w/roommate.

Will family or others participate in your counseling? \_\_Yes, \_\_No; Relationship? \_\_\_\_\_

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**WORK/EDUCATION INFORMATION/MILITARY**

Type of Work: \_\_\_\_\_ Employer: \_\_\_\_\_

Years of formal education: \_\_\_\_\_; Have you served in Military? \_\_Yes, \_\_ No

Did you serve PRE: 9/11 or POST: 9/11? \_\_\_\_\_

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**MEDICAL INFORMATION**

Are you being treated for any medical problems/or have a medical problem that you need medical attention? \_\_Yes \_\_ No; What: \_\_\_\_\_

Are you being treated for any mental health problems? \_\_Yes \_\_No; What: \_\_\_\_\_

\*What are your current medications: \_\_\_\_\_

\*Have you been taking medications but have not taken them in awhile? \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

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**LEGAL ISSUES:**

Incarcerated: \_\_\_ Yes \_\_\_ No; Possible release date: \_\_\_\_\_

Any sexual offenses: \_\_\_ Yes \_\_\_ No; Case #: \_\_\_\_\_

How many DWI's: \_\_\_\_\_

ANY OTHER CHARGES, WHEN, AND OUTCOME: \_\_\_\_\_

\_\_\_\_\_. Pending Cases: \_\_\_\_\_ Court date: \_\_\_\_\_

Parole or Probation Officer Name and number: \_\_\_\_\_

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**SUBSTANCE ABUSE INFORMATION**

Do you feel you have a substance abuse problem, nicotine included? \_\_\_ Yes \_\_\_ No; Circle ones used:

ALCOHOL MARIJUANA BARBITUATES METH COCAINE NICOTINE OPIUM CRACK OTHER.

What is your drug of choice (the drug, including alcohol, you use most often)? \_\_\_\_\_

How often do you use this drug/alcohol? \_\_\_\_\_; When was the last time you used? \_\_\_\_\_

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**TREATMENT HISTORY**

Have you been in treatment or counseling before? \_\_\_ Yes \_\_\_ No If so, please give us:

PURPOSE/ISSUES	NAME OF FACILITY	WHEN/HOW LONG	RESULTS
_____	_____	_____	_____

What are your goals for the outcome of coming to Quality Living Center for treatment?

Please describe how you hope your life will be different:

\_\_\_\_\_

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Financial Support: \_\_\_ Yes \_\_\_ No

How do you plan on paying for treatment? \_\_\_\_\_

**THIS IS A TOBACCO FREE ENVIRONMENT AND NICOTINE IS TREATED LIKE ANY OTHER ADDICTIVE DRUG SO THERE IS NO SMOKING ALLOWED.**

**OUR INTAKE FEE: \$350.00**

NOTES: \_\_\_\_\_  
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