**First Step Home Screening**

First Step Home is a program that provides substance abuse treatment for women, allowing children 12 years of age and under to live onsite with their mother, based on bed availaibility. Services available at First Step Home include a *combination* of residential treatment for 30 days, intensive outpatient treatment 5 days per week while living in FSH supportive housing, duration is approximately 3-6 months. Intensive outpatient and outpatient treatment are also offered for client’s with independent housing. Level of care is determined by intake team at assessment.

Services include group therapy, individual counseling, case management, peer support vocational and mental health treatment. You will be required to provide random urine samples as requested by staff.

First: M: Last:

Phone Number:

E-mail:

Social Security Number:

Date of Birth:

First Date of Contact with FSH:

Current Living Situation? (circle one)

Independent Living Homeless Other’s Home Residential Care

Temporary Housing Incarcerated Crisis Care

Do you have Insurance? (Circle all that apply)

None Applied Buckeye United Health Care

CareSource Molina Straight Medicaid Paramount Advantage

Private (Please Identify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VA- Tricare

Are you receiving any Medicare and/or SSI/SSDI Benefits?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a VALID Photo ID? Yes No

County of residency:

Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral source:

Do you have any urgent or critical needs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of treatment are you seeking: Residential, Intensive outpatient or Outpatient treatment?

If Hamilton County what is your anticipated length of stay?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous substance abuse treatment? When, where and did you complete?

\_\_\_\_\_ \_\_\_\_\_\_

Was past treatment successful? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If you left before, completion, briefly explain why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had an assessment or have been a client previously at First Step Home?

YES NO

Drug of choice, how often were you using?

Date of Last Use?

**Children**

Do you have any children that you would like to have, live with you at FSH? If so, please list their ages and gender.

Child’s Pediatrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the child last see the pediatrician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outstanding concerns for your child or upcoming surgeries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Open CPS or FAIR (Hamilton County)? If so, who is your FAIR care manager?

**Legal**

Legal issues (ongoing court, probation, parole, warrant)?

History of Arson, violence, or crimes involving children? If so, please explain.

**Medical**

\*Are you being discharged from a hospital other than GSH? [ ] Yes [ ] No If yes, please provide the name and contact information of your physican.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized for medical reasons in the last 5 years? [ ] Yes [ ] No If yes, please provide the reason and which hospital. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following: For any yes response, list when diagnosed and where.

Cardiac disease/heart valve infection

[ ] Yes [ ] No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart attack When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Yes [ ] No

Stroke When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Yes [ ] No

Diabetes When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Yes [ ] No

Epilepsy/Seizures When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Yes [ ] No

Neurologic disease When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Yes [ ] No

Skin Infections When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Yes [ ] No

Other (Please list medial issue(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your condition(s) currently being managed? Who is managing them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What outside appointments do you have scheduled that are related to your medical condition(s)? If medical conditions exist, how many times per week do you need to attend visits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant? YES NO

a. Due Date:

b. Have you received pre-natal care? If so, where and when was your last appointment?

Have you ever been given a Mental Health Diagnosis, if so what was the diagnosis(s).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing symptoms. Yes\_\_\_\_\_ No\_\_\_\_\_\_ If yes, what are your symptoms?\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on medication(s) for mental health conditions? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_ If yes what are they?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are they helpful? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

Any recent psychiatric hospitalizations, overdose or suicide attempts? Yes \_\_\_\_\_ No \_\_\_\_\_\_ If yes, provide dates starting with most recent within the past year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current prescribed Medication(s) for conditions other than mental health:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who prescribes your medications? \_\_\_\_\_\_\_

Alternate Resources When Services canot be provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_