Client Admission Form

Client Information

Name _____ **Date** _____

Date of Birth _____ **Age** _____

Cell Number _____ **Home Phone Number** _____

Email Address _____

Home Address _____

City _____ **State** _____

ZIP Code _____

Emergency Contact Name _____ **Relationship** _____

Referred By _____

Height _____ **Weight** _____ **Gender** ☐ Male ☐ Female

Do you have a valid passport? ☐ Yes ☐ No **Expiration Date** _____

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Treatment Goals and History

What are you seeking help with?

What are your treatment goals?

List any significant illness or health problems

List any surgeries in the last 10 years

List any medical or psychiatric hospitalizations in the last 5 years

List all previous substance abuse treatment, including inpatient or outpatient, counseling or therapy

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Medical and Substance Use Information

List all currently prescribed medications

List any over-the-counter medications, vitamins, or supplements

Any allergies to medications

Have you ever had an EKG? ☐ Yes ☐ No **If yes, when was your last one?** _____

EKG Result ☐ Normal ☐ Abnormal ☐ Unknown

Do you exercise? ☐ Yes ☐ No **Do you drink alcohol?** ☐ Yes ☐ No

What are you drinking and how frequently?

Have you ever experienced delirium tremors? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No **If yes, how much?** _____

Do you smoke cigarettes? ☐ Yes ☐ No **Do you vape?** ☐ Yes ☐ No

How much per day do you smoke or vape?

Recreational / Street Drug Use

Drug Type	Amount of Daily Use	Last Use

Client Consent Form

I acknowledge that I have received, I have read and understand the information provided to me by the Oceanside Treatment Center regarding the therapy that I am considering further that I have had all my questions thoroughly answered.

I do hereby consent to taking part in the recovery orientated system of care provided by the Oceanside Treatment Center, and I am entering into this treatment without cohesion, promise, demand or threat.

I have provided Oceanside Treatment Center with a completely thorough and truthful account of my medical history, current and past prescription medication use and current and past recreational drug use.

It has been explained to me that my failure to provide this complaint and truthful account could affect the outcome of my treatment and may result in adverse health consequence consequences and/or death.

I further recognize that my active participation in the program is necessary to receive the full benefit of the treatment being provided, and I agree to engage in the active role in my recovery.

I understand that no promises have been made to me as to the anticipated results of this treatment, behavioral health, counseling, supportive services, or any other procedures provided by Oceanside treatment center.

I am aware that I am free to stop the course of treatment at any time, but that all fees and costs are nonrefundable, and that any outstanding fees will be required to be honored and settled with the Oceanside treatment center.

My signature below indicate that I understand and agree with all of these statements.

Client Signature _____ **Date** _____

Printed Name

_____

Oceanside Treatment Center Representative _____ **Date** _____