



Screening Form: to be asked directly to potential client

Name: _____

Date of birth: _____

Best contact # : _____

Email Address: _____

Address: _____

County of Residence: _____

Do you have health insurance (circle one)? Yes No Medicaid Medicare

What services are you seeking at McLeod Center (circle one)? 28 Day Inpatient DWI Residential

Substance Use History:

- 1) Have you ever been in treatment before for substance abuse? If yes, date(s), episode(s), where, for what substance(s).
- 2) Have you ever been to detox? If yes, date(s), episode(s), where, for what substance(s)
- 3) Have you ever had withdrawals from any substance? If yes, what substance(s)? Do you think you may be at risk of withdrawals from any substance at the current time?
- 4) Have you ever had a seizure? Yes or No. If yes, was the cause:
 - a. Withdrawals?
 - i. If yes, then from what substance? Benzos / alcohol / other
 - b. Epilepsy?
 - i. If yes, then are you on medication?
 - ii. Who is your doctor?
 - iii. When was last visit?
 - iv. What medication(s)?
 - c. Trauma / TBI
 - d. Other / unknown
- 5) When was the last time you used opioids, if ever? _____. Have you ever used opioids daily? If yes, how recently did you use them daily?

- 6) When was the last time you used benzos, if ever? _____. Have you ever used benzos daily? If yes, how recently did you use them daily?
- 7) When was the last time you used alcohol, if ever? _____. Have you ever used alcohol daily? If yes, how recently did you use it daily?
- 8) When was the last time you used cocaine in any form, if ever? _____. Have you ever used cocaine in any form daily? If yes, how recently did you use it daily?
- 9) When was the last time you used amphetamines (including crystal meth, adderall), if ever? _____. Have you ever used amphetamines daily? If yes, how recently did you use them daily?
- 10) When was the last time you used marijuana / cannabis / THC, if ever? _____. Have you ever used THC daily?

Medical History:

- 1) When did you last see a medical doctor? Who and for what? What is the name of your current medical provider(s)?
- 2) What are your medical diagnoses, if any, past and present?
- 3) What medications do you currently take?
- 4) Do you need to be taking any prescribed medications that you are currently not taking?
- 5) Have you ever been hospitalized? If yes, for what and dates?
- 6) Do you have any problems ambulating or breathing? Do you have current or regular bouts of chest pain or shortness of breath?

Mental Health History:

- 1) When did you last see a mental health provider, if ever? Who and for what? What is the name of your mental health provider?
- 2) Have you ever been hospitalized for mental illness? If yes, dates, for what diagnosis(s), episodes, where?
- 3) Do you take any medications for mental health currently?
- 4) Do you need to be taking any mental health medications that you are currently not taking?
- 5) Have you ever been diagnosed as having bipolar disorder? Schizophrenia?

- 6) Have you ever had hallucinations (seen or heard things that are not there)?
- 7) Have you ever attempted suicide? Do you currently have any thoughts of hurting yourself or anyone else?

How did you hear about McLeod Center? _____

Why do you want to enter treatment?

Sending your referral:

***Providers: Please include in your fax: completed McLeod Referral form, clinical assessment and/or mental status examination, and most current medication list.

You can send your information to the McLeod Referral fax at 704-972-2086, Attention: Michelle Barker

If you do not have access to a fax machine feel free to email your information to:
michelle.barker@mcleodcenter.com