Pioneer Human Services
Pioneer Center East

Admission Screening

Name: ___________________________________ Date of Birth: ___/___/____ Date of first Contact: ___/___/____

Date of Assessment: ___/___/____ Where is the client coming from: ______________________________________

Contract/Payer: ***(Check all that apply)***
MCO: ____ Pre-Auth rec'd: __/___/___ # Days: _______
Other: ____ Days approved: _________________________

Notes: ____
____

Use and W/D history:
Date of last use: ___/___/___ Substance used:____________________________________ IV user: Y N
Date of last use: ___/___/___ Substance used:____________________________________ IV user: Y N
Current MAT recipient: Y N Date started: ___/___/___ Medication: ___________________
Returning client? Y N Date: ___/___/___ Completed: Y N

Notes: ____
____

Medical/Psychiatric:
Presenting medical or psychiatric problems:
____
____

Compliant with meds: Y N If not, why: ____
Stable on Medications: Y N If not, why: ____

History of any of the following: *(any checked boxes require elaboration)*
- Suicidal Ideation/Attempt
- Homicidal Ideation
- Self-harm
- Audio/Visual Hallucinations
- Eating disorder

Currently Pregnant: Y N How many weeks: _______ OB Provider: ______________________________
Can complete all ADLs: Y N
Assistance needed:
____
____
Hospitalized in last 30 days: Y N Date: ___/___/___ Place: ___________________________________
Reason: ____

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Do you have a history of seizures: Y N Date of last seizure: ___/___/___
Allergies: ____

Notes: ____
____

Legal History/ Involvement:

Do you have any of the following charges:
Arson ___________________ Assault____________________ Homicide ______________________
Sexual offense _____________________________Level: ___ Kidnapping __________________________
Active No Contact orders___________________ Pending charges ______________________________
Other violent crimes: ____

Currently on supervision
Currently in confinement
Known Gang affiliation
Evictions

Notes: ____
____

Below portion to be completed by Pioneer Center East staff only:

Approved Denied Reason for denial: _________________ Requires additional Information (see notes)

Requires Approval by Provider

Notes:

Reviewed By: ____ Date: ___/___/____