Warrior Spirit Intake Screening Date: _____

Potential Client Name: _____

Tribal Affiliation: _____ Enrollment #: _____

Current location: _____

Last Use and substance: _____

Detox: Yes. ____ No ____ why not? _____

Legal Issues. Current: _____

Past: _____

Medications: _____

Medical Problems: _____

Psychiatric Diagnosis: _____ Psych Hospitalization in past year: _____

Suicidal Ideation: 1 2 3 4 5 6 7 8 9 10

Self-Harm: _____ History of Eating Disorder: _____

Gang Affiliation: _____ Registered Sex Offender: _____

Assessment from Agency:

Yes: ____. No: ____ why not: _____

Verification of Insurance:

DOB: _____

ID or SSN #: _____

Clinical Feedback:

Approved: ☐

Denied: _____

Need more information: _____