TCOYL Intake Form

Name: ____ Date:____/____/______

Date of Birth: ____/____/______Age: ____ Place of Birth:______________________

Citizenship (circle one): Y / N SS#_______-_____-________ Sex (circle one): M / F

Marital Status (circle one): M S W D

Contact Info:
Mobile Phone: ____-____-______ Home Phone: ____-____-______
Email:_____________________________
Home Address:____
City: _____________________________ State: _________________ Zip Code:____________

Education level:____

Is your family willing to support you and/or participate in the treatment procedure? Yes [ ] No [ ]
Do you want your spouse or significant other to know about this program/procedure? Yes [ ] No [ ]

Please list the names and phone numbers of individuals TCOYL PLUS is authorized to give information to:
____
____
____

How did you hear about TCOYL PLUS:____

Treatment History (Please describe any treatment you've received from Residential
Treatment Programs, Outpatient Programs, Clinicians and/or Therapists and include
reason for discharge):
____
____

Do you have ALLERGIES? Yes [ ] No [ ]
Drug Name: _________________________Reaction:______________________
Drug Name: _________________________Reaction:______________________
Drug Name: _________________________Reaction:______________________

Please List ALL Medications:
1. Medication: ________________________ Amount: _____________
Dosage:________________
2. Medication: ________________________ Amount: _____________
Dosage:________________
3. Medication: ________________________ Amount: _____________
Dosage:________________
4. Medication: ________________________ Amount: _____________
Dosage:________________
5. Medication: ________________________ Amount: _____________
Dosage:________________
6. Medication: ________________________ Amount: _____________
Dosage:________________
7. Medication: ________________________ Amount: _____________
Dosage:________________

Do you have a current or past diagnosis of any of the following?
Diabetes Type 1/Type II: Yes [ ] No [ ]
High blood pressure: Yes [ ] No [ ]
Cancer: Yes [ ] No [ ]
Heart disease: Yes [ ] No [ ]
Hepatitis / type ____: Yes [ ] No [ ]
HIV: Yes [ ] No [ ]
Lyme disease: Yes [ ] No [ ]
Fibromyalgia: Yes [ ] No [ ]
Chronic fatigue: Yes [ ] No [ ]

Emergency care or other hospitalization?
Please list any history of emergency care, such as stroke, heart attack, acute gallbladder,
or pancreas, kidney stone, ectopic pregnancy, broken bones, vehicular accident,
concussion, or other injury or severe acute illness that resulted in hospitalization.
____
____
____
____
I certify that the above information is accurate and I have not knowingly omitted any significant condition(s) that may be potentially life threatening.
Signed____ Date:
____