



Lakewood - 9720 South Tacoma Way, Lakewood WA 98499 Phone: 253-503-3666 Fax: 253-503-1633	Tacoma - 3727 South Tacoma Way, Tacoma, WA 98409 Phone: 253-300-7474 Fax: 253-442-6122	Puyallup - 3800 3rd St SE, Puyallup WA 98374 Phone: 253-200-0415 Fax: 253-845-4742	Tacoma- 5929 Westgate Blvd., STE A Tacoma, WA 98406 Phone: 253-503-0226 Fax: 253-625-7912
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Date: _____

Patient Admission Form

New Admit Transfer Re-Engage First Contact Date: _____ Phone In Person Episode: _____

Client Demographics

Legal Name: _____ **Preferred Name:** _____

DOB: _____ **SSN:** _____

Marital Status: Single/Never Married Married Divorced Separated Widowed

Race: Alaskan Native American Indian Asian Black/African American Native Hawaiian
 Multi-Racial Other Pacific-Islander White Unknown Refused to Identify
 Other: _____

Ethnicity: Hispanic/Latino: Central American Cuban Dominican Mexican Puerto Rican
 South American Not Hispanic/Latino Refused to Identify Unknown Other: _____

Gender: Female Male Transgender Female Transgender Male Non-Binary Unknown
 Choosing not to disclose Other: _____

Sexual Orientation: Straight/Heterosexual Gay/Lesbian Bisexual Queer/Pansexual/Questioning
 Unknown Choosing not to disclose Other: _____

Housing Status: Independent Housing Shared Housing Homeless Homeless (Sheltered)
 Residential Care Crisis Residence Institutional Setting Jail/Correctional Facility
 Other: _____ Unknown Other: _____

Military Status: No Yes – VA Benefits Yes – No VA benefits Unknown Refused to answer

Employment: Full Time Part Time Unemployed Homemaker Student Retired Disabled
 Sheltered/ Non-Competitive Employment Unknown Not Collected Other: _____

Pregnant: No Yes, LMP: _____

Religious or Cultural Considerations: _____

Seeking the following services: Mental Health MAT SUD Primary Care Other: _____

Would like support with: Housing Food Transportation Employment Other: _____



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Contact Information	
Address: _____	City: _____ State: _____ ZIP: _____
Primary Phone Number: _____	Secondary Phone Number: _____
Email: _____	Driver's license #: _____
Emergency Contact	
Name: _____	Phone: _____ Relationship: _____
Insurance	
Primary Insurance: _____	Secondary Insurance: _____
ID: _____	ID: _____
Questionnaire	
How did you hear about us/Referral Source: _____	
Substances Used: _____	
Last date of use: _____	
Other Concerns: _____	
Last assessment date and treatment facility: _____	
Are you transferring from another program? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	ROI Signed: <input type="checkbox"/> No <input type="checkbox"/> Yes
Are you Court ordered to complete treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes	Copy of court order: <input type="checkbox"/> No <input type="checkbox"/> Yes
Are you seeking services for a DUI? <input type="checkbox"/> No <input type="checkbox"/> Yes	Copy of driving abstract/police report: <input type="checkbox"/> No <input type="checkbox"/> Yes