



# Pre-Admission Form

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If you need assistance in completing this form, feel free to ask office staff or contact us at:  
 541-278-6330 / Pendleton  
 541-564-9390 / Hermiston

Please Answer Each Question

<b>CLIENT INFORMATION</b>		PAT ID# (leave blank)	Date of Birth.
Legal Last Name.		Home Phone.	
Legal First Name.		Cell Phone.	
Middle Initial		SSN.	
Name at Birth.		Preferred Name.	
Mailing Address.		City.	
County of Residence.		State.	
County of Responsibility.		Zip.	
Is it OK to send a letter? <input type="checkbox"/> YES <input type="checkbox"/> NO		Legal Guardian.	
Is it OK to call this number? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is it OK to leave a message? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>Race.</b> <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other single Race <input type="checkbox"/> Two or more Unspecified <input type="checkbox"/> White		<b>Ethnicity.</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Hispanic non-specific <input type="checkbox"/> Not of Hispanic Origin <input type="checkbox"/> Other Specific Hispanic <input type="checkbox"/> Puerto Rican	
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		<b>Tribal Affiliation.</b> <input type="checkbox"/> Burns Paiute Tribe <input type="checkbox"/> Conf. Tribes of Coos, Lower Umpqua & Siuslaw <input type="checkbox"/> Conf. Tribes of Grande Ronde <input type="checkbox"/> Conf. Tribes of Siletz <input type="checkbox"/> Conf. Tribes of Umatilla <input type="checkbox"/> Conf. Tribes of Warm Springs <input type="checkbox"/> Coquille Indian Tribe <input type="checkbox"/> Cow Creek Band of Umpqua Indians <input type="checkbox"/> Klamath Tribes <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable	
<b>Primary Language.</b>		<b>Group Number.</b>	
<b>Interpreter Needed?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>Primary Insurance ID#.</b>	
<b>Interpreter Type.</b> <input type="checkbox"/> Foreign Language <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> None			
<b>Marital Status.</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Married/Living as married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed			
<b>Primary Health Insurance.</b> <input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> Private Ins. <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> None			

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<p><b>Veteran Status.</b> <input type="checkbox"/> No <input type="checkbox"/> No, but Current or Former Guard/Reserve Military <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Yes, Current or Former Active Duty Military</p> <p><input type="checkbox"/> Yes, Current or Former Guard/Reserve Military</p> <p><input type="checkbox"/> Yes, Not Specified Branch of Service</p>	<p><b>Employment Status.</b> <input type="checkbox"/> Disabled</p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Homemaker</p> <p><input type="checkbox"/> Hospital Patient/Resident of Other Institutions</p> <p><input type="checkbox"/> Not in Labor Force (not looking for work)</p> <p><input type="checkbox"/> Other Reported Classification (e.g. Volunteers)</p> <p><input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Sheltered/Non-competitive Employment <input type="checkbox"/> Student <input type="checkbox"/> Unemployed (Looking for work) <input type="checkbox"/> Unknown</p>
<p><b>Employer.</b></p>	<p><b>Employer Address.</b></p>
<p><b>Employer Phone.</b></p> <p><b>Your Monthly Income.</b> _____</p> <p><b>Others Monthly Income.</b> _____</p> <p><b>Total Income.</b> _____</p>	<p><b>Living Arrangement.</b> <input type="checkbox"/> Alcohol &amp; Drug Free Housing <input type="checkbox"/> Foster Home <input type="checkbox"/> Jail <input type="checkbox"/> Other Private Residence <input type="checkbox"/> Oxford Home <input type="checkbox"/> Prison <input type="checkbox"/> Residential Facility <input type="checkbox"/> Room &amp; Board <input type="checkbox"/> Supported Housing <input type="checkbox"/> Supported Housing (congregate) <input type="checkbox"/> Supported Housing (scattered site) <input type="checkbox"/> Transient/Homeless <input type="checkbox"/> Unknown</p>
<p><b>Source of Income.</b> <input type="checkbox"/> Wages/Salary <input type="checkbox"/> Public Assist. <input type="checkbox"/> Disability/SSDI <input type="checkbox"/> Retirement/Pension/SSI <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown</p>	<p><b>Source of Payment.</b> <input type="checkbox"/> AMH/County Fin. Asst. Agreement <input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> Other <input type="checkbox"/> Other Governmental Non-Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Self-Pay <input type="checkbox"/> Unknown <input type="checkbox"/> Worker's Comp</p>
<p><b>Number of Dependents.</b></p>	<p><b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown</p>
<p><b>Number of Dependents under 18.</b></p>	<p><b>DUII Arrests in past month.</b></p>
<p><b>Highest Grade Completed.</b></p>	<p><b>Total Arrests including DUII.</b></p>
<p><b>Tobacco Use?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown</p>	<p><b>SID # (if applicable).</b></p>
<p><b>Arrests in past month.</b></p>	<p><b>Reason for Services.</b></p>
<p><b>Total DUII Arrests.</b></p>	<p><b>Emergency Contact Address.</b></p>
<p><b>Driver's License or ID# (DUII only).</b></p>	
<p><b>Referral Source.</b></p>	
<p><b>Emergency Contact Name &amp; Phone.</b></p>	

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**SUBSTANCE PROBLEMS**

<b>Primary Substance</b>	<b>Age at First Use</b>	<b>Frequency of Use</b>	<b>Usual Route of Administration</b>
<b>Secondary Substance</b>	<b>Age at First Use</b>	<b>Frequency of Use</b>	<b>Usual Route of Administration</b>
<b>Tertiary Substance</b>	<b>Age at First Use</b>	<b>Frequency of Use</b>	<b>Usual Route of Administration</b>
<b>Frequency of attendance at self-help groups during the past month.</b> <input type="checkbox"/> None <input type="checkbox"/> 1-3 times <input type="checkbox"/> 4-7 times <input type="checkbox"/> 8-15 times <input type="checkbox"/> 16-30 times <input type="checkbox"/> Some attendance, but frequency unknown <input type="checkbox"/> Unknown			

By Signing, I certify that I have answered these questions to the best of my knowledge

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

GAIN-Short Screener (GAIN-SS)  
Version [GVER]: GAIN-SS 2.0.3

What is your name? a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_  
(first name) (M.I.) (last name)

What is today's date? (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

<p>The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.</p> <p>After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago (2), "1 or more years ago" (1), or "Never" (0).</p>	In the past month	2 to 12 months ago	1 + years ago	Never
	3	2	1	0

IDSr 1. When was the last time that you had significant problems...

- a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?.....3      2      1      0
- b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?..... 3      2      1      0
- c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?.....3      2      1      0
- d. with becoming very distressed and upset when something reminded you of the past?.....3      2      1      0
- e. with thinking about ending your life or committing suicide?.....3      2      1      0

EDScr 2. When was the last time that you did the following things two or more times?

- a. Lied or conned to get things you wanted or to avoid having to do something?.....3      2      1      0
- b. Had a hard time paying attention at school, work, or home?.....3      2      1      0
- c. Had a hard time listening to instructions at school, work, or home?.....3      2      1      0
- d. Were a bully or threatened other people?.....3      2      1      0
- e. Started physical fights with other people?.....3      2      1      0

SDScr 3. When was the last time that...

- a. you used alcohol or other drugs weekly or more often?.....3      2      1      0
- b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs?.....3      2      1      0
- c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?..... 3      2      1      0
- d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events..... 3      2      1      0
- e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?.....3      2      1      0

