



Date: \_\_\_\_\_

AMCI ID # \_\_\_\_\_

### REQUEST FOR SERVICES

Name:

\_\_\_\_\_ (First) (Middle Initial) (Last)

STREET Address: (no P.O. Boxes please)

\_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Another # where you can be reached \_\_\_\_\_

SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male  Female  Date of Birth: \_\_ (mm) / \_\_\_\_ (dd) / \_\_\_\_ (yy)

What type of services are you requesting?

\_\_\_\_\_ Alcohol Assessment \_\_\_\_\_ Drug Assessment What type of drug? \_\_\_\_\_

Other: \_\_\_\_\_

Who referred you? (PO, Courts, Family, Self ... etc.)

\_\_\_\_\_

Do we need to report to probation, parole, or metropolitan court that you are being assessed?

Yes  No

Who should we report to?

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Organization Person Title Phone

Are you currently in a treatment program?

Name \_\_\_\_\_

Do you have health insurance? Name \_\_\_\_\_

Do you have Medicaid? What type (Lovelace, Pres, Molina, UNMCare ...etc)

\_\_\_\_\_

Are you pregnant? Yes  No



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**AMCI HEALTH HISTORY FORM**

Client Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Health Insurance type including Medicaid \_\_\_\_\_

Physician name \_\_\_\_\_ Phone \_\_\_\_\_

**Please check any medical condition you have ever had in your lifetime**

- |  |   |
|--|---|
| <input type="checkbox"/> Alcohol Use                         | <input type="checkbox"/> Inherited Disorders      |
| <input type="checkbox"/> Allergies                           | <input type="checkbox"/> Kidney/Bladder           |
| <input type="checkbox"/> Anesthetic Complications            | <input type="checkbox"/> Major Accidents          |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Mental Illness           |
| <input type="checkbox"/> Blood Disease/Anemia                | <input type="checkbox"/> Mitral Valve Prolapse    |
| <input type="checkbox"/> Blood Transfusion                   | <input type="checkbox"/> Musculo/Skeletal         |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Physical/Sexual Abuse    |
| <input type="checkbox"/> Congenital Malformations            | <input type="checkbox"/> Pregnant                 |
| <input type="checkbox"/> DES/Hormones                        | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Drugs                               | <input type="checkbox"/> STD's                    |
| <input type="checkbox"/> Eating Disorders                    | <input type="checkbox"/> Surgery                  |
| <input type="checkbox"/> GYN Surgery                         | <input type="checkbox"/> Thyroid                  |
| <input type="checkbox"/> Heart Disease                       | <input type="checkbox"/> Tobacco Use              |
| <input type="checkbox"/> <b>Hepatitis/Liver</b>              | <input type="checkbox"/> <b>Tuberculosis (TB)</b> |
| <input type="checkbox"/> <b>HIV/AIDS</b>                     | <input type="checkbox"/> Ulcers/Colitis           |
| <input type="checkbox"/> History of Injection Drug Use       | <input type="checkbox"/> Uterine Abnormality      |
| <input type="checkbox"/> History Abnormal Pap                | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Infertility                         | <input type="checkbox"/> Varicosities/Phlebitis   |
| <input type="checkbox"/> <b>Methicillin-Resistant</b>        | <input type="checkbox"/> Other                    |
| <input type="checkbox"/> <b>Staphylococcus Aureus (MRSA)</b> |   |

Is there anything else you'd like to tell us about your medical history?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_