Driver Intervention Program - Intake

This information should be filled out by DIP staff to guarantee DIP standards are being met.

Client Name or ID #: _____ **Date intake completed:** _____

Is the client currently taking any prescription drugs? ◯ **Yes** ◯ **No** **If yes, list type of medication and amount brought to the program.**

Medication(s):	Amount	Medication(s):	Amount

Is the client pregnant? ◯ **Yes** ◯ **No** ◯ **Not Applicable**

Is the client currently taking any over-the -counter medications? ◯ **Yes** ◯ **No** **If yes, list type of medication and amount brought to the program.**

Medication(s):	Amount	Medication(s):	Amount

Does the client have any special dietary requirements? If yes, list: ◯ **Yes** ◯ **No**

Does the client have any known allergies to medications? ◯ **Yes** ◯ **No** **If yes, list medicine and reactions:**

Does the client have any food reactions? ◯ **Yes** ◯ **No** **If yes, list food and reactions:**

Does the client have any special needs? ◯ **Yes** ◯ **No** **If yes, list needs:**

Emergency Contact Information:

Name _____ Relationship: _____

Address _____ Telephone: _____

City _____ State _____ Zip Code _____

_____ _____

Signature Date

Driver Intervention Program - Screening

This information should be filled out by DIP staff to guarantee DIP standards are being met.

Client Name or ID #: **Date screening completed:**

Presenting problem and/or precipitating factors leading to the need for a screening:

Past and present use of alcohol and other drugs:

Client's history of AoD treatment:

Medical problems:

Legal history:

Signature

Date

Screening Instruments Administered

This information should be filled out by DIP staff to guarantee DIP standards are being met.

Client Name or ID #: **Date intake completed:**

First screening instrument used: **Results:**

Second screening instrument used: **Results:**

Recommendations for referral, if applicable, for a comprehensive assessment to determine the extent and severity of alcohol and other drug abuse problems and need for treatment:

Signature and credentials

Date

Please rate your overall satisfaction with the product.