Rocky Mountain
TREATMENT CENTER

PHONE: (406) 453-5080 / FAX: (406) 727-8172

www.RehabRocky.com

920 4th Ave North, Great Falls, MT 59401

In-Network with most Insurance Companies and Private Pay Accepted. Unfortunately, Medicare/Medicaid is not accepted as a form of payment. Please call admissions and we will be happy to assist you in completing the Intake Form. We greatly appreciate the opportunity to work with you.

Name of Individual / Agency referring Client: _____

Phone Number and Best Time to Call Back: _____

Client's Name: _____ **Client's Phone Number:** _____

Date of Birth: _____ **Sex:** Male / Female **If Female, Possible Pregnancy:** Yes / No

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Insurance Type: _____ **ID#:** _____ **Group#:** _____

Drug & Alcohol Use History: _____ **Date of Last Use:** _____

Length of Use: _____ **Amount Used:**_____ **Detox history:** _____ **Prior Treatment:** _____

Motivating Factors for Seeking Treatment: _____ **Living Situation:** _____

Suboxone use: YES / NO **If Yes, Use History:** _____ **How Long:**_____

Method of Use: _____ **When Using, How Much Do You Use:** _____

Diagnosed Medical Conditions:_____

Allergies: _____ **Medications:** _____

Seizures: YES / NO **If Yes, Last Occurrence:** _____ **Due to Substance Use:** YES/NO

If Medical, Do Seizures Occur While Taking Medications: YES / NO **If Yes, are you Taking Prescribed Meds Daily:** YES / NO

Mental Health History: _____

Suicidal Ideation: YES / NO **If Yes, Please Specify Suicidal History:** _____

History of Cutting: YES / NO **If Yes, Last Cutting Occurrence**: _____

Are You A Registered Violent or Sexual Offender: YES / NO **Pending Legal Concerns:** YES / NO

If Yes, Please Specify: _____

Open Wounds / History of MRSA: YES / NO **Ambulation / Disabilities:** YES / NO **Stairs OK:** YES / NO

Preferred Bed Date and Time of Admission: _____