

MEN'S FIRSTSTEP
 WOMEN'S FIRSTSTEP

OKC METRO ALLIANCE
SCREENING

REFERRAL SOURCE: (Circle One)

COURT DHS PROBATION DRUG COURT ATTORNEY SELF OTHER _____

NAME: _____ DATE: _____ MALE FEMALE

DOB: _____ AGE: _____ SOCIAL SECURITY # _____

PHONE #: _____ HOMELESS: Yes No

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ CHILD SUPPORT GARNISHMENT? Yes No _____

ETHNIC GROUP: _____ VETERAN: Yes No

TRIBAL AFFILIATION: _____ Are you pregnant? Yes No

Have you registered as a Sex Offender? Yes No if yes, refer to Hands Up Ministry 405-236-3349
Are you able to work six (6) days/week? Yes No willing to commit to 6 to 24 month program? Yes No
Are you able to lift 40 pounds? Yes No are you currently receiving Workers Comp? Yes No
SSI/SSDI/Military Disability Yes No Amount? _____
Have you ever been a client at Firststep? Yes No Month/Year? _____
Do you know any current or former clients of Firststep? Yes No If so, who: _____

FAMILY/EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

LEGAL INVOLVEMENT Yes No

COUNTY _____ CASE NUMBER _____

JUDGE: _____ PHONE: _____ ADDRESS: _____

ATTORNEY _____ PHONE: _____ ADDRESS: _____

PO: _____ PHONE: _____ ADDRESS: _____

DHS: _____ PHONE: _____ ADDRESS: _____

PENDING CHARGES: _____

Are any of your charges violent, present or previous? Yes No EXPLAIN: _____

Do you have any domestic violence issues? Yes No _____

One form of valid state issued photo ID (non DOC) and a SSC are required to be admitted to the program.

Driver's License Yes No

State ID Yes No

Social Security Card Yes No

Birth Certificate Yes No

Substance Abuse Issues: (Check yes or no)

Tobacco: (cigarettes, chewing tobacco, cigars) Yes No Date last used: _____

Alcoholic Beverages: Yes No Date last used: _____

Marijuana: (Pot, weed, grass) Yes No Date last used: _____

Cocaine: (coke, crack, rock) Yes No Date last used: _____

Meth: (speed, crystal meth, ice) Yes No Date last used: _____

Inhalants: (glue, gas, paint) Yes No Date last used: _____

Sedatives/Benzos: (Xanax, Valium, Klonopin) Yes No Date last used: _____

Hallucinogens: (LSD, acid, mushrooms, PCP, X) Yes No Date last used: _____

Heroin or Opium: Yes No Date last used: _____

Prescription Opioids Yes No Date last used: _____
(Fentanyl, Oxycodone, Hydrocodone, Methadone, Suboxone, Subutex)

Other _____ Yes No Date last used: _____

Have you ever injected drugs for a non-medical use: Yes No

Physical and Mental Health Concerns: (check Yes or No)

Have you had or do you have suicidal or homicidal thoughts? Yes No (If yes, please specify) _____

Do you have diabetes? Yes No Do you have asthma, COPD
or other breathing disorders? Yes No

Do you have allergies Yes No If yes, please list _____

Are you currently receiving treatment for/or have any physical health concerns? Yes No (If yes, please specify) _____

Do you have or have you ever had any broken bones? Yes No (If yes, please specify) _____

Are you currently recovering from any recent surgery or procedures? Yes No (If yes, please specify) _____

Are you currently taking any prescribed medications for physical health problems? Yes No _____

Do you have any history of seizure, stroke or heart attack? Yes No

Are you currently receiving treatment for/or have any mental health concerns? Yes No _____

Are you currently taking any prescribed medications for mental health problems? Yes No _____

You need to have enough med's that will last you for 30days? Are you able to have a 30 day supply when you come in? _____

When is the last time you worked? Date: _____

SCREENER SIGNATURE: _____ DATE: _____