## **HDDTC Intake Form**

	Referral Date: Referral Source:					
Defendant (	Contact Information:					
Name:	DOB: Last 4 SSN:					
Address:						
	Email:					
Substance o	of Choice: Date of last use:					
Case/Court	Information:					
Charge(s): _						
Case #(s):						
Next Hearing Date/Time: Hearing Type:						
Transferring	Court Name/location:					
	son:					
Phone #:	Email:					
Attorney Co	ontact Information:					
Name:	P#:					
Phone #:	Email:					
Defendant l	Demographics: (check all that apply)					
Gender:	Male Female Non-Binary Unknown Prefer not to answer					
	Other					
Pronoun:	He/Him She/Her They/Them Unknown Prefer not to answer					
	Other					
Ethnicity:	Hispanic or Latino/a Non-Hispanic or Latino/a Unknown Prefer not to answer					
Race:	African American/Black American Indian/Alaska Native Arab American Asian					
	Middle Eastern North African White Unknown Prefer not to answer:					
	Multi-Racial Other					
Employmen	nt: (check all that apply)  *** We will not contact your employer ***					
Are you cur	rently employed: Yes No					
If yes, are yo	ou: Full-time Part-Time Number of hours worked per week:					
Employer: _						

## HDDTC Intake Form (Continued)

Health Insurance Information: (check all that apply)						
Do you have health insurance: Yes No						
If yes, who is your provider:						
Provider Type: Medicare Medicaid Employer Private Insurance						
Treatment History: (check all that apply)						
Currently seeing a treatment provider: Yes No						
If yes, how often Therapist's name						
Therapist's contact information:						
Facility:						
Prescriptions: (check all that apply)						
Are you currently prescribed any medications: Yes No						
Do you have a medical marijuana card: Yes No						
If you are prescribed medications, please list them below:						

## \*\*\* Please send photos of prescription bottles with completed packet\*\*\*

Name of Prescription	Reason	Dosage	Frequency	Prescriber