IMPAIRED DRIVER REHABILITATION PROGRAM

Intensive Intake Questionnaire

First Name: ______________________ Middle Initial: ______ Last: ______________________

Address: ____

Telephone:(Home) _____________________________ (Cell) ___________________________

Date of birth: __________________________________

Emergency contact person_____________________________ Relationship: ________________
Phone #________________________ Alternate Number: __________________________

Primary Care Physician: ____
Address: ____
Phone: _____________________________ Preferred Hospital: _________________________

Have you ever been hospitalized? ______ Have you ever had a serious injury? ________
If yes, please explain:
____
____

Do you have any medical problems (heart, diabetes, seizures, etc)? _________________________
____

Allergies: ____
____

Please list current medications:

Medication	Doctor	Reason for taking	Will you be bringing with you to IDRP?
			□ Yes □No
			□ Yes □No
			□ Yes □No
			□ Yes □No
			□ Yes □No
			□ Yes □No

Evergreen Substance Abuse Services
45 Union St. Rutland, VT 05701
Phone: 802-747-3588 Fax: 802-775-7196