



IOP INTAKE FORM

Date of Intake: _____

Initial Screening Completed By: _____

Personal Information

Full Name: _____

Date of Birth: _____

Social Security #: _____

Gender: _____

Race: _____

Address: _____

Phone Number: _____ Email: _____

Emergency Contact Name: _____ Relation: _____

Number: _____ Email: _____

Referral Information

Referred By (if applicable): _____

Contact Information of Referrer: _____

Reason for Referral: _____

Vitals

Blood Pressure: _____ Height: _____

Pulse Ox: _____ Heart Rate: _____

Weight: _____

Urine Drug Screen (UDS)

Details: _____

Substance Use History

Substance(s) of Use: _____

(include alcohol, illicit drug, non-prescribed meds)

Primary Substance(s) of Use: _____

Frequency and Quantity of Use: _____

Age of First Use: _____

Date of Last Use: _____

Route of Administer: _____

Previous Attempts to Reduce or Quit (if any): _____

Current Medications for Substance Use (if any): _____

Overdose History: _____

Number of Overdoses: _____

Dates of Overdoses: _____

Have you ever experienced withdrawal symptoms in the past?:

Yes No

If yes, describe the symptoms you experienced:

Nausea/Vomiting

Shakes/Tremors

Sweating

Anxiety

Insomnia

Hallucinations

Seizures

Delirium Tremens (DTs)

Other: _____

Impact of Substance Use on Physical Health

1. Do you believe your substance use has affected your physical health?

Yes No

If yes, please explain: _____

2. Have any medical professionals expressed concerns about how substance use may be impacting your health?

Yes No

If yes, please explain: _____

3. Do you experience withdrawal symptoms that cause medical concerns (e.g., seizures, dehydration, heart issues)?

Yes No

If yes, please explain: _____

DX for Substance use:

Alcohol Use Disorder (AUD):

- F10.10 - Alcohol Use Disorder, mild
- F10.20 - Alcohol Use Disorder, moderate
- F10.20 - Alcohol Use Disorder, severe

Opioid Use Disorder (OUD):

- F11.10 - Opioid Use Disorder, mild
- F11.20 - Opioid Use Disorder, moderate
- F11.20 - Opioid Use Disorder, severe

Cannabis Use Disorder:

- F12.10 - Cannabis Use Disorder, mild
- F12.20 - Cannabis Use Disorder, moderate
- F12.20 - Cannabis Use Disorder, severe

Sedative, Hypnotic, or Anxiolytic Use Disorder:

- F13.10 - Sedative, Hypnotic, or Anxiolytic Use Disorder, mild
- F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, moderate
- F13.20 - Sedative, Hypnotic, or Anxiolytic Use Disorder, severe

Stimulant Use Disorder (e.g., cocaine, methamphetamines):

- F14.10 – Cocaine, Mild
- F14.20 - Cocaine, Moderate/Severe
- F15.10 - Amphetamine-type substance, Mild
- F15.20 - Amphetamine-type substance, Moderate/Severe

Phencyclidine Use Disorder (e.g., PCP)

- F16.10 - Phencyclidine Use Disorder, mild
- F16.20 - Phencyclidine Use Disorder, moderate
- F16.20 - Phencyclidine Use Disorder, severe

Other Hallucinogen Use Disorder (e.g., LSD, Psilocybin, Ketamine, Salvia)

- F16.10 - Other Hallucinogen Use Disorder, mild
- F16.20 - Other Hallucinogen Use Disorder, moderate
- F16.20 - Other Hallucinogen Use Disorder, severe

Inhalant Use Disorder

- F18.10 - Inhalant Use Disorder, mild
- F18.20 - Inhalant Use Disorder, moderate
- F18.20 - Inhalant Use Disorder, severe

Mental Health Information

1. Have you ever been diagnosed with a mental health condition? Yes No

If yes, when and where? _____

2. Are you interested in meeting with a therapist to discuss your mental health? Yes No

3. Which symptoms have you experienced in the LAST 2 WEEKS? (check all that apply):

NONE Depression Anxiety Mood Swings Hallucinations/Delusions Suicidal Thoughts Anger/Irritability Poor Concentration Impulsivity Self-Harming Behaviors Trouble Sleeping Decreased energy/Fatigue Increased Energy Panic/Fear

4. Do you believe your mental health has contributed to past substance use or relapses?

Yes No

If yes, please explain: _____

5. Current Psychiatric Medications: _____

6. Prescribing Provider: _____

7. Date of Last Psychiatric Evaluation: _____

8. Have you ever been hospitalized for mental health? Yes No

If yes, when and where? _____

Physical Health Information

1. Primary Care Physician: _____

2. Last physical Exam: _____

3. Do you need a referral to see a physician for a physical? Yes No

4. Do you have any current medical conditions? Yes No

If yes, please list? _____

5. Current Medications: _____

6. Are you currently able to afford your medications and medical care? Yes No

If no, please explain: _____

7. Allergies: _____

• **Other:** _____

Housing and Transportation:

1. Outside of treatment or detox facilities, where do you live?

Homeless

Living with Family/Friends

Own/Rent Housing

Other (please specify): _____

2. Do you have consistent access to transportation? Yes No

Employment Status

1. Are you currently employed? Yes No

If yes, what type of job? _____

If yes, what is your schedule? _____

Education

1. Highest Level of Education Achieved: _____

2. Are you currently in school? Yes No

If yes, where? _____

3. Can you read/write in English and/or your native language? Yes No

Family and Social History

1. Describe your current family dynamic: _____

2. Do you have a support system? Yes No

If yes, who? _____

3. Are you currently in a relationship? Yes No

If yes, (check all that apply):

Supportive Stressful Involved in Substance Use Abusive Other: _____

4. Do you have children? Yes No

If yes, are you the primary caretaker? Yes No

5. Have you experienced physical violence from a loved one? Yes No

6. Have you experienced a loved one causing you emotional/psychological harm? Yes No

7. As a child, were your caregivers ever unable to supply sufficient food/shelter/clothing?

Yes No

Legal History

1. Have you ever been arrested? Yes No

If yes, please explain: _____

2. Have you ever been convicted of a crime? Yes No

If yes, what were the charges: _____

3. Have you ever been incarcerated? Yes No

If yes, when, for how long, and for what charges: _____

4. Are you currently on probation or parole? Yes No

• Probation/Parole Officer Name & Phone: _____

Strength and Goals

1. List 3 personal strengths: _____

2. What are your goals for treatment? _____

3. What do you hope to achieve by participating in services? _____

Physical Health Status

1. How would you rate your overall physical health?

- Excellent
- Good
- Fair
- Poor

2. How motivated are you to improve or manage your physical health?

- Not at all
- Somewhat motivated
- Moderately motivated
- Very motivated

3. Do you have any current medical conditions?

- Yes No

If yes, please list all diagnosed conditions: _____

4. Have you had any recent hospitalizations, surgeries, or ER visits?

- Yes No

If yes, provide dates and reasons: _____

5. Do you experience any of the following on a regular basis? (*Check all that apply*)

- Chronic pain
- Headaches or migraines
- Breathing difficulties
- Heart issue
- Gastrointestinal issues
- Fatigue or weakness
- Seizures

6. Do you have any disabilities or chronic illnesses that affect your daily functioning?

Yes No

If yes, please explain: _____

7. Do you have difficulty remembering things or making decisions? Yes No

8. Do you have any developmental disabilities or history of brain injury? Yes No

If yes, please describe: _____

9. Do you require any of the following to assist with mobility or care? Yes No

Wheelchair or walker

Personal care assistant

Home health nurse

Medical equipment (e.g., oxygen, CPAP)

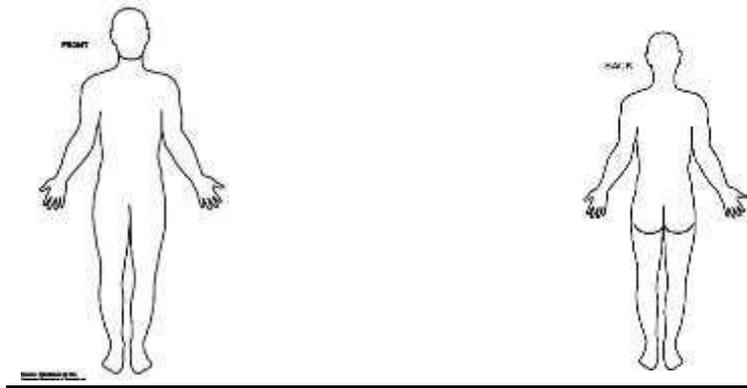
Other: _

10. Do you have any untreated or undiagnosed physical health symptoms or conditions that you are concerned about? Yes No

If yes, describe: _____

Pain Assessment Tool

Pain location



- | | | |
|-------------|---------|--------|
| • Head | • Arms | • Hips |
| • Neck | • Hands | • Legs |
| • Shoulders | • Groin | • Foot |

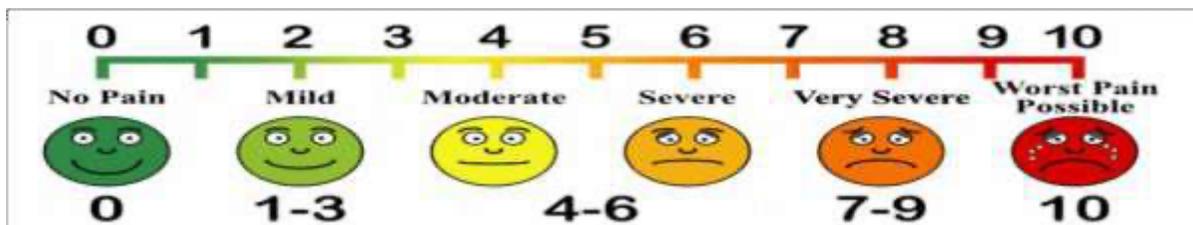
Description of pain

- Morning Afternoon Evening Night

Patient Description of Pain- Check all that apply

- | | | |
|-------|---------|-----------|
| Sharp | Tingles | Throbbing |
| Dull | Stings | Burning |
| Ache | Tender | Other |

- Does the pain radiate? Patient Unable to describe/respond



Pain Rating Score-



Nutrition Assessment

1. Food Allergies (Confirmed or suspected) Please list:

2. Have you lost or gained 10 pounds or more in the last 3 months? Yes No
If yes, how much? _____

3. Have you had a decrease in food intake and/or appetite? Yes No

4. Do you have any dental problems? Yes No

5. Do you have any of the following eating habits or behaviors?

- Bingeing
- Inducing vomiting/purging
- Misuse of laxatives

6. Do you avoid family dinners and social events involving food? Yes No

Suicide Screening

1. In the past TWO weeks, have you wished you were dead? Yes No

2. In the past TWO weeks, have you felt that you or your family would be better off if you were dead? Yes No

3. In the past week, have you been having thoughts about killing yourself? Yes No

4. Have you ever tried to kill yourself? Yes No

If yes, when and what means did you use? _____

If the client answers yes to any of the above, ask the following question:

5. Are you having thoughts of killing yourself right now? Yes No

6. Do you have a plan for how you would end your life? Yes No

If yes, what is that plan? _____

7. Do you have access to the means (weapon/pills/etc.) to end your life? Yes No



INTENSIVE OUTPATIENT PROGRAM (IOP) RULES & POLICIES AGREEMENT

Client Rules and Policies Agreement

Welcome to the Intensive Outpatient Program at Elevated Wellness Clinic. To ensure a safe and supportive environment for all clients, please review the following rules and policies. Your signature confirms your understanding and agreement.

Program Schedule

- **IOP meets Monday through Thursday**
 - **Minimum of 9 hours of group therapy per week**
-

1. Attendance and Participation

- Attend all scheduled group and individual sessions (in person or virtual)
 - Notify staff at least 24 hours in advance if you will miss a session, unless in an emergency
 - More than two unexcused absences per month may result in clinical review
 - Be on time, stay for the full session, and participate actively and respectfully
-

2. Virtual Participation Expectations

If participating virtually:

- Always keep your camera on with your face clearly visible (unless clinically approved)
 - Join from a quiet, private, and stationary location (no driving, walking, or public places)
 - Be fully present—no multitasking (e.g., cooking, texting, working)
 - Dress appropriately (no pajamas, underdressed, or lying in bed)
 - Ensure a stable internet connection—frequent tech issues may require clinical review
-

3. Sobriety and Drug Testing



INTENSIVE OUTPATIENT PROGRAM (IOP) RULES & POLICIES AGREEMENT

- Remain free from alcohol and non-prescribed substances during enrollment
 - Random drug and alcohol testing may occur
 - Refusal to test is treated as a positive result
 - Positive results may lead to clinical review and adjustment of the treatment plan
-

4. Respect and Confidentiality

- Maintain confidentiality: what is shared in group stays in group
 - Communicate respectfully with all staff and peers
 - Harassment, threats, or discriminatory language will not be tolerated
-

5. Safety and Conduct

- No weapons, drugs, or alcohol are permitted on-site
 - Violent or aggressive behavior will result in immediate removal
 - Dress appropriately for both in-person and virtual sessions
-

6. Use of Technology

- Phones must be silenced and not used during sessions unless approved by staff
 - Recording, texting, or photographing during sessions is strictly prohibited
-

7. Medication and Health Disclosure

- Inform staff of all medications you are currently taking
 - Take medications as prescribed and report any changes or concerns to staff
-

8. Treatment Engagement



INTENSIVE OUTPATIENT PROGRAM (IOP) RULES & POLICIES AGREEMENT

- Collaborate with your treatment team and work actively on your goals
 - Complete assignments and participate in all required check-ins and sessions
-

9. Discharge and Aftercare Planning

- Before program completion, a discharge plan will be developed
 - This may include referral to Outpatient Program (OP), Psychiatric Rehabilitation Program (PRP), or Outpatient Mental Health Clinic (OMHC)
 - Final clinical review will determine readiness for discharge
-

10. Crisis and Emergency Procedures

- If a crisis arises during a session, notify the facilitator immediately
 - In an emergency, call 911 or go to the nearest hospital
 - Keep current address and emergency contact information on file
-

Noncompliance

Failure to follow these expectations will result in: 1. Verbal warnings 2. Infraction Contract (Write Up) 3. Last Chance Contract 4. Discharge from the Program

Acknowledgment and Agreement

By signing below, I acknowledge that I have read, understood, and agree to follow the rules and policies of the Elevated Wellness Clinic IOP program.

Client Name: _____

Client Signature: _____

Date: _____



INTENSIVE OUTPATIENT PROGRAM (IOP) RULES & POLICIES AGREEMENT

Staff Name: _____

Staff Signature: _____

Date: _____



Virtual Group Expectations

Virtual Group Expectations

Virtual Intensive Outpatient Program (IOP)

To maintain a safe, respectful, and effective group experience, all clients are expected to follow these guidelines during virtual group sessions:

1. Attendance & Presence

- Log in **on time** and remain in group for the **full session**.
- Be fully present and engaged throughout group.

2. Phones & Distractions

- **No phone use during group.**
- No texting, scrolling, social media, or multitasking.
- Give group your full attention.

3. Camera & Participation

- Cameras must be **on at all times**, unless approved by the facilitator.
- Clients should be seated upright and attentive (not lying down, driving, or moving around).

4. Meals, Smoking & Substances

- **No meals during group.**
- **No smoking or vaping during group.**
- These activities are permitted **only during scheduled breaks**, unless otherwise approved by staff.
- Clients must attend group free from alcohol or non-prescribed substances.

5. Privacy & Confidentiality

- Attend group in a **private space** where others cannot hear.
- No recording, screenshots, or sharing of group content.
- What is shared in group stays in group.

6. Respectful Communication



- Speak respectfully and allow others to finish speaking.
- Use “I” statements and avoid judgment, interruptions, or side conversations.
- Harassment, threats, or discriminatory language are not allowed.

7. Facilitator Direction

- Follow all instructions and redirection from the facilitator.
- Concerns about group or facilitation should be discussed **outside of group time**.

8. Expectations & Accountability

Failure to follow these expectations may result in redirection, removal from group, or review of continued participation in the program.

Client Signature: _____

Date: _____