SANTA FE
Recovery Center
THE PATH TO RECOVERY

First / Last Name:_____ Date of Birth: _____

Sex: Male / Female Email Address: _____

Communication Preference: Phone / Text / Email / Letter Drug/ Substance:_____

Do you have access to the Internet?: Yes / No Primary Language:_____ Needs Interpreter?: Yes / No

Are you vaccinated against COVID?: Yes / No Are you vaccinated against the flu?: Yes / No

If NOT Covid or Flu vaccinated, Are you willing to become vaccinated: Yes / No

Do you have health insurance?: Yes / No Are you on Methadone, Suboxone, or Benzodiazepines: Yes or No

If Yes what Insurnace do you have? _____

If you are on Methadone, where is it filled?:_____

If you use Benzodiazepines, are they prescribed?:_____

Social Security Number: _____ Phone #: _____

Home Address, City, State, Zip:_____

Pronouns: _____ Sexual Orientation: _____ Ethnicity: _____ Race: _____

Tribal Association: _____ Do you live on Tribal Land?: Yes /No Are you eligible for IHS?: Yes /No

Religion: _____ Marital Status: _____ Living Situation: _____

Are you the Head of Household?: Yes / No Head of Household Employment Status: Full / Part / Unemployed / Disabled

If Head of Household is not Client, HOH Gender: Male / Female Total Income: _____

How many people live in the household?: _____ What is your highest level of education?:_____

Client Employment Status: Full / Part / Self Employed / Unempolyed Client Occupation:_____

Are you a Veteran: Yes / No Military Branch:_____ Discharge Date: _____

Type of Military Discharge: _____

Are you on Worker's Comp?: Yes / No Work Comp, Start and End Dates:_____

Agency Involvement: Drug Court / DWI Compliance / Parole & Probation

Probation/Parole Officer's Name & Number: _____

Accessibility & Conditions: Glass/Contact, Oxygen, Hearing Aid, Pacemaker, Walker, Cane, Wheelchair

Are you hearing or visually impaired?: Yes/ No Do you have any difficulty reading or writing?: Reading / Writing / None

Are you pregnant?: Yes / No / Doesn't not apply If yes, have you been for regular doctor visits?: _____

Do you have a Primary Care Provider?: Yes / No If Yes Name of Primary Care Provider (PCP): _____

Do you have any children 0-8 years old in your life? Yes or No