STEP AHEAD

DRIVER INTERVENTION PROGRAM
458 GLACIERVIEW DR. YOUNGSTOWN, OHIO 44509
PHONE: (330) 779-3801

DATE:_____

NAME:_____ PHONE:_____

ADDRESS:_____CITY:_____

STATE:_____ ZIP CODE:_____ MALE:____ FEMALE:____

S.S.#_____ DATE OF BIRTH:_____

COURT: _____ MEDICAID: _____ INDIGENT: _____

CASE # :_____ ASSESSMENT _____

PRIVATE ROOM___ SCHOOL DATE:_____ LOCATION:_____

List current over the counter and prescription drugs being taken by the client:

_____

Does client have any medical problems?

_____

Describe the pregnancy status of female clients:

_____

Does client have any allergies that include food or drug reactions?

_____

Does client have any special dietary requirements?

_____

Does client have any other special needs?

_____

Emergency contact number:

_____

Physician:_____ Phone:_____

Smoker Non-Smoker

_____
Employee Signature