CONSOLIDATED PATIENT INTAKE HISTORY
(*To be completed by patient, PLEASE take your time and fill out completely and legibly*)

Name_____

DOB _____ Age _____SS#_____

I. MEDICAL/ SOCIAL/ BEHAVIORAL (*PSYCHIATRIC) HISTORY*

Your Current or past medical conditions (*check all that apply*)

( ) Asthma/respiratory ( ) Cardiovascular (heart attack, high cholesterol, angina)

( ) Hypertension ( ) Epilepsy or seizure disorder ( ) Gastrointestinal disease

( ) Head trauma ( ) HIV/AIDS ( ) Diabetes

( ) Liver problems ( ) Pancreatic problems ( ) Thyroid disease

( ) Sexually Transmitted Diseases ( ) Abnormal Pap smear ( ) Nutritional deficiency

( ) Kidney Disease ( ) Stroke or Neurologic Problem ( ) Blood Disorder

( ) History of Tuberculosis or exposure to TB or a positive TB skin test in the past.

Other Medical problem(s) (Please describe)

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? ( ) N ( ) Y (*Please*

Have you ever taken or been prescribed **antidepressants or other psychiatric drugs**? ( )N ( )Y

If Yes what medication and for what reason?

If no longer taking above medication, why did you stop?

Please list all **current prescription medications** and how often you take them (example: Dilantin 3x/day). Include all current **over the counter, herbal medicines**, **vitamin supplements**, etc. and how often you take them as well.

DO NOT include medications you may be currently misusing (that information is needed later)

Medication Name	Dose (*strength*)	When & how many pills at a time and how often taken
For Example: Penicillin	***250 mg***	***1 tablet three times a day***

Allergies: Please list and allergies you have (medication, food, bees, etc.)

II: SUBSTANCE USE/ABUSE HISTORY

Tobacco Use: Now ( ) N ( ) Y In the past? ( ) N ( )Y

Please briefly describe your substance abuse history:

Have you ever been treated for substance abuse before now? ( ) N ( ) Y (*Please describe when, where and for how long*)

SUBSTANCE USE CHART (*VERY IMPORTANT TAKE YOUR TIME*) **When was your last dose of opiate/ narcotic before coming in for your initial doctor visit?
PLEASE BE SPECIFIC THIS IS IMPORTANT FOR YOUR SAFETY.

	NO	YES PAST	YES NOW	How Taken	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol								
Cocaine								
Crystal Methamphetamine								
Heroin								
Inhalants								
LSD or Hallucinogens								
Marijuana								
Methadone &/or Suboxone								
Pain pills i.e. oxycontin, Percocet,								
Stimulants (pills)								
Anxiety/Sleeping pills								

Have you ever overdosed? ( ) N ( ) Y
Did you ever stop using any of the above for fear of addiction ( ) N ( )Y Which ones?
What was your longest period of abstinence?
What caused you to relapse?

Name (print) _____ Last four of SSN _____ Rev. 5-29-18

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Name (print) _____ Last four of SSN _____ Rev. 5-29-18

III. SOCIAL/ LEGAL/ FAMILY HISTORY

Relationship Status:

(Circle one) Married Single Long-term relationship Divorced/Separated Widowed

Years married/ in long-term relationship _____Times Married _____

Children? ( ) N **( )** Y Current ages (list)

Residing with you? **( )** N **( )** Y If no, where?

Where are you currently living?

Are you living with anyone who uses non-prescribed drugs or street drugs or has an alcohol problem? ( ) N ( ) Y If yes describe

Do you have a support network in place? **( )** N ( )Y (*Please describe*):

Education/ Military (check most recent degree):

( ) Graduate school **( )** College **( )** Professional or Vocational School

( ) High School Grade completed _____

Are you currently employed? **( )** N Where (*if "no," where were you last employed?*)

What type of work do/did you do?

How long have/did you work(*ed*) there?

Have you ever served in the military? **( )** N **( )** Y If yes please give details

Have you ever been arrested, convicted or had to serve time in jail or prison? **( )** N **( )** Y

If yes please check the appropriate item and explain)

( ) DUI **( )** Drug-related **( )** Domestic violence **( )** Other

Have you ever been abused? ( ) N **( )** Y
( ) Physically **( )** Sexually (including rape or attempted rape) **( )** Verbally **( )** Emotionally
Who was the abuser?
If yes, have you ever been in treatment for abuse? ( )N ( )Y

Have you ever attended (Check all that apply)

Alcoholics Anonymous ( ) Current ( )Past	Narcotics Anonymous ( ) Current ( ) Past
Cocaine Anonymous ( ) Current ( )Past	Opiate Anonymous ( ) Current ( )Past
Any other counseling ( )N ( )Y If yes describe	
If you are not currently attending meetings, what factors led you to stop?	
What benefited you the most from attending meetings?	
What forms of treatment for opiate addiction have you attempted? (i.e. Inpatient, intensive outpatient, detoxification, when and how long)?	
Do you currently have any aggressive, homicidal, and/or suicidal thoughts? ( ) N ( )Y	
Other Pertinent Information:	

IV. TREATMENT GOALS & EXPECTATIONS

How did you hear about this treatment program and what are your reasons for entering this program? Please briefly describe your goals or expectations from your treatment in this clinic.

Thank you for your assistance. At the time of the visit we will review this information in further detail.

I certify that the historical information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____ _____ _____

Patient/examinee Signature **Printed Name** **Date**

If the patient/examinee required assistance completing this form or if this form was completed by someone other than the patient/examinee but done under the direction of the patient/examinee, please provide the name and relationship of that person as noted below. If spouse, friend, medical staff or legal counsel etc. so state.

_____ _____ _____

Signature of person assisting **Printed Name** **Date**

State relationship to patient _____