New Addictive Services Patient

Patient Name:____

Are you pregnant:_________

Have you ever been abused:

( ) Physically ( ) Sexually (including rape) ( ) Verbally

Are you in addiction counseling
Currently:________________Where:___________________________

MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLIES)

Asthma	Cardiovascular (heart attack, angina)	Cancer : type______________
Hypertension	HIV/AIDS	Diabetes
Motor vehicle accident with severe trauma		
Head trauma		
Liver problems	Hep C (ever treated ?)	
Pancreatic problem	Hep A or B	

PSYCHO/SOCIAL SUPPORTS (list your support system)

Family Support -____

Friend/social/peer support____

Community support____

Meaningful/Leisure Activities____

Employment: ______________________Children living in the home:__________

Drug Use History: **(PLEASE CIRCLE ALL THAT APPLIES) How many years:_____________________**

Heroin – amount:____________________________________ Date last used:_________________

Oxy – amount:______________________________________ Date last used:_________________

Percocet, Vicodin-amount:____________________________ Date last used:_________________

Cocaine – amount:___________________________________ Date last used:_________________

Benzos (Klonopin, Xanax, Ativan, etc) – amount:____________ Date last used:_________________

Do you have a history of any other addictive behaviors?

Gambling Sex Shopping Eating Disorder (over eating, bulimia, anorexia)

Addiction Treatment History

Have you ever been in a medically assisted treatment program before? _____Yes _____No

If yes, what medication were you on ?____FORM: Tablets/films__________________________

Name of clinic:___________How long were or have you been in treatment?__________________________When did you stop tx?_______________________

Smoking History: Cigarettes_____ Marijuana______

Alcohol use: Daily____ Weekly_____ Socially_______

Mental Health History:

Have you even been diagnosed with any of the following mental health conditions? **Please circle**

Depression Obsessive compulsive disorder (OCD) Bipolar ADD

Anxiety Post traumatic stress disorder (PTSD) Panic Attacks

MEDICATIONS Prescribed to you: Please list medication and reason

ALLERGIES:

SURGERIES:

____

Last pap smear: date_________________

Birth Control being used:_____________________________________