MHP
Michigan Healthcare Professionals

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Family Medicine
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PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name _____

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

Years married/ in long-term relationship _____ Times Married _____ Times Divorced _____

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

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

Where are you currently living? _____

Do you have family nearby? ( ) N (Please describe) _____

Education (check most recent degree):

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

( ) High School Grade _____

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 been arrested or convicted? ( ) N

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

Have you ever attended:

AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? ( ) N (Please describe) _____

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PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name _____

Address _____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N Date _____

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

( ) Asthma/respiratory	( ) Cardiovascular (heart attack, high cholesterol, angina)	
( ) Hypertension	( ) Epilepsy or seizure disorder	( ) GI disease
( ) Head trauma	( ) HIV/AIDS	( ) Diabetes
( ) Liver problems	( ) Pancreatic problems	( ) Thyroid disease
( ) STDs	( ) Abnormal Pap smear	( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**

MD NOTES _____

_____

_____

Is there a family history of anything NOT listed here? (Please explain) _____

_____

_____

MD NOTES _____

_____

Have you ever had ***surgery*** *or been* ***hospitalized****? (Please describe)* _____

_____

_____

MD NOTES _____

_____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

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

_____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason

_____

Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

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

_____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc. and how often you take them

_____

MD NOTES _____

_____

_____

Please list any **allergies** you have (penicillin, bees, peanuts)

_____

MD NOTES _____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _____ For how many years? _____

Pipe: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day on average? _____ For how many years? _____

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

_____

How long have you been **using substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? ( ) N (Please list)

What was your longest period of abstinence?

MD NOTES

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PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

14. I agree to provide random urine samples and have my doctor test my blood alcohol level.

15. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature _____ Date _____

*Valium® is a registered trademark of Roche Products Inc.
†Klonopin® is a registered trademark of Roche Laboratories Inc.
‡Xanax® is a registered trademark of Pharmacia & Upjohn Company