NAME:_____ DOB: _____

Today's date: _____

PATIENT INTAKE: MEDICAL AND SOCIAL HISTORY

(To be completed by patient)

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

Patient Name_____

Address _____

Phone (W)_____(H)_____(cell) _____

DOB_____Age_____SS# _____

Emergency Contact _____

Relationship to patient_____Phone _____

Primary care physician_____Phone _____

Date of last physical exam_____Findings_____

_____

_____

Have you ever had an EKG? ( )Y **( )** N Date _____

Physician performing physical _____

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

Childhood Illnesses

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

Have you ever been diagnosed with a psychiatric or mental illness or been hospitalized for mental health problems?

(Please describe)_____

_____

_____

_____

Please list all current **prescription** medications, dosages, and frequency of use (example: Dilantin, 300 mg capsules, 3x/day).

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

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

Medication, dosage, and frequency of use _____

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

Medication/Vitamin _____

Medication/Vitamin _____

Medication/Vitamin _____

Medication/Vitamin _____

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

_____

Have you ever been treated for substance abuse? ( ) Y **( )** N

If yes, please describe when, where, and for how long:

_____

_____

List current substances of abuse (including name, amount, frequency of use, how taken):

1) _____

2)_____

3)_____

4)_____

Substance Abuse History (Fill in each block)

↓Substance↓	Not misused	Currently misused	Misused in past, but not currently	Route of abuse	How much abused	How often abused	Date/Time of Last Use	Quantity last used
Alcohol								
Caffeine (pills or beverages)								
Cocaine								
Methamphetamine								
Inhalants								
LSD or other Hallucinogens								
Marijuana								
Heroin								
Methadone								
Narcotic Pain Medications (List)								
PCP								
Stimulants (example Ritalin)								
Benzodiazepines/ Sleeping Pills								
Ecstasy								
Other (List)								
Other (List)								
Other (List)								
Other (List)								

What was your longest period of abstinence? _____

When was your longest period of abstinence? _____

Current weekly cost of Substances of Abuse_____

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

Starting with what substance?_____

Tobacco History:

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

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

For how many years? _____

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

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

Provide details regarding your legal history, including DUIs, whether drug-related or not drug-related:

_____

_____

_____

Provide information regarding any history of violence, directed to self or to others:

_____

_____

(Circle one) Married Single Divorced/Separated

Current relationship: ( ) Long-term ( ) Short-term ( ) None Current

Years married/in long-term relationship_____Times Married_____Times Divorced _____

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

Children residing with you? **( )** N **( )** Y If no, where and with whom?_____)_____

_____

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

Education (check all degrees):

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

( ) High School Grade completed

High School diploma or equivalency? ( ) Y ( ) N

Are you currently employed? ( ) Y **( )** N

If No, when were you last employed?_____

If yes, what kind of work are you doing now? _____

How long have you worked there? _____

What other type of work have you done in the past? _____

History of abuse? ( ) Y **( )** N

If Yes, indicate: **( )** physically **( )** sexually (including rape or attempted rape) **( )** emotionally

Explain_____

_____

_____

Are you now or have you ever attended:

Alcoholics Anonymous **( )** Current **( )** Past

Narcotics Anonymous **( )** Current **( )** Past

Other 12-step type programs **( )** Current **( )** Past If yes, list_____

If you are not now attending meetings, why not? _____

_____

Have you ever been in counseling or therapy? ( ) Y **( )** N (If yes, please describe):

_____

_____

_____

What are your goals with regards to treatment with Suboxone:

_____

_____

_____

_____

Additional information that would be useful for me to know:

_____

_____

_____

_____

_____