

Pine Lodge Addiction Recovery Inc - Medical Form

Client Name: _____ DOB: _____

HSN: _____ Allergies: _____

Concern			Further Information
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type: _____
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
STBBI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type: _____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
HIV/AIDS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lice	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lung Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Physical Disabilities	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cognitive Disabilities	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Stabilized for Tx	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Mental Health Concerns:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Borderline Personality Disorder	<input type="checkbox"/> PTSD	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Suicidal Ideation	_____	
<input type="checkbox"/> Suicide Attempt	_____	
<input type="checkbox"/> Other(s)	_____	

Medical Appointments: _____ At _____
_____ At _____

Medications: (Medication - Dose)

_____	_____
_____	_____
_____	_____
_____	_____

☐ Client has enough medications for treatment and they are bubble packed

Completed by: _____