Palmetto Corner Initial Contact Form

Demographics

Referral Source (Name and Phone Number): _____

Patient Name: _____

Social Security Number: _____ **DOB:** _____ **Age:**_____

Sex: Male Female **If Female:** Pregnant (Due Date:_____) Not Pregnant

Race: White African American Hispanic/Latino **Other:** _____

Patient Address:

Street: _____

City: _____ **State:** _____ **Zip:** _____

Patient Phone: (H): _____ **(C):** _____

Living Arrangements: Homeless/Shelter Spouse Friends Family

Substance Abuse History

Substance	Route	Frequency	Amount Using	Age 1st Use	Last Use

Tobacco User: Yes No **History of Overdose:** Yes (Date of last: _____) No

History of Seizures: Yes (Date of last: _____) No

History of Blackouts: Yes No **History of DT's:** Yes No

Treatment History

Type of Treatment	Number of Times	Date
Inpatient (Yes/No)		
Outpatient (Yes/No)		
Detoxification Only		
Methadone Maintenance	Current Dose:	
Suboxone Maintenance	Current Dose:	

Psychiatric/Medical Status

Open Wounds: Yes No **Abscesses:** Yes No **Can walk around unassisted?** Yes No

History of Suicide Attempt : Yes (Last attempt: _____) No

Current Suicidal Thoughts: Yes No **Current Homicidal Thoughts?** Yes No

History of Hallucinations/Delusions: Yes No **NOTES:** _____

Medical/Psych Condition Diagnosis	Is condition stable?	Provider?

Medication	Dose & Frequency	Reason for Medication?

Legal Status

Current Charges: Yes No Registered Sex Offender: Yes No Past Charges: Yes No

On parole/probation: Yes (Officer Name: _____) No

Upcoming Court Dates: Yes (Date(s)_____) No

Insurance Information

Insurance/Managed Care Company:	
Policy or MA number:	
Policy Holder's Name (if different than patient)	
Policy Holder's DOB & Social Security Number (if different than patient)	