PATIENT INTAKE: MEDICAL HISTORY

Name_____**Date:__/___/___**

Address_____

Phone (W)_____ **(H)**_____ **(C)**_____

DOB_____ **Age**_____ **SS#**_____

Emergency Contact_____ **Relationship to patient**_____ **Phone**_____ **Primary care physician**_____

Have you ever had an EKG? Y 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 is a family history of any of the illnesses listed above, **please put an "F" next to that illness.**

MD NOTES

_____

_____

_____

Date: __/__/__ Patient Name:_____

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 Y N Mumps Y N Chicken Pox Y N

Have you or a family member ever been diagnosed with a **psychiatric or mental illness?**

Have you ever taken or been prescribed **antidepressants**? ( ) Y ( ) N If yes, 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).

_____

_____

Date: __/__/__ Patient Name:_____

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? Y N In the past? Y N

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

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

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

_____

Notes:_____
Date: __/__/__ Patient:_____

Substance Use History

	No	Yes/Past And/Or Yes/Now	Route	How Much	How Often	Quantity Date/Time of Last Use
Alcohol						
Caffeine (pills or beverages)						
Crystal Meth-Amphetamine						
Cocaine						
Heroin						
LSD or Hallucinogens						
Marijuana						
Methadone						

Pain Killers						
PCP						
Stimulants (pills)						
Tranquilizers /Sleeping Pills						
Ecstasy						
Inhalants						
Other						

_____

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

What was your longest period of abstinence? _____
Date:__/__/__ Patient Name_____

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(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? (Y) (N) (Please describe)

Education (check most recent degree):

( ) Graduate School ( ) College ( ) Professional or Vocational School
( ) High School Grade _____

Are you currently employed? (Y) (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? (Y) (N)
( ) DWI/DUI ( ) Drug-related ( ) Domestic violence ( ) Other
Have you ever been abused? (Y) (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 of therapy? (Y) (N) (Please describe)
_____
_____