Ashley
Addiction Treatment

Patient Name: _____

Date of Birth _____/_____/_____ Date completing this form _____/_____/_____

1. Name of Family Physician:_____ Date of Last Exam: _____/_____/_____
2. Do you have medical concerns at the present time? ☐ No ☐ Yes (if yes please describe): -
   _____
3. Preferred Pharmacy? _____
4. Please list all medications that you are currently taking, including both physician-prescribed and over-the-counter medications (aspirin, laxatives, vitamins, herbal supplements, diet pills, etc.).

MEDICATION	DOSAGE & DIRECTIONS	TAKING AS PRESCRIBED	HOW LONG HAVE YOU TAKEN?	WHO PRESCRIBES?	SIDE-EFFECTS?

5. Are you allergic to any medications or environmental substances (i.e. pollen, molds, etc.)?
☐ No ☐ Yes: _____
6. Have you had any unexpected weight gain for weight loss within the past 3 months?
☐ No ☐ Yes: _____
7. Do you smoke cigarettes, pipes, cigars, or chew tobacco?
☐ No ☐ Yes: _____
8. Are you interested in receiving Naloxone (Narcan) certification? *We offer this as a part of treatment at no additional cost.* _____
9. Family Medical History – To the best of your knowledge, please put a check if you have or anyone in your family has had the following:

	Self	Mother	Father	Brother	Sister	Children	Grandparent	Other Family
Anemia								
Arthritis								
Asthma								
Cancer								
Dementia								
Diabetes								
Eating Disorder								
Emphysema								
Epilepsy								
Heart Problems								

Irritable Bowel								
HIV/ AIDS								
Kidney Problems								
Mental Illness								
Migraines								
Substance Abuse								
Thyroid Problems								

10. Are you currently receiving mental health or substance abuse treatment elsewhere?
☐ No ☐ Yes - _____

11. Are any of the following services or agencies currently involved in your life and/or providing you with services?

Service	Yes	Service	Yes
Probation or Parole		Social security	
MH / MR		CPS	
Domestic Relations		Other Agencies or Services? _____ _____ _____	

12. Have your ever been diagnosed with the following? (Please mark yes or no)

Diagnosis	Yes	No	Diagnosis	Yes	No	Diagnosis	Yes	No
Cancer			Tuberculosis			Bleeding Disorder		
Heart Attack			Positive TB Skin Test			HIV		
Artery Disease			Arthritis			Gonorrhea/Chlamydia		
Rheumatic Fever			Gout			Syphilis		
Heart Murmur			Rheumatoid Arthritis			Herpes		
Heart Failure			Bladder Infection's			IV Drug Use		
High Blood Pressure			Kidney Stones			Migraines		
Stroke			Kidney Disease			Depression		
Diabetes			Chicken Pox			Anxiety		
Gallstones			Infectious Mono			Bipolar		
Liver Disease			Anemia			Schizophrenia		
Hepatitis			Sinus Infections			Personality Disorder		
Ulcer Disease			Glaucoma			ADD		
Heartburn / Reflux			Thyroid Disease			ADHD		
Asthma / COPD			Head Injury			Other:		
Seizures			Broken Bones					
Pneumonia			Blood Transfusion					

13. Surgical history (if applies then please indicate the year):

Surgery	Year		Surgery	Year		Surgery	Year
Eyes			Gall Bladder			Uterus	
Ears			Appendix			Spinal / Neck	
Sinus / Nasal Septum			Intestine Colon			Spinal / Back	
Tonsils / Adenoids			Hemorrhoids			Hip / Knee	
Thyroid			Hernia			Shoulder	
Heart			Hysterectomy			Hand / Feet	
Stomach			Breast			Other:	
Varicose Veins			Ovaries				
C-Section			Tubal Ligation				

14. How many hospitalizations have you had and when was your last admission? _____

_____

15. When was your last TB test? _____

16. When was your last HIV test? _____

17. When was your last Hepatitis C test? _____

18. Gynecological / Obstetrical History:

a. Date of last menstrual period? _____

b. Is there any change you are pregnant? _____

c. Are you currently using birth control? _____

d. Number of pregnancies? _____

e. Number of live births? _____

f. Any complications during birth? _____

19. Have you experienced the following in the last week?

General	Yes	No
Fatigue		
Fever		
Weight Gain		
Weight Loss		
Trouble Sleeping		

HEENT	Yes	No
Double Vision		
Blurry Vision		
Eye Redness		
Eye Pain		
Eye Drainage		
Decreased Hearing		
Ringing in Ears		
Ear Drainage		
Ear Pain		
Nose Bleeds		
Sore Throat		
Trouble Swallowing		
Oral Ulcers		
Bleeding Gums		
Broken Teeth		
Active Cavities		
Headaches		
Dizziness		

Neck	Yes	No
Neck Pain		
Swollen Glands		

Respiratory	Yes	No
Ongoing Cough		
Difficulty Breathing		
Coughing up Blood		
Wheezing		

Cardiovascular	Yes	No
Chest Paint		
Leg Pain with Walking		
Decreased Exercise Tolerance		
Shortness of Breath		
Trouble Sleeping Due to Difficulty Breathing		
Leg Swelling		

Gastrointestinal	Yes	No
Abdominal Pain		
Constipation		
Diarrhea		
Nausea		
Vomiting		
Rectal Bleeding		
Change in Bowel Habits		
Blood in Stools		
Dark Tarry Stools		

Genitourinary	Yes	No
Painful Urination		
Change in Urinary Stream		
Increased Urination		
Loss of Bladder		
Night time Urination		
Trouble Urinating		
Flank Paint		
Penile Discharge		
Testicular Pain		
Testicular Mass		
Groin Pain		
Swollen Glands		

OB-GYN History	Yes	No
Breast Mass		
Breast Pain		
Deformities		
Nipple Discharge		
Skin Changes		
Vaginal Discharge		
Irregular Periods		

Musculoskeletal	Yes	No
Joint Pain		
Joint Swelling		
Joint Deformities		
Joint Redness		
Joint Stiffness		
Muscle Aches		
Muscle Weakness		
Back Pain		

Skin	Yes	No
Rash		
New Lesions		
Nail Changes		
Change in Moles		
Inj. Site Redness		
Inj. Site Discharge		
Inj. Site Swelling		

Neurological	Yes	No
Seizures		
Tremors		
Numbness/Tingling		
Memory Issues		
Trouble Focusing		
Difficulty Concentrating		
Paralysis		
Loss of Bowel Control		
Loss of Bladder Control		

Psychiatric	Yes	No
Anxiety		
Depression		
Racing Thoughts		
Suicidal Thoughts		
Suicide Attempts		

Endocrine	Yes	No
Appetite Changes		
Cold Intolerance		
Increased Thirst		
Increased Urination		

Hematology		
Easy Bruising		
Enlarged Lymph node		
Prolonged Bleeding		

Vocational Status

- **I am presently:** ***(Please mark with an "X")***

	Employed Full-Time
	Employed Part-Time
	Assigned Temporary Work
	Unemployed
	Laid Off
	Disabled / On Disability
	Retired
	Student
	On Leave-Of-Absence

- **If employed, please provide the occupation: _____**

- **Please place an "X" in any of the following that are currently problems for you:**

	Family Problems *(i.e. death of family member, health problems in family, lack of social support, isolated from others, discrimination, do not get along well with others, etc.)*
	Social/Friendship Problems *(i.e. death or loss of friend, lack of social support, isolated from others, discrimination, do not get along well with others, etc.)*
	Job or School Problems *(i.e. unemployment, stressful schedule, poor work, school conditions, job dissatisfaction, do not get along with boss/teachers/coworkers/classmates, etc.)*
	Housing Problems *(i.e. homeless, poor housing conditions, unsafe neighborhood, problems with neighbors, problems with landlord, etc.)*
	Money Problems *(i.e. cannot pay bills, not enough money for basic necessities like food, shelter, clothing, excessive debt, bankruptcy, etc.)*
	Problems with Health Care *(i.e. do not have a doctor, do not have a way to get to appointments, do not have health insurance, cannot obtain needed medications, etc.)*
	Legal Problems *(i.e. involved in court, on probation or parole, victim of a crime, pending lawsuit, DUI, etc.)*
	Gambling Problems *(i.e. lack of control, being deceptive about the amount spent or frequency of gambling, etc.)*

Patient Name _____ DOB: _____ / _____ / _____

Ethnic Origin:

- ☐ Cuban
- ☐ Hispanic or Latino
- ☐ Mexican
- ☐ Not of Hispanic Origin
- ☐ Puerto Rican

Marital Status:

- ☐ Divorced
- ☐ Life Partner
- ☐ Married
- ☐ Never Married
- ☐ Separated
- ☐ Unknown
- ☐ Widowed

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other
- ☐ Unknown
- ☐ White

SSN: _____

Please choose <u>3 out of 5</u> questions:

1. What is your mother's maiden name? _____
2. What is your favorite color? _____
3. What is your fahter's middle name? _____
4. What is your favorite TV show? _____
5. What is the name of the street you great up on? _____