PATIENT INTAKE: MEDICAL HISTORY

Name_____

Address_____

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

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

Emergency Contact_____

Relationship to patient_____ **Phone**_____

Primary care physician_____ **Phone**_____

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

_____
_____
_____
_____
_____

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?** (Please describe)

Have you ever taken or been prescribed **antidepressants**? ( ) 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).

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? _____

Pipe: Now? Y N In the past? Y N

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

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

_____
_____
_____

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

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? ( ) N (Please describe)

_____

Education (check most recent degree):
( ) Graduate School ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Are you currently employed? ( ) 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? ( ) N
( ) DWI/DUI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) 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? ( ) N (Please describe)

_____

_____