Patient Social and Medical History

Name:

Weight: lbs Height: (feet/inches)

If you have any allergies, list them here. List all medications you are allergic to or do not tolerate

Provide the name, address, and telephone number of the person who is closest to you - spouse, parent, child, or companion

*Companions Name:

Companion Address:

*Companion Phone:

*Companion Relationship:

Provide the name, telephone, and fax numbers of your current local Primary Care Physician.

Primary Care Physician Name:

Primary Care Physician Address:

Primary Care Physician Phone:

Primary Care Physician Fax:

Prior Evaluation and Treatment

Please provide the name, address, and telephone of the clinic or physician who treated or evaluated you most recently.

Physician Name:

Physician Address:

Physician Phone:

Physician Specialty:

CHECK ANY ITEMS THAT APPLY TO YOU PRESENTLY OR IN THE PAST

1-Yes ☐	No ☐	When I use prescription drugs I am in a better mood.
2-Yes ☐	No ☐	I have used prescription drugs for other than medical reasons.
3-Yes ☐	No ☐	When I was younger I experimented with illegal drugs.
4-Yes ☐	No ☐	I feel more comfortable when I can stockpile my prescription drugs.
5-Yes ☐	No ☐	I often take prescription drugs more often than instructed.
6-Yes ☐	No ☐	I believe I may be dependent upon prescription drugs.
7-Yes ☐	No ☐	I've filled the same prescription from different doctors at the same time.
8-Yes ☐	No ☐	I tend to use more prescription drugs when I am under stress.
9-Yes ☐	No ☐	I have used other people's prescription drugs.
10-Yes ☐	No ☐	My family and friends worry about how much I use prescription drugs.
11-Yes ☐	No ☐	My use of prescription drugs has cause problems with my family or work.
12-Yes ☐	No ☐	I can think of little else if I do not have my medications.
13-Yes ☐	No ☐	I do not think I can get along without drugs.
14-Yes ☐	No ☐	I have used illegal methods to obtain prescription drugs.
15-Yes ☐	No ☐	I have been arrested as a result of prescription drugs.
16-Yes ☐	No ☐	Even though I try I cannot stop using prescription drugs.
17-Yes ☐	No ☐	Prescription drugs other than the ones I use do not seem to work.
18-Yes ☐	No ☐	I have blacked out or lost track of time while on prescription drugs.
19-Yes ☐	No ☐	I have spent money on prescription drugs which I probably didn't need.
20-Yes ☐	No ☐	Without my prescription drugs I experience withdrawal symptoms.
21-Yes ☐	No ☐	If I could no longer get my prescription drugs I could become suicidal.
22-Yes ☐	No ☐	I find myself using alcohol if I do not have my prescription drugs.
23-Yes ☐	No ☐	Using prescription drugs has caused me to have other medical problems.
24-Yes ☐	No ☐	I have considered or sought treatment for prescription drug abuse

Have you ever had any of the following conditions?

	Yes	No
Depression	☐	☐
Bipolar (Manic-Depressive) Illness	☐	☐
Panic Attacks	☐	☐
Phobias	☐	☐
Chronic Anxiety	☐	☐

If you have recently been under the care of a psychologist or psychiatrist, please provide his or her name, address, and telephone number below.

Name: ____________

Address: ____________

Phone: ____________

Suicide Attempts	☐	☐
Obsessive Compulsive Disorder	☐	☐
Physical/Sexual Abuse as a child	☐	☐
Head Injury	☐	☐

List any other psychiatric problems from which you suffer or have suffered in the past.

List any medications you currently take for any psychiatric condition or symptom.

Name Dose Frequency Reason

Have you ever used the following substances?

	Yes	No	Year Of Last Use
Marijuana	☐	☐	
Heroin	☐	☐	
Cocaine	☐	☐	
Amphetamines	☐	☐	
Alcohol to Excess	☐	☐	
Other	☐	☐	

If you've ever been treated for drug or alcohol abuse, please indicate:

A. When you were in treatment.

B. Where you received treatment:

Name:

Address:

Phone:

Have you used a methadone drug treatment program to obtain medication for pain control?

If you have had any legal problems relating to the use of drugs, alcohol, or medications, please list the year and describe the circumstances.

Education and Employment

A. Highest level of education.

B. Professional Training.

C. Most recent or current employment.

D. How long were you employed in your last position?

E. Current Employment Status

Living arrangements

Marital status.

Do you drive?

Any accidents or traffic violations while driving under the influence of medications or alcohol?

Are you involved in litigation relating to your medical condition?