FREEDOM RECOVERY CENTER

COMMUNITY-BASED RESPONSIBLE MEDICAL TREATMENT FOR OPIOID DEPENDENCY

Patient Intake Form

Use the opposite side of the page as necessary to complete your answers.
Please print legibly.

Patient name: _____ **DOB:** _____

Address: _____

_____

Phone: home (____)_____-_____ work (____)_____-_____

cell (____)_____-_____

Social security number: _____-_____-_____

Emergency Contact: _____ **Relationship to patient:** _____

Phone number: (____)_____-_____

Primary Care Physician: _____

Phone number: (____)_____-_____

Insurance: _____ **Contract number:** _____

Group number: _____ **Phone number:** (___)____-_____

Date of last physical: _____ **Have you ever had an EKG?** (circle one) **Y or N**

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)		

Family History:

Have you ever had surgery or been hospitalized? (circle one) **Y or N** If yes, please describe.

Have you or a family member ever been diagnosed with a psychiatric or mental illness? (circle one) **Y or N** If yes, please describe.

Have you ever taken or been prescribed antidepressants? (circle one) **Y or N**
If yes, please list name, dates taken, and why stopped:

List all current medications and how often you taken them:

Please list all current herbal medicines, vitamins, supplements, etc. and how often you take them:

Please list any allergies you may have:

Tobacco History:

Cigarettes (circle one): Now? **Y or No** In the past? **Y or N** Year quit? _____

Packs per day? _____ For how many years? _____

Other tobacco use? (circle one): Pipe Chewing tobacco

Substance Use History:

Have you ever been treated for substance misuse? (circle one) **Y or N** If yes, please describe.

How long have you been misusing substances? _____

What substances have you used in the past 3 months?

Did you ever try to stop using any of the above because of dependence? (circle one) **Y or N**
If yes, please describe:

_____

_____

_____

_____

What was your longest period of abstinence? _____

Are you receiving, or have you ever received counseling support? (circle one) **Y or N**
If yes please describe when and for how long:

_____

_____

_____

_____

_____

Social History:

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/in long-term relationship: _____ **Times married:** _____

Times divorced: _____

Children? (circle one) **Y or N**

Current ages (please list): _____

_____

Residing with you? (circle one) **Y or N** If no, where?

_____

Do you have family near your current residence? (circle one) **Y or N**
Please describe:

_____

_____

Education: (check most recent degree)

( ) Graduate School ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Are you currently employed? (circle one) Y or N

Where? If no, where were you last employed?

_____

What type of work do/did you do?

Length of employment: _____

Have you ever been arrested or convicted? (circle one) **Y or N**
Check all that apply:

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other _____

Are you currently in legal trouble? (circle one) **Y or N**
Please describe:

Have you ever been abused? (circle one) **Y or N**
Check all that apply:

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally

( ) Emotionally

Have you ever attended: (check all that apply)

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?

Thank you for completing the intake form. Please hand in to physician to review.