S.C.A.N.

Change is beautiful

PATIENT INTAKE: MEDICAL HISTORY

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

Name: _____

Address: _____

Phone: (w) _____ (h) _____ (c) _____

DOB: _____ Age: _____SS no.: _____

Emergency contact: _____

Relationship to patient: _____ Phone: _____

Primary care physician: _____ Phone: _____

Date of last physical: _____ How did you hear of The SuboxCAN Clinic?_____

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

Other (Please describe) : _____

_____

_____

If there is a family history of any of the illnesses listed above, **please put an "F" next to that illness**.

Have you ever had **surgery** or been **hospitalized**? ( ) N ( ) Y (Please describe) _____

_____

Please note any family history of Alcohol/Drug Abuse or Dependence:

_____

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: _____

_____

Please list any **allergies** you have (eg, penicillin, bees, or peanuts): _____

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? **( )** N **( )** Y (Please describe) _____

_____

Have you ever taken or been prescribed **antidepressants**? **( )** N **( )** Y For what reason _____

Medication(s) and dates of use_____

_____Why stopped: _____

Are you receiving, or have you ever received counseling support? **( )** N **( )** Y (Please describe when and for how long) _____

MD NOTES: _____

_____

_____

Tobacco: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y

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

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

_____

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

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Suboxone							

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

_____

_____

What was your longest period of abstinence? _____

Have you ever experienced withdrawal? **( )** N **( )** Y

MD NOTES: _____

_____

_____

SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name: _____

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

Years married/in long-term relationship: _____Times married: _____Times divorced: _____

Children? **( )** N **( )** Y Current ages (Please list) _____

Residing with you? **( )** N **( )** Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? **( )** N **( )** Y (Please describe) _____

Education (check most recent degree):

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

( ) High School Grade _____

Are you currently employed? **( )** N **( )** Y 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 **( )** Y (Check all that apply)

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

Have you ever been abused? **( )** N **( )** Y

( ) 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 or therapy? **( )** N **( )** Y (Please describe) _____

_____

MD NOTES: _____

_____

_____