Addiction Medicine Intake

Medical

1. Number of times hospitalized in life, for medical reasons: ______
2. How long ago was last hospitalization: ______
3. Any chronic medical problems, include obstetrical history and current birth control as applicable:

4. Current prescribed medications:

5. On disability: ______
6. Number of days with medical concerns in the past 30: ______
7. How bothered is patient by medical problems: 0-not at all, 1-slightly, 2-moderately, 3 considerably, 4-extremely, X-not answered

Employment/Support

1. Education completed: ______years (GED=12)
2. Driver’s license: YES NO
3. Have a car: YES NO
4. Current (or most recent) occupation: ________________________________
5. How bothered is patient by employment problems, scale 0-4: ______________

Alcohol/Drug Use

1. Alcohol Use: Last 30 days____; Lifetime Use____; Comments, include withdrawal history and date last used ________________________________
2. Heroin: Last 30 days____; Lifetime Use____; Route____; Comments, include date last used, amount, overdose history ________________________________

3. Methadone: Last 30 days____; Lifetime Use____; Route____; Comments, include date last used, dose, and street vs prescribed ________________________________
4. Other Opioids: Last 30 days____; Lifetime Use____; Route____; Comments, include date last used, types, overdose, amount ________________________________

5. Barbiturates: Last 30 days____; Lifetime Use____; Route____; Comments, include date last used, types (e.g. qualuudes), overdose, amount ________________________________
6. Other sedatives (benzos): Last 30 days: ____; Lifetime Use: ____; Route: ____;
   Comments, include date last used, types, amount, overdose, withdrawal history:______

7. Cocaine/Crack: Last 30 days: ____; Lifetime Use: ____; Route: ____;
   Comments, include date last used, forms, amount:______________________________

8. Amphetamines/Meth: Last 30 days: ____; Lifetime Use: ____; Route: ____;
   Comments, include date last used, forms, amount:______________________________

9. Marijuana: Last 30 days: ____; Lifetime: ____; Comments, include date last used and
   amount:______________________________

10. Hallucinogens: Last 30 days: ____; Lifetime: ____; Comments, include date last used
    and form:______________________________

11. Inhalants: Last 30 days: ____; Lifetime: ____; Comments, include date last used and
    form:______________________________

12. Tobacco: Age at onset: ____; Current use and form:___________________________;
    Comments, include previous quit attempts/use of NRT or medication:______________

13. Which substance(s) is the major current problem:____________________________

14. How long was the last voluntary abstinence from the major substance:__________

15. How many months ago did this abstinence end:______________________________

16. How many times have you had alcohol withdrawal/DTs:_____________________

17. How many times have you overdosed on drugs:______________________________

18. How many times have you been treated for alcohol use:_______________________

19. How many of these were detox only:__________________________

20. How many times have you been treated for drug use:_______________________

21. How many of these were detox only:__________________________

22. How many days in the last 30 have you been treated as an outpatient for alcohol or drug
    problems:______________________________

23. How many days in the last 30 have you experienced problems with alcohol:_______

24. How troubled or bothered are you by these alcohol problems:_______ (scale 0-4)

25. How many days in the last 30 have you experienced problems with drugs:_______

26. How troubled or bothered are you by these drug problems:_______ (scale 0-4)

27. How important is it for you to get treatment for alcohol problems, scale 0-4:_____

28. How important is it for you to get treatment for drug problems, scale 0-4:_____

29. Rate patient's need for alcohol treatment, 0-9 scale:_________________________

30. Rate patient's need for drug treatment, 0-9 scale:___________________________
Legal Status

1. Is your evaluation for this treatment program prompted or suggested by the criminal justice system (e.g., court ordered, requirement of parole/probation):

2. Are you on parole or probation:

3. How many times in your life have you been charged with disorderly conduct, public intoxication, possession of drugs/paraphernalia:

4. Have you ever had a DUI, if so how many and when:

5. How many months have you been incarcerated in your life:

6. Are you presently awaiting trial, sentence, or have pending charges:

7. If so, what for:

8. How serious do you feel your legal problems are, scale 0-4:

9. How important to you is counseling or referral for legal problems, scale 0-4:

10. Rate patient’s need for legal services, scale 0-9:

Family History

Have any of your immediate family (include aunts/uncles), or the person(s) who primarily raised you, suffered from an alcohol, drug, or psychiatric problem:

Mother’s Side:

Father’s Side:

Family/Social Status

1. Marital Status: . Current partner/significant other:

2. How long have you been in this marital status:

3. Are you satisfied with this situation:

4. Usual living arrangements: . For how long:

5. Do you live with anyone who has a current alcohol problem:

6. Do you live with anyone who uses drugs, illicit or prescribed controlled substances:

7. How many children do you have, include ages:

8. What is your relationship with your children:

9. How bothered are you by family problems in the last 30 days: (scale 0-4)

10. How important to you is treatment or counseling for family problems: (scale 0-4)

Psychiatric Status

1. How many times have you been treated for a BH problem as an inpatient:

2. How many times have you been treated for a BH problem as an outpatient:
3. Do you receive a pension/disability for a BH problem: ____________________________

4. Have you experienced thoughts of suicide in the past 30 days: __________ or in your lifetime: ____________________________

5. Have you attempted suicide in the past 30 days: __________ or in your lifetime: ____________________________

6. Have you been prescribed medication for a BH problem in the past 30 days: __________
   ____________________________ or in your lifetime: ____________________________

7. Is the patient obviously depressed or withdrawn: ____________________________

8. Is the patient obviously hostile or agitated: ____________________________

9. Is the patient obviously anxious or nervous: ____________________________

10. Is the patient having trouble with reality testing, thought disorders, or paranoid: ______
    ____________________________

11. Is the patient having suicidal thoughts: ____________________________

12. How would you rate the patient’s need for mental health treatment: ______ (scale 0-9)