MEDICAL HEALTH HISTORY AND ADDICTION SCREENING

Your answers on this form will help your clinician understand your medical history. All information you give is confidential. Your records will not be released to any party without your written consent. Best estimates are fine if you can not recall specific details.

GENERAL DEMOGRAPHIC INFORMATION:

Place of Birth_____
Race / Nationality _____ Native Language_____
Marital Status (Circle): Single Married Separated Divorced Widowed Cohabiting
Spouse / Partners (Name and Age)_____
Who lives with you at home _____
Citizenship (Circle): Native Naturalized Alien
Occupation and Job Title_____
_____

First list name of *PRIMARY CARE PHYSICIAN* and then all other Doctors seen in the last 1.5 years:

Name	Address	Phone
*		( ) -
		( ) -
		( ) -
		( ) -
		( ) -

Date of last visit to Primary Physician _____ Reason for visit _____

Date of last complete physical ___/___/___Want coordination of care with your medical doctor? No Yes

Any current serious health /medical problems? Yes No
_____
_____
_____

Past traumatic injuries such as broken bones or concussions? No Yes (give dates and type of injuries):
_____
_____
_____

PAST HOSPITALIZATIONS

List the hospitalizations (not including child birth) for Medical Illness, Injury, Surgery.

Date / Age	Place	Cause

PAST MEDICAL CONDITIONS… List those you have been treated for

Medical Conditions	Start Date	Types of Therapeutic Interventions	Resolved or Ongoing?	Name of Treating Providers

List all **ALLERGIES** TO MEDICINES/ FOODS/ OTHER AGENTS (eg. penicillin , sulfa, latex , codeine, none known)

Medication/ other Agent	Reactions or Side Effects

Current Height_____ Current Weight _____(Give best estimate)
Do you eat three meals a day? No Yes Do you eat from all food groups? No Yes
Is eating or weight a problem for you No Yes If yes explain:_____

SUBSTANCES
TOBBACCO USE:
Cigarettes
Quit: Date _____
Never
Current Smoker: Paks/day___# of yrs_____

ALCOHOL USE
Do you drink Alcohol? No Yes # of drinks/Week ____
Is your Alcohol use concerning to you or others No Yes
DRUG USE:
Do you use any recreational drugs? No Yes _____
Have you ever used needles? No Yes
Do you drink caffeinated beverages No Yes_____

EXERCISE: Do you exercise regularly? No Yes Describe_____

SLEEP : hours per day _____
Difficulty falling asleep? No Yes
Difficulty staying asleep? No Yes
Ever have a sleep study No Yes
Do you have a C-pap Machine? No Yes

FAMILY HISTORY Please "Circle" if you or family have a history:

Diabetes	High Blood Pressure	Heart Attack/Heart Disease	Blood Clots /Stroke	Tuberculosis
Cancer	Alzheimer's	Family History Unknown	Mental Illness	Epilepsy/Seizure
Thyroid	Migraines	Autoimmune Disorders	Other_____	

If you "Circled" to any of the above, please explain: _____

_____
_____
_____

Please list any medical issues not identified on previous section of this questionnaire:

_____
_____
_____
_____
_____

Substance Use and Addiction Screening

for ages 12 to adulthood

FAMILY HISTORY

"Did anyone of your biological parents or family members have substance abuse problems?"

Mother : No / Yes What and when

_____

Father : No / Yes What and when

_____

Siblings: No / Yes What and when

_____

Children: No / Yes What and when

_____

Other family substance history: (Spouse)

_____

_____

CAGE QUESTIONNAIRE

"Have you ever felt you should Cut down on your drinking?" No / Yes

"Have other people Annoyed you by criticizing your drinking?" No / Yes …

Who_____

"Have you ever felt bad or Guilty about your drinking?" No / Yes

"Have you ever had a Drink in the Morning to Steady Nerves or get rid of a hang over?" No / Yes

CONSEQUENCES OF USE

Has your drug or alcohol use affected any of the following areas for you? (Mark with "X")

(Pos. response = persuasion stage of treatment)

	Alcohol	Drug Use
None / No Consequences		
Arrests, Police or Legal problems		
Blackouts		
DUIs		
Family or Social Disruptions Arguments		
Money and Finances		
Health Consequences		
History of Unsafe /Risky Sexual Behaviors while under the influence		
Job Jeopardy		
Lost Job		
Truancy / Academic Failures		
Other :		

How many times have you tried to cut down or Quit but later started using drugs /alcohol again?_____

Have you reduced your alcohol or drug use in past month _____
(Pos. response = potential for active tx)

Do you Binge Drink No / Yes _____
Ever had the D.T.s or Seizures (Delirium Tremens) No / Yes _____

PREVIOUS SUBSTANCE ABUSE TREATMENT

How many times in your life have you been treated for
_____ Alcohol Abuse/Dependence
_____ Drug Abuse/Dependence

	Alcohol Admission Dates	Substance Abuse Dates
Inpatient Detox		
Residential or housing		
Intensive Outpatient		
Out patient		
AA , 12 step or self help		

_____
_____

In the past, how often have you seen a counselor because of alcohol or drugs? _____
(Regular contact = engagement stage of tx)

PROCESS ADDICTION BEHAVIORS

Gambling
Did you gamble any time during the 6 months before today? No /Yes
Do you buy tickets for the State Lottery (including scratch off games)? _____
What is the total value (in dollars) of all the money or other goods gambled during those 6 months $_____
How many times have you wanted or decided to Quit but later started gambling again? _____

Do you find yourself in the past or present preoccupied with thoughts about any of the following?
Do you have any trouble stopping yourself when you know your behaviors are inappropriate in any of the following areas ?

Spending /Shopping No /Yes
Indebtedness No /Yes
Shoplifting No /Yes
Stealing No /Yes
Sex No /Yes
Virtual Gaming or Internet use No /Yes

Please rate the following question based on the scale of 1 – 5 **1) Not at all 2) Slightly Difficult 3) Moderately Difficult 4)Considerably Difficult 5)Extremely Difficult**					
Openly discuss your personal issues with a counselor?	1	2	3	4	5
Accept personal responsibility for problems you have?	1	2	3	4	5
Think seriously about things in your life that need to change?	1	2	3	4	5
Take action to solve personal problems?	1	2	3	4	5
Attend weekly sessions?	1	2	3	4	5

How long do you expect to be in therapy/ counseling? (Circle your response)				
Under 3 mos	3-6 mos.	6-12 mos.	1-2 yrs.	Over 2 yrs.

MEDICATIONS

(Please complete this portion with as much detail as you can recall.

Please list all Prescribed Medications/ Over the Counter Meds / Vitamins / Herbal Supplements that you are currently taking.

Date Begun	Medication	Reason	Dosage	Times per day	Prescribing Doctor

To the best of your ability, please list any PAST psychotropic medications and the results;

Medication	Illness What was the response

____I attest that I have answered these question to the best of my knowledge

_____/_____/____

PATIENT SIGNATURE DATE

_____ This form was reviewed by the therapist with the Pt. during assessment

_____/_____/____

CLINICIAN SIGNATURE DATE

NOTES_____
_____
_____
_____

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*For clinician use below this line: Medication Updates

Date began	Medication	Reason	Dosage	Times per day	Prescribing Doctor / Note

_____ update to med log

_____ update to med log

_____ update to med log

_____ update to med log

_____ update to med log

_____ update to med log