Addiction Medical Clinic LLC

New Patient Intake History & Physical

Patient Name:
DOB:
Date:

Chief Complaint and Symptom:

Substance Abused:

Current amount per use and Frequency/day used:

Last use: Date & Time:

Route: Current and in the past:

Duration of Use: Both Current and Lifetime:

Have you ever been treated for substance misuse: Yes/No (Please describe below when, where and for how long)

Have you ever experienced withdrawal symptoms in the past? Yes/No (circle all that apply)

Blackouts
Tremors
Nausea/vomiting
Diarrhea
Runny nose
Anxiety
Alcohol Seizures
Sweats
DTs
**Addiction Medical Clinic LLC**

**New Patient Intake History & Physical**

*Patient Name:*

*DOB:*

*Date:*

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### Substance Use History:

<table>
<thead>
<tr>
<th>Substance</th>
<th>No</th>
<th>Yes/Past</th>
<th>Route</th>
<th>How much</th>
<th>How often</th>
<th>Date/time last use</th>
<th>Quantity last used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
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<td>Alcohol</td>
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<tr>
<td>Caffeine</td>
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<tr>
<td>Heroin</td>
<td></td>
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<tr>
<td>Pain killers</td>
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<tr>
<td>Methadone</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Meth</td>
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<tr>
<td>Tranquilizers/sleeping pills</td>
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<tr>
<td>Cocaine/Crack</td>
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<tr>
<td>LSD or Hallucinogen</td>
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<tr>
<td>PCP</td>
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<tr>
<td>Stimulants</td>
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<tr>
<td>Inhalants</td>
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<tr>
<td>Ecstasy</td>
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</tbody>
</table>

Did you stop any of the above due to dependence? Yes/No: (Please List)

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What was your longest period of abstinence?

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### Social/Family History:

**Marital Status: (Circle one)**

- Married
- Long Term Relationship
- Single
- Divorced/Separated

Years Married/LTR: Times Married: Times Divorced:

Does spouse/partner use drugs? Yes No
New Patient Intake History & Physical

Patient Name: 
DOB: 
Date: 

Children: Yes   No   Current Ages:  

Are they Living with you? Yes/No.  If No where are they Living?  

Where are you currently living?  

Do you have any Family nearby?  

Do you Have a PCP? Yes  No. Last Visit:  

Education: (Circle )  
High School   Grade   College   Professional/Vocational   Graduate School  

Employment:  
Are you currently employed? Yes   No  
If No where where you last employed?  

What type of work do/did you do?  

How long did/have you worked there?  

Legal issues:  
Have you ever been arrested or convicted? Yes/No.  

Any legal issues we need to be aware of?  

Deferred Prosecution? Court Ordered treatment?  

Have you ever been abused? Yes  No
Addiction Medical Clinic LLC

New Patient Intake History & Physical

Patient Name: __________________________
DOB: __________________________
Date: __________________________

Have you ever been in counselling or therapy? Yes ___ No ___
If Yes please give details:
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Have you ever attended? ___ Yes ___ No (Circle)
Alcohol A ___ Cocaine A ___ Narcotic A ___ Overeaters A

If you are not currently attending, what led you to stop?
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Any family history of Substance abuse?
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Behavioral History:
Number sexual partners in past 5 yrs.: ___0, ___1, ___2-5, ___>5
  Opposite sex ___ Same ___
Number sexual partners in last 4 wks: ___0, ___1, ___2-5, ___>5
  Opposite sex ___ Same ___
Have you shared works? _________ How recently?
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
Contraceptive used: ____________________________ Condoms used: _________ times/last week
STD: Ever had Syphilis ___ Gonorrhea ___ Herpes ___ Chlamydia ___ Genital warts

Medical History:
Any Allergies? (Medication, Food etc)
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Any medical conditions? (Circle if positive)

<table>
<thead>
<tr>
<th>Asthma/COPD</th>
<th>Cardiovascular</th>
<th>Hypertension</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy/Seizure</td>
<td>GI Disease</td>
<td>Head Trauma</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Liver problems</td>
<td>STD</td>
<td>Thyroid condition</td>
<td>MVA</td>
</tr>
<tr>
<td>Abnormal Pap smear</td>
<td>Nutritional deficiency</td>
<td>Chronic Pain</td>
<td>Back issues</td>
</tr>
</tbody>
</table>

Family history of any medical conditions?
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Have you or family member diagnosed with psychiatric or mental Disease? Yes/No, Please provide details
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
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Addiction Medical Clinic LLC (AMC)
Addiction Medical Clinic LLC
New Patient Intake History & Physical

Patient Name: 
DOB: 
Date: 

Any Major surgeries or Hospitalizations? Yes/No, Please list below

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Are you currently taking any Medications or herbal medicines/OTC meds Vitamins etc? Yes/No please list below and how much and often?

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Have you ever been prescribed with antidepressant? Yes/No. If yes please provide details:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Are you pregnant? Yes No

Trying to get pregnant? Yes No

LMP: 
Last Pap Smear:

__________________________________________

__________________________________________

Review of Systems: (Circle if Positive)

Drug/withdrawal related: Runny nose___, Bodyaches___, Irritable___, Chills___, Nausea___, Stomach cramps___, Diarrhea___, Agitation___, Difficulty concentrating___, Tremors____.

General: Weight change___, Loss of appetite___, Fever___, Night sweats___, Fatigue___.

Immunol./Integ.: Swollen “glands”___, Skin rash___, Abscess___.

ENT: Poor vision___, Poor hearing___, Dental problems___, Hoarseness___.

Pulmonary: Cough___, Wheezing___, Shortness of breath___.

Circulatory: Chest pain___, Fainting___, Palpitations___, Ankle swelling___, Cold or painful extremity___.

Gastrointest.: Heartburn___, Abdominal pain___, N / V / D / C (circle)___, Hemorrhoids___.

Urogenital: Nocturia___, Urgency/freq.___, Hematuria___, Discharge___.

Decreased Libido___, Irregular Periods___, Amenorrhea___.

Musculoskeletal: Back pain___, Joint pain___, Joint swelling___, Muscle weakness___.

Neurologic: Headache___, Memory loss___, Incoordination___, Depression___, Anxiety___.