**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone number:** (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_

**Current or past medical conditions** (check all that apply):

\_\_ Asthma/ Respiratory

\_\_ Hypertension

\_\_ Head Trauma

\_\_ Liver problems

\_\_ STDs

\_\_ Cardiovascular (heart attack, high cholesterol, angina)

\_\_ Epilepsy or seizure disorder

\_\_ HIV/AIDS

\_\_ Pancreatic problems

\_\_ Abnormal Pap smear

\_\_ GI disease

\_\_ Diabetes

\_\_ Thyroid disease

\_\_ Nutritional deficiency

\_\_ Other: (please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

**Have you ever had surgery or been hospitalized? YES or NO. If yes please describe:**

**Have you or a family member ever been diagnosed with a psychiatric or mental illness? YES or NO. If yes please describe:**

**Have you ever taken or been prescribed antidepressants? YES or NO. 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 medications, vitamins, supplements, etc. and how often you take them:**

**Please list any allergies you may have:**

**Tobacco History:**

**Cigarettes:** Now?  **YES or NO** In the past?  **YES or NO**

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) **YES or NO.** 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? YES or NO. If yes please describe:**

**What was your longest period of abstinence?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you receiving, or have you ever received counseling support? YES or NO. 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) **YES or NO**

**Current ages** (please list):

**Residing with you?** (circle one) **YES or NO** If no, where?

**Do you have family near your current residence?** (circle one) **YES or NO** please describe:

**Education:** (check most recent degree)

\_\_ Graduate School \_\_ College \_\_ Professional or Vocational School

\_\_ High School Grade \_\_\_\_

**Are you currently employed?** (circle one) **YES or NO**

**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) **YES or NO** check all that apply:

\_\_ DWI \_\_ Drug-related \_\_ Domestic violence \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently in legal trouble?** (circle one) **YES or NO** please describe:

**Have you ever been abused?** (circle one) **YES or NO** 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

**OA:** \_\_ current \_\_ past **CA:** \_\_ current \_\_ past

**ACOA:** \_\_ current \_\_ past

**If you are not currently attending meetings what led you to stop?**

**Thank you for completing the intake form. Please EMAIL TO** [**RECOVERY@ALL-ACCESS-CARE.COM**](mailto:RECOVERY@ALL-ACCESS-CARE.COM) **.**