Release of Medical Information

I, ______________________________, direct New Hope Integrative Medicine to disclose my protected health information described below to:

Name: ______________________________ Relationship: ______________________

Address: ____

Phone # ______________________________ Please Circle One: Home Cell Work

Email: ____

Health Information to be disclosed upon request of the person above:
(Check either A or B)

◯ A. **Disclose** my complete health record (including but not limited to diagnoses, lab test, prognosis, treatment, billing and appointment dates and time) **OR**

◯ B. **Disclose** my health records, as above, **BUT DO NOT Disclose** the following information (check all appropiate)

- ◯ Mental Health Records
- ◯ Comunicable Diseases (including HIV and AIDS)
- ◯ Other (please specify):

____

____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

◯ Hard Copy

◯ Other: ______________________________

This authorization shall be effective until (check one):

◯ All past, present and future periods, OR

◯ On this Date or in the event: ______________________________

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider in writing.)

______________________________ ______________________
Print Name of the Individual Giving this Authorization Date of Birth

______________________________ ______________________
Signature of the Individual Giving this Authorization Date

______________________________ ______________________
Print Witness Name Date

____
Witness Signature

Note: HIPAA Authority for Right Of Access: 45 C.F.R. § 164.524

Consent to Release / Receive Confideltial Information

I, ______________________________, authorize ______________________________ to:
Patient Name (Please Print) Physician Name (Please Print)

MD check all that apply

- ○ Receive my medical history information from the following physician(s):
  (Name, Address) ______________________________
  (Name, Address) ______________________________

- ○ Receive my treatment records from the following therapist:
  (Name, Address) ______________________________

- ○ Release my treatment information/records to the following healthcare professional:
  (Name, Address) ______________________________

- ○ Release my treatment information to the health insurance company listed below, for billing purposes:
  (Name, Address) ______________________________

The informations is for the following purposes (any other use is prohibited): ______________________________

I understand that I may withdrawl this consent at any time, either verbally or in writing, except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opiod dependence by the physician specified above unless I withdrawl my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or drug dependence. These records may also contain confidential information about communicable diseases, including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2), which prohibits the recipient of these records from making further disclosures to thirds parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Name (Please Print)	Patient Signature	Date
Parent/Guardian Name (if applicable) (Please Print)	Parent/Guardian Signature	Date
Witness Name (Please Print)	Witness Signature	Date

Patient Resposibility Form

1. **Patients Financial Resposibility**
   - I understand that I am financially resposible for my health insurance deductible, coinsurance, copay, or non-covered service.
   - Copayments/Co-Insurance are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health insurance plan determines a service "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am unisured or self pay, I agree to pay for the medical services rendered to me at the time of service.
   - I understand that I will be responsible for any laboratory services provided at the office.
2. **Insurance Authorization for Assigment of Benefits**
   - I hereby authorize directpayment of medical services to New Hope Integrative Medicine on my behalf for any services furnished to me by the providers.
3. **Authorization to Release Records**
   - I hereby authorize New Hope Integrative Medicine to release to my insurer, governmental agencies, or any any other entity financially resposible for my medical care, all information, including diagnosis and the records of any treatments or examination rendered to me needed to substantiate payment for such medical services as well as information requiredfor precertification, authorization or referral to other medical provider.
4. **Medicare Request for Payment**
   - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me or in New Hope Integrative Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information neededto determine these benefits or benefits related services.

______________________________ ______________________________

Signature of Patient, Authorized Representative, or Resposible Party | Date

______________________________ ______________________________

Print Name of Patient, Authorized Representative, or Resposible Party | Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice Has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

______________________________________   ______/______/______

Printed Name-Patient or Responsible Party   DOB

______________________________________   ______/______/______

Patient Signature or Responsible Party   Date

____

Relationship to patient (if other than patient) Witness

______________________________________   ______________________________________

Printed Name-Practice Representative   Practice Representative Signature

Suboxone Treatment

Opioid dependence is a disease in which there are physical, psychological and social changes to the detriment of the individual.

Physical changes include the need for increasing amounts of opioids to produce the same effect, symptoms of withdrawal if narcotics are not consumed, feeling of craving, and changes in sleep patterns. Risk-taking behaviors lead to increased probability of contracting STDs, HIV or Hepatitis C.

Psychological components of opioid dependence include a reliance on heroin or narcotic medications to help you cope with everyday problems or the inability to "feel good" or celebrate without narcotics. Worsening depression and anxiety are common.

The social components of opioid dependence include less frequent contacts with people that are important in your life and an inability to participate in important events due to drug use/intoxication. Illegal activity, risk-taking behavior, loss of employment due to poor performance/attendance, alienation of family and friends, as well as spending all of your money and/or selling your possessions to seek drugs are hallmarks of drug addiction.

The classic signs of opioid dependence are: the continued use of drugs despite their negative effects; the need for increasing amounts of opioids to have the same effect; and the development of withdrawal symptoms upon stopping narcotics.

Treatment: Treatment for opioid dependence is best considered a long-term process. Recovery from opioid dependence is not easy or painless. It involves change in drug use and lifestyle, such as adopting new coping skills.

Recovery can and will involve hard work, commitment, discipline, and a willingness to examine the effects of opioid dependence on your life. At first it is not unusual to feel impatient, angry or frustrated.

The changes you will need to make will depend upon how opioid dependence has specifically affected your life.

The following are some common areas of change to think about when developing your specific recovery plan:

Physical: Good nutrition, exercise, sleep and relaxation.

Emotional: Learning to cope with the feelings, problems, stresses, and negative feelings without relying on opioids.

Suboxone Management Policy

In the interest of providing optimal treatment and care to our patients, the following is for the purpose of establishing an agreement between physician and patient regarding clear conditions for the use of medications prescribed by the physician.

The patient agrees to and accepts the following conditions for the management of medications prescribed by the physician for the patient:

- I understand that an improvement in my quality of life is the goal of this program.
- I realize that all of the medications have potential side effects and I will have the recommend laboratory studies required to keep the regimen as safe as possible, including urine drug screens.
- I will not use any illicit/illegal substances, including marijuana, cocaine, etc.
- I will not share, sell, or trade my medication for money, goods, or services. Random pill counts are possible.
- I will not attempt to get pain medications from any other health care provider and I understand it is against the law to do so.
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication.
- I agree not to contact the physician after hours requesting refills or medication.
- I agree to keep all scheduled appointments with the medical practice.
- I agree that counseling is an important component of my recovery and will seek counseling, either in a group (N.A./A.A.) or individual sessions.

If any of the above rules are violated, the physician will no longer participate in the treatment of the patient.

- I agree to avoid people and places that I know will hinder my recovery.
- I agree that I have been given a copy of this policy and will adhere to the conditions as outlined above.

I have read the Suboxone Management Policy and agree with all the requirements.

Starting Suboxone – A Patient's Guide

You can't just start or stop using Suboxone – you have to be eased into it and off of it. The process of easing into it is known as induction.

Heroin, prescribed painkillers, and methadone all belong to a family of drugs called opioids. Before starting on Suboxone you need to refrain from taking narcotic pain medication, heroin or methadone. The exact amount of time you will need to stay off of opioids depends on what kind of drugs you have been taking and how much you use per day.

After going for a day or two without opioids, you will be in the early stages of withdrawal.

You may feel uncomfortable for a little while, but you will feel better once you start taking Suboxone.

If you relapse and start using opioids during this time, you run the risk of sudden intense withdrawal.

During induction, which usually runs three days, your physician will gradually increase the dose of Suboxone until the correct dose is determined.

During this time period, do not use opioids. Be prepared for a few days of cravings. These symptoms will improve.

Typically, induction involves:

Day One: ½ tablet/film, then waiting 2 hours, then another ½ tablet/film. That is your dose for Day One.

Day Two: 1 tablet/film, then waiting 2 hours, then another ½ tablet/film. That is your dose for Day Two.

Day Three: 11/2 tablets/films, then waiting 2 hours, then another ½ tablet/film. That is your total dose for Day Three.

Day Four and each day thereafter: 2 tablets/films once per day. This is your total dose for Day Four.

When you and your doctor decide you are stabilized and doing well enough to stop Suboxone, we will begin a tapering dose of Suboxone, decreasing your dosage at an agreed upon rate. This may take several weeks or months.

Our goal with treatment is to reach that point where you are able to decrease, and ultimately stop Suboxone, and resume your life being a productive member of society – not dependent on any dug or medication.

Towards this end, counseling is an important component to your recovery, and mandatory counseling, either with group or individual therapy, is required of each participant enrolled in Suboxone treatment.

Explanation of First Visit

Your first visit is generally the longest, and may last anywhere from 1 to 4 hours.

When preparing for your first office visit, there are a couple of logistical issues you may want to consider:

- You may not want to return to work on the day of your visit – this is very normal, so just plan accordingly
- Because the medication can cause drowsiness and slow reaction times, particularly during the first few weeks of treatment, you may want to make arrangements for a ride home

It is very important to arrive for your visit already experiencing moderate opioid withdrawal symptoms. If you are in withdrawal, the medicine is supposed to help lessen the symptoms. However, if you are *not* in withdrawal, the medicine will "override" the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure you are in withdrawal for the visit**. (If this concerns you, it may help to schedule your first visit in the morning. Some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours
- No heroin or short-acting painkillers for at least 4 to 6 hours

Bring ALL medication bottles with you to your first appointment.

All of the paperwork provided must be completed before the doctor can see you. If your doctor provided the paperwork to you prior to this visit, bring it completed, or arrive 30 minutes early to fill them out.

Urine drug screening is a regular procedure of treatment, because it provides physicians with important insights into your health and your treatment. Your first visit will include urine drug screening, and may also entail a Breathalyzer®(a) test and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that this medicine is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss the medicine and your expectations of treatment.

After this portion of your visit is completed, your doctor will administer your first dose. Your doctor may have you fill the prescription at the pharmacy and return to the doctor's office so you can take the medication under observation.

Once you take your first dose, you should begin to feel better within 30 minutes. Your doctor may choose to give you additional doses while you are in the office. It's important that you are honest about how you are feeling during induction(b) so your doctor can find the appropriate dose for you.

(a) Breathalyzer® is a registered trademark of Draeger Safety, Inc., Breathalyzer Division.
(b) Suboxone (buprenorphine and naloxone) Sublingual Film (CIII) is not indicated for induction.

Selected Safety Information

Patients hypersensitive to buprenorphine or naloxone should not use Suboxone Film, as serious adverse reactions, including anaphylactic shock, have been reported.

Frequently Asked Questions

- **Why do I have to be in withdrawal to start the medication?**

  When you take your first dose of Suboxone, if you have a high level of another opioid in your system, the Suboxone will compete with those opioid molecules and replace them at the receptor sites in your brain. This may lead to rapid and intense withdrawal symptoms. Being in mild to moderate withdrawal when you take your first dose of Suboxone, the medication will make you feel noticeably better, not worse.

- **How does Suboxone work?**

  Suboxone binds to the same receptors in your brain as other opioid drugs. It mimics the effects of the other opioids by alleviating cravings and withdrawal symptoms.

- **When will I start to feel better?**

  Most patients feel a measurable improvement within 30 minutes, with the full effect being clearly noticeable after one hour.

- **How long will Suboxone last?**

  Response to Suboxone will vary due to factors such as tolerance and metabolism, so each patient's dosing is individualized. Once you're on your regular dose, Suboxone will typically last for 24 hours.

- **Is it important to take the medication at the same time each day?**

  In order to make sure that the medication is optimized, it is important to take your medication at the same time every day in one-a-day dosing. **Do not divide your mediation into more than one dose per day.**

- **If I have to take more than one tablet/film a day, do I need to take them at the same time?**

  The answer is yes and no. You don't need to take them both at the same time, but you do need to take them at the same sitting. Some people may be able to take two tablets/films at once and some people find that taking one after another works better. Whatever works for you is the best. In order for Suboxone to work, it must be taken at about the same time each day. The medication dosage is **never** divided into morning and evening doses.

- **Why does Suboxone need to be placed under the tongue?**

  The medication is absorbed directly into your bloodstream from underneath your tongue. If you chew or swallow your medication it will not be effective.

- **What happens if I take drugs *then* take Suboxone?**

  More likely than not you will become sick and experience a condition known as precipitated withdrawal.

- **What happens if I take Suboxone and *then* take other drugs?**

  As long as the Suboxone is in your body it will significantly reduce the effects of any other opioid used. Suboxone serves to dominate the receptor sites and block other opioids from producing any effect.

- **What are the side effects of Suboxone?**

  Some of the most common side effects are nausea, headache, constipation, body aches and pains. However, most of these effects occur during the first two weeks of treatment and generally subside.

Patient Counseling Log

I attest that ____, attended regularly scheduled counseling/treatment through my office on the dates listed below.

1. Date ____________________ Name: ________________________________
2. Date ____________________ Name: ________________________________
3. Date ____________________ Name: ________________________________
4. Date ____________________ Name: ________________________________
5. Date ____________________ Name: ________________________________
6. Date ____________________ Name: ________________________________
7. Date ____________________ Name: ________________________________
8. Date ____________________ Name: ________________________________
9. Date ____________________ Name: ________________________________
10. Date ____________________ Name: ________________________________
11. Date ____________________ Name: ________________________________
12. Date ____________________ Name: ________________________________
13. Date ____________________ Name: ________________________________
14. Date ____________________ Name: ________________________________
15. Date ____________________ Name: ________________________________

NARCAN® (naloxone HCl)
NASAL SPRAY 4mg

BE PREPARED FOR AN OPIOID EMERGENCY

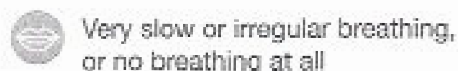
OPIOIDS ARE PRESCRIPTION MEDICINES THAT CAN BE USED TO TREAT PAIN

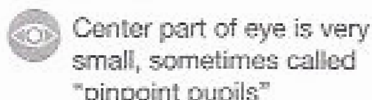
Opioids work by attaching to structures in your brain called "receptors" and send signals that block pain, slow breathing, and calm the body down. Because they affect the part of the brain that controls breathing, if opioid levels in your blood are too high, your breathing can slow down to dangerous levels, which could even cause death. Examples of opioids are morphine, codeine, oxycodone (eg, OxyContin®), oxycodone + acetaminophen (eg, Percocet®), and hydrocodone + acetaminophen (eg, Vicodin®).

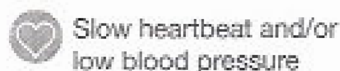
ABOUT 80% OF OPIOID EMERGENCIES SUCH AS AN OVERDOSE ARE DEEMED ACCIDENTAL

Anyone taking opioids may be at risk for a possible overdose. The risk increases if you take higher doses of opioids, take them with alcohol, combine them with certain medicines, or have other medical conditions (eg, HIV, liver or lung disease, or depression). In 2015, more than 22,000 people died from overdoses involving prescription opioids—about 62 deaths a day.

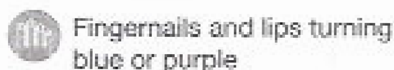
If you are taking an opioid medicine, it is important that someone around you (a spouse, family member, or caregiver) recognizes the symptoms of a possible overdose. They include:


Very slow or irregular breathing, or no breathing at all


Center part of eye is very small, sometimes called "pinpoint pupils"


Slow heartbeat and/or low blood pressure

Not waking up or responding to voice commands or touch


Fingernails and lips turning blue or purple

BE READY WITH NARCAN® (NALOXONE HCl) NASAL SPRAY

More than 80% of opioid overdoses occur at home when a friend or caregiver is present. That's why it is important to keep NARCAN® Nasal Spray within reach in case of an emergency.

NARCAN® Nasal Spray is a prescription medicine used for the treatment of an opioid emergency such as an overdose or a possible opioid overdose with signs of breathing problems and severe sleepiness or not being able to respond. It works in the brain to temporarily reverse the effects of an opioid overdose until medical help arrives. It is needle-free, ready to use, and can be administered by friends and caregivers.

NARCAN® Nasal Spray is not a substitute for emergency medical care. If you suspect an opioid overdose, get emergency medical help right away.

Sudden opioid withdrawal symptoms. In someone who has been using opioids regularly, opioid withdrawal symptoms can happen suddenly after receiving NARCAN® Nasal Spray and may include: body aches, diarrhea, increased heart rate, fever, runny nose, sneezing, goose bumps, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, stomach cramping, weakness, increased blood pressure.

Not actual size.

Please see Indications and Important Safety Information on reverse side. Please see accompanying full Prescribing Information.

If you have additional questions about NARCAN® Nasal Spray, talk to your doctor or pharmacist.

What is NARCAN® (naloxone HCl) Nasal Spray?

NARCAN® Nasal Spray is a prescription medicine used for the treatment of an opioid emergency such as an overdose or a possible opioid overdose with signs of breathing problems and severe sleepiness or not being able to respond.

NARCAN® Nasal Spray is to be given right away and does not take the place of emergency medical care. Get emergency medical help right away after giving the first dose of NARCAN® Nasal Spray, even if the person wakes up.

NARCAN® Nasal Spray is safe and effective in children for known or suspected opioid overdose.

What is the most important information I should know about NARCAN® Nasal Spray?

NARCAN® Nasal Spray is used to temporarily reverse the effects of opioid medicines. The medicine in NARCAN® Nasal Spray has no effect in people who are not taking opioid medicines. Always carry NARCAN® Nasal Spray with you in case of an opioid emergency.

1. Use NARCAN® Nasal Spray right away if you or your caregiver think signs or symptoms of an opioid emergency are present, even if you are not sure, because an opioid emergency can cause severe injury or death. Signs and symptoms of an opioid emergency may include:
   - unusual sleepiness and you are not able to awaken the person with a loud voice or by rubbing firmly on the middle of their chest (sternum)
   - breathing problems including slow or shallow breathing in someone difficult to awaken or who looks like they are not breathing
   - the black circle in the center of the colored part of the eye (pupil) is very small, sometimes called "pinpoint pupils" in someone difficult to awaken
2. Family members, caregivers, or other people who may have to use NARCAN® Nasal Spray in an opioid emergency should know where NARCAN® Nasal Spray is stored and how to give NARCAN® Nasal Spray before an opioid emergency happens.
3. **Get emergency medical help right away after giving the first dose of NARCAN® Nasal Spray.** Rescue breathing or CPR (cardiopulmonary resuscitation) may be given while waiting for emergency medical help.
4. The signs and symptoms of an opioid emergency can return after NARCAN® Nasal Spray is given. If this happens, give another dose after 2 to 3 minutes using a new NARCAN® Nasal Spray and watch the person closely until emergency help is received.

Who should not use NARCAN® Nasal Spray?

Do not use NARCAN® Nasal Spray if you are allergic to naloxone hydrochloride or any of the ingredients in NARCAN® Nasal Spray.

What should I tell my healthcare provider before using NARCAN® Nasal Spray?

Before using NARCAN® Nasal Spray, tell your healthcare provider about all of your medical conditions, including if you:

- have heart problems.
- are pregnant or plan to become pregnant. Use of NARCAN® Nasal Spray may cause withdrawal symptoms in your unborn baby. Your unborn baby should be examined by a healthcare provider right away after you use NARCAN® Nasal Spray.
- are breastfeeding or plan to breastfeed. It is not known if NARCAN® Nasal Spray passes into your breast milk.

Tell your healthcare provider about the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

What are the possible side effects of NARCAN® Nasal Spray?

NARCAN® Nasal Spray may cause serious side effects, including:

Sudden opioid withdrawal symptoms. In someone who has been using opioids regularly, opioid withdrawal symptoms can happen suddenly after receiving NARCAN® Nasal Spray and may include: body aches, diarrhea, increased heart rate, fever, runny nose, sneezing, goose bumps, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, stomach cramping, weakness, increased blood pressure.

In infants under 4 weeks old who have been receiving opioids regularly, sudden opioid withdrawal may be life-threatening if not treated the right way. Signs and symptoms include: seizures, crying more than usual, and increased reflexes.

These are not all of the possible side effects of NARCAN® Nasal Spray. Call your doctor for medical advice about side effects.

The FDA-approved product labeling can be found at http://www.narcan.com/pdf/NARCAN-Prescribing-Information.pdf or 1-844-4NARCAN (1-844-462-7226).

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see accompanying full Prescribing Information, including Patient Information, for NARCAN® Nasal Spray.

For more information on NARCAN® Nasal Spray, talk to your doctor or pharmacist.

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ADAPT PHARMA

New Patient Information

Record # ______________

Name: ______________________________ DOB: ____/____/____

Gender (Circle One): Male Female Transgender Male Transgender Female Other: ________

Social Security Number: ____/____/____ Drivers Lic. #: ______________

Address: ______________________________
Street City State Zip Code

Home #: ( ) ______________ Cell # : ( ) ______________

Email: ______________ Ethnicity/Race: ______________

Marital Status: (select one) ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Sexual Orientation (optional): ◯ Straight/Heterosexual ◯ Lesbian/Gay/Homosexual ◯ Bisexual ◯ Other: ________

Emergency Contact: ______________ Relationship: ______________

Home #: ( ) ______________ Cell # : ( ) ______________

Insurance Information

Primary Insurance	
Insurance Name	
Subscriber's Name	
Policy # / ID #	
Group #	
Insurer's DOB	/ /

Secondary Insurance	
Insurance Name	
Subscriber's Name	
Policy # / ID #	
Group #	
Insurer's DOB	/ /

Referring Physician: ______________ Specialty: ______________

Address: ______________________________
Street City State Zip Code

Phone #: ( ) ______________ Fax #: ( ) ______________

Primary Care Doctor ______________________________

Address: ______________________________
Street City State Zip Code

Phone #: ( ) ______________ Fax #: ( ) ______________

Pharmacy Information

Name: ______________________________

Pharmacy Phone #: ( ) ______________ Fax: ( ) ______________

Address: ______________________________
Street City State Zip Code

I certify I have filled this above form with current and correct information to the best of my abilities.

______________________________ ____/____/____
Patient Signature, Authorized Representative or Responsible Party Date

______________________________ ______________
Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Patient's Medical History

Name: ______________________ Date of Birth: ____/____/____

Current or Past Medical Conditions

(check all that apply)

- ◯ Asthma/Respiratory
- ◯ Hypertension
- ◯ Head Trauma
- ◯ Liver Problems
- ◯ STD's
- ◯ Cardiovascular (heart attack, high cholesterol, angina)
- ◯ Addiction / Dependence
- ◯ Epilepsy or Seizure Disorder
- ◯ HIV/AIDS
- ◯ Pancreatic Problems
- ◯ Abnormal Pap smear
- ◯ Cancer
- ◯ GI Disease
- ◯ Diabetes
- ◯ Thyroid Disease
- ◯ Nutritional Deficiency
- ◯ Other (Please Describe)

____

MD Notes ______________________

Family History

(check the all that apply)

- ◯ Asthma/Respiratory
- ◯ Hypertension
- ◯ Head Trauma
- ◯ Liver Problems
- ◯ STD's
- ◯ Cardiovascular (heart attack, high cholesterol, angina)
- ◯ Addiction / Dependence
- ◯ Epilepsy or Seizure Disorder
- ◯ HIV/AIDS
- ◯ Pancreatic Problems
- ◯ Abnormal Pap smear
- ◯ Cancer
- ◯ GI Disease
- ◯ Diabetes
- ◯ Thyroid Disease
- ◯ Nutritional Deficiency
- ◯ Other (Please Describe)

____

MD Notes ______________________

Have you ever had surgery or been hospitalized? ◯ Yes ◯ No Please explain:

____

MD Notes ______________________

Patient's Medical History

Page 2....

Name: ______________________________ DOB: ____/____/____

Childhood Illnesses

Measles ◯ Yes ◯ No   Mumps ◯ Yes ◯ No   Chicken Pox ◯ Yes ◯ No

Have you or a family member ever been diagnosed with a psychiatric or mental illness? ◯ Yes ◯ No

Describe: ______________________________

Have you ever been prescribed antidepressants? ◯ Yes ◯ No For what reason: ______________

Medication(s) ______________ Why Stopped? ______________

and dates of use: ______________ Why Stopped? ______________

______________ Why Stopped? ______________

Please list **ALL** current prescription medication and how often you take it. DO NOT include medication you are misusing

Medication	Dosage	Frequency	Start Date	End Date	Prescribing Physician

Please list all current herbal medicines, vitamin supplements, etc...., and how often you take them.

Medication	Dosage		Frequency		Start Date	End Date

MD Notes: ______________________________

____

____

Please list ALL allergies (eg. Penicillin, bees, or peanuts): ______________

____

____

MD Notes ______________________________

____

____

Patient's Medical History

Page 3....

Name: ______________________ DOB: ___/___/___

Tabaco History

Cigarettes: Now? ◯ Yes ◯ No In the past? ◯ Yes ◯ No

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

Pipe: Now? ◯ Yes ◯ No In the past? ◯ Yes ◯ No

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

Have you ever been treated for substance misuse? ◯ Yes ◯ No Please describe:

When: ______________ (MM/YY) Where: ______________ (Facility / State) How Long: ______________ (Length of Time)

How long have you been misusing substances? ______________

Substance Use History

Substance	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time 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							
Other:							

Did you ever stop using any of the above because of dependence? ◯ Yes ◯ No Please List: ______________

____

What was the longest periods of abstinence? ______________ Why? ______________

Are you receiving or have you ever received counseling support? ◯ Yes ◯ No Please describe where and for how long:

____

____

Patient Social & Family History

Name: ______________________________

(circle one) Married Single Long-term Relationship Divorced Separated Widowed

Years Married/in Long-term Relationship: ________ Times Married: ________ Times Divorced: ________

Children? ◯ Yes ◯ No Current ages (please list) ______________________

Residing with you? ◯ Yes ◯ No If no, where? ______________________

Where are you currently living? ______________________

____

Do you have family near by? ◯ Yes ◯ No Please describe: ______________________

Education (check most recent degree):

◯ Graduate School ◯ College ◯ Professional/Vocational School

◯ High School, Grade ________

Are you currently employed? ◯ Yes ◯ No Where (if no when were you last employed)? ________

What type of work do/did you do? ______________ For how long? ______________

Have you ever been arrested or convicted ? ◯ Yes ◯ No (check all that apply)

◯ DWI ◯ Drug-related ◯ Domestic Violence ◯ Other: ______________

Have you ever been abused? ◯ Yes ◯ No

◯ 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 to counseling or therapy? ◯ Yes ◯ No (please describe) ______________

____

MD Notes: ______________________________

____

____

____

____