therapeutic solutions
Behavioral Health Services

On behalf of the entire staff, we welcome you to Therapeutic Solutions. We are fully committed to you and promise to deliver the highest quality of care in a welcoming, friendly, and confidential environment.

Please read the enclosed information. Sign and date all forms where indicated and bring the complete packet to your appointment.

In this packet, you will find the following information:

- **Consent for Services**: you have the right to give or refuse consent to treatment
- **Consent for Laboratory** & **Consent for Drug and Alcohol Testing:** The purpose of labs and testing is to help measure and formulate your needs and treatment strategy. Labs and testing include the following:
  - Complete blood count with differential
  - Comprehensive metabolic panel
  - Thyroid Panel
  - Urinalysis & Urine Toxicology
  - Beta HCG for Women
- **Patient Financial Responsibilities**
- **Notice of Privacy Practices: Acknowledgement of Receipt**
- **Authorization for Disclosure of Health Information**: you give us permission to release medical records to individuals, therapists, doctors pertaining to your care. (Optional)
- **New Patient Packet**: please provide us with as much accurate information as possible in this packet to allow us to provide you with the best possible care.

We look forward to having you here and want to provide you with the best possible care. If you have any questions, comments, or concerns please ask a member of my team. Someone will assist you.

PLEASE NOTE:
YOU WILL NOT BE ABLE TO SEE A PROVIDER WITHOUT THIS PACKET COMPLETED

CONSENT FOR SERVICES

Therapeutic Solutions

THE RIGHT TO CONSENT

California law provides that all patients, including those who receive mental health services, have the right to give or refuse consent to treatment. All mental health patients have a right to:

1) an explanation of their diagnosis; information about their recommended treatment, including the possible risks and expected benefits;
2) any alternatives to the recommended treatment, along with the risks and benefits of such alternatives; and
3) give or refuse to give consent for treatment.

By signing below, I am agreeing to receive mental health services from Therapeutic Solutions. These services may include psychiatric evaluation, psychotherapy and medication management.

By signing below, I am voluntarily agreeing to receive mental health services from Therapeutic Solutions. These services may include psychiatric evaluation, psychotherapy and medication management. I understand that I may decide to stop such treatment or services at any time. I understand that my medical information is protected by federal and state confidentiality laws and that my treatment information will be kept confidential to the extent possible by law.

Name:_____ Birth date:_____

Signature:_____

Date:_____/____/_____

PATIENT CONSENT FORM - LABORATORY

Therapeutic Solutions

Please read this form carefully and sign where indicated. This consent is required to render medical laboratory services and to obtain payments from our insurance carrier(s). Please ask our staff member if you have any questions regarding the contents of this form.

PERMISSION TO EXAMINE AND TREAT:

I hereby give my permission to Therapeutic Solutions, PC, its physicians and staff to obtain medical history, insurance information, and laboratory specimens to establish baseline and follow up medical parameters needed to provide a diagnosis and medical treatment.

REFUSAL OF MEDICAL TREATMENT

I understand that I have a right to refuse any and all medical treatments and recommendations. I shall take full responsibility of my actions in case of refusal of treatment or not following medical recommendations.

FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for all the charges whether or not they are covered by my insurance carrier(s). I also understand that some insurance do not cover all laboratory procedures. I agree to pay any co-payments, deductibles and/or services not covered by my insurance carrier on the date of service.

Therapeutic Solutions, PC will submit a claim to your insurance carrier(s) on your behalf, if correct insurance information is provided on the date of service. If we are unable to collect on your outstanding debt within a reasonable time (6 weeks or so) we shall hand over your account to a collection agency and dismiss you as a patient of our medical practice.

LABORATORY TESTS:

I authorize Therapeutic Solutions, PC, to send my blood/urine etc. specimens to the Therapeutic Solutions, PC Laboratory and/or reference laboratories for testing. I understand that I shall be financial responsible for payments of the laboratory services that are not covered by my insurance carrier(s). I understand that bills for unpaid laboratory services will come from the laboratory where my specimens were sent.

ASSIGNMENT OF BENEFITS:

I hereby assign, transfer, and set over Therapeutic Solutions, PC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. A photocopy of this document shall be considered as effective and valid as original. Medicare assignment of benefits will apply accordingly. This authorization shall remain valid until a written notice is given by me revoking said authorization.

AUTHORIZATION TO RELEASE MEDICAL RELATED INFORMATION:

I authorize release of medical information needed to determine my medial reimbursement benefits. (Your insurance may request such information to prove that you were seen in the office. In California, we are required to provide this information by law).

SUMMARY:

We may treat you
You may refuse treatment
You permit us to bill your insurance
Ultimately you are responsible for the payments
Laboratory tests go to Therapeutic Solutions, Quest and Millennium

Signature:_____ Date:_____

(Patient or Guardian)

Relationship to patient if you are a guardian:_____

NOTICE - LABORATORY

Therapeutic Solutions

Therapeutic Solutions, PC owns and operates a clinical laboratory. The samples collected are processed here at Therapeutic Solutions, PC. If your provider requests tests outside of the Therapeutic Solutions Laboratory menu, your samples will be sent to a reference laboratory. In the event that this happens, you will receive a bill from both laboratories. You have the right to choose any clinical laboratory for purposes of medical testing. Please inform the staff immediately if you choose to use another clinical laboratory for your testing. Laboratory testing is required to be completed prior to meeting with your provider.

Have you had lab-work completed within the last three months? If ***yes***, please provide all lab work results to Therapeutic Solutions ***before your appointment***. Any lab work required by the Psychiatrist that has not been completed within the last three months will be ordered at time of your appointment.

Name:_____ Birth date:_____

Signature:_____

Date:_____/____/_____

CONSENT FOR RANDOM DRUG AND ALCOHOL TESTING

Therapeutic Solutions

It is the policy of Therapeutic Solutions, P.C. to do random drug testing throughout your treatment for medication management purpose. When you sign the document below you are voluntarily giving the nursing staff of Therapeutic Solutions, PC the following permission:

I, _____, hereby give my permission for random drug and alcohol testing at a designated lab throughout my treatment at Therapeutic Solutions, P.C.

The results of the urine analysis will be kept confidential to the extent possible by law. If the lab report returns positive, this does not necessarily mean that you will be unable to continue treatment with Therapeutic Solutions, P.C. The purpose of this test is to help measure and formulate your needs and treatment strategy. Thank you for your cooperation.

Therapeutic Solutions would also like to notify you that there will be a charge for the urine screen in addition to a charge for the urine confirmation from our office. The samples collected are processed here at Therapeutic Solutions, PC. Billing for this service will be in accordance with standard Therapeutic Solutions, P.C. policies. You have the right to choose any clinical laboratory for purposes of medical testing. Please inform the staff immediately if you choose to use another clinical laboratory for your testing.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

Therapeutic Solutions

NAME: _____

I hereby authorize Therapeutic Solutions and/or the undersigned Psychiatrist and/or Nurse Practitioner to release information acquired in the course of my examination or treatment, for the purpose of processing and payment of claims.

I hereby assign and authorize my insurance benefits that are payable to me to instead be paid directly to Therapeutic Solutions, and/or physician(s). The amount is not to exceed the balance due toward programs and physician's regular charges for this period of treatment. I understand I may be financially responsible to Therapeutic Solutions and physician(s) for charges not covered by this authorization.

INSURED SIGNATURE DATE

_____ _____

PATIENT SIGNATURE DATE

_____ _____

Therapeutic Solutions

PATIENT FINANCIAL RESPONSIBILITIES

The fundamental ingredient in the psychotherapeutic relationship is clear communication between the doctor and the patient. This philosophy extends to our policies on fees and services. Please feel free to discuss these with us at any time.

INSURANCE: If you have insurance which cover this service, we will be happy to bill your insurance company. **Your co-payment is due and payable at the time of each session**.

****We will need a copy of your current insurance card at the time of your appointment. If you do not have your insurance card with you at the time of your appointment you must present one within 30 days of your appointment or all charges will be billed to you.**

Please note that the Mental Health portion of insurance coverage often differs from other medical coverage. Pre-authorization is often required. Some mental health services may not be covered by your health insurance plan, or may only be partially covered. We strongly suggest you contact your insurance company before treatment begins to be certain that you thoroughly understand both your obligation and that of the insurance company in regard to mental health coverage. If we provide services to you that are not covered by your health insurance plan, you will be responsible for payment in full for those services. If we provide services to you that are only partially covered by your health insurance plan, you may be responsible for the remainder of payment for those services. Your signature below constitutes agreement to pay for such services.

If there are questions regarding your account, please contact our billing department at (530) 899-3150.

LATE CANCELLATIONS AND MISSED APPOINTMENTS: Your appointment time has been reserved for you. If you must cancel an appointment, contact us within 24 hours at (530) 899-3150 so that we may schedule another patient on the waiting list. If our office is not notified of a cancellation 24 hours in advance of your scheduled appointment, **you will be charged $125 fee for a no-show appointment**. **As a courtesy to our office and other patients, we ask that you please cancel your appointments within the 24-hour period to avoid the no-show charge, and to allow us to schedule another patient during that time. Please be informed that three consecutive no-shows could lead to termination of care.**

CONSULTATIVE REPORTS AND FORMS: As a courtesy, we will send a report to the professional who referred you at no additional charge. You may need to request completion of other reports or forms. Fees for this service are determined on an individual basis; **typically the charge is $15** depending on the length and complexity of the report. Insurance does not cover this service and payment is due upon completion of the report.

I have read and understand these policies. You may have a copy of this for your records upon request.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____

Therapeutic Solutions

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGMENT OF RECIEPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Therapeutic Solutions, P.C. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (530) 899-3150.

If you have any questions about our "Notice of Privacy Practices," please contact us at (530) 899-3150.

I acknowledge receipt of the "Notice of Privacy Practices" of Therapeutic Solutions, P.C.

Date: _____ Time: _____AM/PM

Signature: _____

If signed by someone other than patient, indicate relationship: _____

Print name: _____

Therapeutic Solutions

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (PERSONAL)

Patient:_____ DOB:_____

1. I hereby authorize **Therapeutic Solutions** to release/request information from the medical records of the patient listed above obtained in the course of treatment and diagnosis, to:

Name:_____

Address:_____

For the Purpose of:_____

2. The type and amount of information to be used or disclosed is as follows:

A. ____ All health information pertaining to my medical history, mental or physical condition and treatment received, OR

B. ____ Only the following records or types of health information (including any dates):

_____

_____

C. ____ I specifically authorize release of the following information (Check as appropriate)

- ____ Mental health treatment information
- ____ HIV test results
- ____ Alcohol/drug treatment information
- ____ Psychotherapy notes

3. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Therapeutic Solutions office, or I may submit my revocation to Therapeutic Solutions at this address: 3255 Esplanade, Chico CA 95973. I understand the revocation will not apply to health information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date: _____

If I fail to specify an expiration date, this authorization will expire sixty days from the date last signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the health information I am being asked to allow the use or disclosure of. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office at 530-899-3150.

Signature of Patient or Legal Representative Date

_____ _____

If signed by a person other than the patient, indicate relationship: _____

Print name: _____

Therapeutic Solutions

NOTIFICATION OF NON-ACCEPTANCE OF MEDI-CAL

By signing this form, you acknowledge that you have been informed that Therapeutic Solutions **does not** accept:

- Anthem Blue Cross Medi-Cal
- Partnership Health Plan Managed Care Medi-Cal
- California Health and Wellness Medi-cal.
- CMSP Medi-cal

Therefore, I understand that I am financially responsible for the balance.

If you have another insurance which covers this service, we will be happy to bill that insurance company.

The balance for services rendered is payable at the time of each session.

If you have any questions, please contact us at (530) 899-3150.

Date: _____

Signature: _____

If signed by someone other than patient, indicate relationship: _____

Print name: _____

NEW PATIENT PACKET

How did you hear about us? ☐ Website ☐ Billboard ☐ Referred by:_____ ☐ Other:_____

For what problem(s) do you seek help?

What goal(s) do you hope psychiatric treatment will help you to achieve?

How long do you expect this to take?

What form of treatment do you expect (psychotherapy, medication, other)?

DEMOGRAPHICS

Name:	DOB:	☐ Male ☐ Female		
Primary Care Physician:	SSN:			
Home Address:		City	State	Zip
Mailing Address:		City	State	Zip
Phone Numbers: Home:	OK to leave Msg: Yes / No	Cell:	OK to leave Msg: Yes / No	
Work:	OK to leave Msg: Yes / No	Other:	OK to leave Msg: Yes / No	
Email Address:				
Emergency Contact:	Phone #:	Relationship:		

IF PATIENT IS A MINOR:

Do you have legal custody? ☐Yes ☐ No	If divorced, has either parent had parental rights terminated? Yes ☐ No ☐
Legal Guardian's Name:	Relationship to Patient:
Legal Guardian's SSN:	Guardian's Date of Birth:
Is Patient a Full-Time Student? ☐Yes ☐ No	School:

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:
Patient ID #:	Policy Holder DOB:
Group #:	Relationship:
Secondary Insurance:	Policy Holder Name:
Patient ID #:	Policy Holder DOB:
Group #:	Relationship:

PSYCHIATRIC HISTORY Please check any that Apply:		
AS A CHILD:	**Y**	**N**
Did you have separation anxiety with parents/caregiver or discomfort being away from home?	Y	N
Did you have difficultly sitting still/paying attention, or diagnosed with ADD?	Y	N
Did you have learning problems with spelling, reading, math, or speech?	Y	N
Did you wet the bed frequently after age 5?	Y	N
ADULT:	**Y**	**N**
Do you have difficulty falling asleep or staying asleep?	Y	N
Have you ever assaulted anyone or had thoughts of harming someone?	Y	N
Have you ever attempted suicide?	Y	N
Have you ever harmed yourself without intending suicide, (cutting, burning, etc.)?	Y	N
Do you gamble?	Y	N
Do you have difficulty resisting the urge to gamble?	Y	N
Have you ever injected anything into your veins?	Y	N
Have you ever had compulsions (repetitive but unnecessary behaviors such as checking the doors several times before leaving home, frequent hand-washing, counting things repeatedly, etc.)?	Y	N
Have you had phobias (fears of specific situations or things such as heights, enclosed places, open places, driving, flying, insects, etc.)?	Y	N
Have you become so anxious in social situations or when called upon to talk or perform that you have difficulty speaking, performing or functioning? In what situations?	Y	N
Have you ever felt fat or tried to lose weight despite family or friends saying that you were not overweight?	Y	N
Have you ever been significantly overweight?	Y	N
To lose weight, have you ever made yourself vomit or taken laxatives, diuretics (water pills), or diet pills?	Y	N
Have you frequently eaten large amounts of food (binge eating) and felt guilty afterwards?	Y	N
Do you use food as a way to cope with depression or anxiety?	Y	N
Have you ever felt confused and lost track of where you were or what day it was, or could not recognize people you knew?	Y	N
Do you often forget where you put things, have trouble finding your way home, or forget what people tell you unless you write it down?	Y	N
Have you ever found personal belongings in places you did not recall having placed them?	Y	N
Have you ever been greeted by people who seemed to know you but you did not know them?	Y	N
Have you ever been unable to account for what you had been doing for some period of time?	Y	N
While you were fully awake, have you ever heard voices talking to you or about you that other people could not hear?	Y	N
Have you ever seen things, such as faces, animals, or ghosts that other people could not see?	Y	N
Have you ever tasted, smelled or felt things touching you or crawling on you when nothing was there?	Y	N
Have you ever been in places without knowing how you got there?	Y	N
When you were in public, have you often felt or believed that people were watching you, following you, talking about you, reading your mind, putting thoughts into your mind, trying to hurt or control you in some way, or plotting against you?	Y	N
Has it often happened that things you've seen appeared larger, smaller, closer, or farther away than you knew them to be?	Y	N
In unfamiliar places, have you often felt that you've been there before, or have familiar places seemed strange, different, or unfamiliar?	Y	N

Were you ever the victim of?		
Physical or Sexual Child Abuse	Y	N
Violent Crime	Y	N
Sexual Assault	Y	N
Molestation	Y	N
Harassment	Y	N
Natural Disaster	Y	N
Motor Vehicle Accident	Y	N
Industrial Accident	Y	N
Combat Injury	Y	N
Discrimination or persecution based on gender, race, ethnicity, religion, or sexual orientation	Y	N

Have you had a period of time lasting days to weeks when you felt clearly different than your usual self:

Your mood was:	Description:	Y	N
Euphoric/ elevated		Y	N
Irritable		Y	N
Energetic		Y	N
Talkative		Y	N
Sociable		Y	N
Creative		Y	N
Thoughts raced		Y	N
Little need for sleep		Y	N
Bought/purchased things without considering whether you could afford them		Y	N
Sex drive was increased		Y	N
Felt you could conquer the world		Y	N

PREVIOUS AND CURRENT PSYCHIATRIC/COUNSELING CARE

Name of Psychiatrist/Counselor	Address/Phone Number	Dates of Service	Frequency of Visits

Do you have a Primary Care Physician? ☐Yes ☐ No	Date of last physical exam:
Physician's Name:	Physician's Phone Number:

PAST MEDICATIONS *PLEASE PROVIDE INFORMATION TO ANY THAT APPLY*					
Medication	**Date Range**	**Helpful? Side Effects, if any?**	**Medication**	**Date Range**	**Helpful? Side Effects, if any?**
ANTIPSYCHOTICS			**MOOD STABILIZERS**		
Abilify/Aripiprzole			Depakote/Depakene/ valproic Acid		
Clozaril/Clozapine			Lamictal/lamotrigine		
Geodon/Ziprasidone			Lithium/Eskalith/Lithobid		
Haldol/ Haloperidol			Neurontin/gabapentin		
Invega/Invega Sustenna			Tegretol/Epitol/Equetro/ carbamazepine		
Latuda			Topamax/topiramate		
Navane/Thiothixene			Trileptal/oxcarbazepine		
Prolixin/Fluphenazine			**ANXIETY / SLEEP**		
Risperdal/Risperidone			Ambien/zolpidem		
Saphris			Ativan/lorazepam		
Seroquel/Quetiapine			BuSpar/buspirone		
Stelazine/Trifluoperazine			Centrax/prazepam		
Symbyax			Dalmane/flurazepam		
Trilafon/Perphenazine			Klonopin/clonazepam		
Zyprexa/olanzapine			Librium/chlordiazepoxide		
ANTIDEPRESSANTS			Lunesta/eszopiclone		
Anafranil/Clomipramine			Paxipam/halazepam		
Asendin/Amoxapine			Restoril/temazepam		
Brintellix/vortioxetine			Rozerem/ramelteon		
Celexa/citalopram			Serax/oxazepam		
Cymbalta/duloxetine			Sonata/zaleplon		
Deplin			Tranxene/clorazepate		
Desyrel/Trazodone			Valium/diazepam		
Effexor/venlafaxine			Xanax/alprazolam		
Elavil/endep/Amitriptyline			**STIMULANTS**		
Lexapro/escitalopram			Adderall/Adderall XR		
Luvox/Fluvoxamine			Concerta		
Nardil/phenelzine			Focalin/dexmethylphenidate		
Norpramin/Desipramine			Metadate/Methylin/ methylphendiate		
Pamelor/Aventyl/ Nortriptyline			Ritalin		
Paxil/Pexeva/Paroxetine			Strattera/atomoxetine		
Pristiq			**OTHER**		
Prozac/Sarafem/ Fluoxetine			Aricept/donepezil		
Remeron/Mirtazapine			Artane/Trihexyphenidyl		
Serzone/Nefazodone			Cogentin/Benztropine		
Sinequan/Adapin/doxepin			Exelon/rivastigmine		
Tofranil/imipramine			Lyrica/pregabalin		
Viibryd			Namenda/memantine		
Wellbutrin/Zyban/Bupropion			Provigil/modafinil		
Zoloft/Sertraline			Reminyl/galantamine		
			Suboxone		

CURRENT MEDICATIONS		
Medication	**Dose/Frequency**	**Start Date**

MEDICAL HISTORY *PLEASE CHECK ANY THAT APPLY:* ☑			
AIDS/HIV Positive	Drug Addiction	HIV Positive	Radiation Treatments
Alzheimer's Disease	Easily Winded	Hives or Rash	Recent Weight Loss
Anaphylaxis	Emphysema	Hypoglycemia	Renal Dialysis
Anemia	Epilepsy or Seizures	Incontinence	Rheumatic Fever
Angina	Esophageal reflux	Infertility	Rheumatism
Arthritis	Excessive Bleeding	Irregular Heartbeat	Scarlet Fever
Artificial Heart Valve	Excessive Thirst	Irritable Bowel	Seizures
Artificial Joint	Fainting Spells/Dizziness	Jaundice	Shingles
Asthma	Frequent Cough	Kidney Problems	Sickle Cell Disease
Blood Disease	Frequent Diarrhea	Kidney Stones	Sinus Trouble
Blood Transfusion	Frequent Headaches	Leukemia	Spina Bifida
Breathing Problem	Gallstones	Liver Disease	Stomach/Intestinal Disease
Bruise Easily	Genital Herpes	Low Blood Pressure	Stroke
Cancer:_____	Glaucoma	Lung Disease	Swelling of Limbs
Cataract	Hay Fever	Lyme Disease	Syphilis
Chemotherapy	Headaches	Malaria	Thyroid Disease
Chest Pains	Head Injury	Meningitis	Tonsillitis
Chronic Bronchitis	Hearing Loss	Mitral Valve Prolapse	Traumatic Injury
Crohn's Disease	Heart Attack/Failure	Mononucleosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Neurological Disorder	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Osteoporosis	Ulcers
Constipation	Heart trouble	Pacemaker insertion	Urinary Tract Infections
Convulsions	Hemophilia	Pain in Jaw Joints	Venereal Disease
Cortisone Medicine	Hepatitis A	Pancreatitis	Vision Loss
Diabetes	Hepatitis B or C	Parathyroid Disease	Wheezing
Diarrhea	Herpes	Poisoning	
Diverticulitis	High Blood Pressure	Porphyria	
Diverticulosis	High Cholesterol	Psychiatric Care	

MEDICAL HISTORY *CONTINUED*	
Any special dietary needs or restrictions? ☐Yes ☐ No	Describe:
Any ongoing dental issues? ☐Yes ☐ No	Describe:
Any recent change in appetite? ☐Yes ☐ No	Describe:
Any weight loss or weight gain of more than 10lbs in the last 60 days? ☐Yes ☐ No	Describe: ☐ weight loss ☐ weight gain
On a scale from 0 - 10 please circle your pain level **today**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating)	Please explain:
On a scale from 0 – 10 please circle your pain level for the **last 30 days**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating)	Please explain:
Other medical issues you would like us to consider during your treatment:	Please explain:

Men ONLY:	Women ONLY:	
☐ Prostate problems ☐ Vasectomy	**Number of:**	Pregnancies_____, Caesarean sections_____, Abortions_____, Stillbirths_____, Miscarriages_____
	☐ D&C, ☐ Hysterectomy, ☐ Tubal Ligation, ☐ Ovary Removal, ☐ Breast Surgery	
Other Illnesses not listed above OR Comments:		

PHARMACY PLAN	
Pharmacy Names:	Pharmacy Addresses/Phone #'s:

ALLERGIES	
MEDICATIONS	**Reaction**
	□Mild □ Moderate □Severe □ Lethal
	□Mild □ Moderate □Severe □ Lethal
	□Mild □ Moderate □Severe □ Lethal
FOOD/OTHER	**Reaction**
	□Mild □ Moderate □Severe □ Lethal
	□Mild □ Moderate □Severe □ Lethal
	□Mild □ Moderate □Severe □ Lethal

SUBSTANCE USE HISTORY								
Substance	**Past OR Present**	**Route**	**Frequency**	**Quantity**	**Age of First Use**	**Date of Last Use**	**Heaviest Use** (amount/ frequency)	**# of days used in last 30 days**
Alcohol	☐Past / ☐Present							
Caffeine (pills or beverages)	☐Past / ☐Present							
Cocaine	☐Past / ☐Present							
Crystal / Meth-Amphetamine	☐Past / ☐Present							
Heroin/ Other opiates	☐Past / ☐Present							
Inhalants	☐Past / ☐Present							
LSD or Hallucinogens	☐Past / ☐Present							
Marijuana	☐Past / ☐Present							
Methadone	☐Past / ☐Present							
Pain Killers	☐Past / ☐Present							
PCP	☐Past / ☐Present							
Stimulants (pills)	☐Past / ☐Present							
Tranquilizers/ Sleeping Pills	☐Past / ☐Present							
Ecstasy	☐Past / ☐Present							
Nicotine	☐Past / ☐Present							
Barbiturates	☐Past / ☐Present							
Benzodiazepine	☐Past / ☐Present							

Ever taken medications more than prescribed OR taken medications prescribed to another person?

What is your drug of choice?

Have you ever experience any of the following in relation to your substance abuse?

- □ Symptoms of withdraw (physical/emotional/mental)
- □ Symptoms of dependence (needing larger amounts in order to get the same effects)
- □ Taking larger amounts than intended
- □ Attempt to quit using, but unable to
- □ Have people around tell you that you have a problem with (substance)
- □ Impaired ability to complete social/home/work related tasks?
- □ Substance related legal issues?

Have you received treatment for substance abuse?

Do you think you need treatment, or are you open to treatment for substance abuse?

SOCIAL HISTORY

Marital Status:	☐ Single	☐ Married, How many times? _____	☐ Divorced, How many times? _____	☐ Widowed
Do you have children? Yes ☐ No ☐ ; Current ages: _____				
Do you have family nearby? Yes ☐ No ☐; Please describe:_____				
Military ☐Yes ☐No	Branch:		☐Active Duty ☐Reserves ☐Veteran	
If so, did you receive a service-connected disability rating? ☐Yes ☐No; What was your Rating?_____				
Have you ever been arrested or convicted? ☐Yes ☐No	☐DUI ☐Drug Related ☐ Domestic Violence ☐Other _____			
Please Explain:				
Have you ever been abused? ☐Yes ☐ No	☐Physically ☐ Sexually (including rape or attempted rape) ☐Verbally ☐ Emotionally			
Please list any spiritual/religious variables that may impact your treatment:				

EMPLOYMENT AND EDUCATION

Employer:	Address:
Dates:	Occupation:
If you are not currently employed, where were you last employed?	

Please check highest level of Education:

☐ Grade: _____ ☐ High School ☐ Professional/Vocational School ☐ Some College ☐ Bachelor Degree

☐ Graduate ☐ Other:_____

FAMILY HISTORY

**Please list the name(s) and relationship to you of any blood relative who have suffered from or been treated for mental/ emotional/ psychological problems, including depression, nervousness, suicide/suicide attempts, alcoholism, drug abuse, schizophrenia, phobias, etc., or from neurological or unusual diseases.

Family Member Name & Relation (i.e., Mother, Father, Siblings, Children, Grandparents, Uncles, Aunt)	**Diagnosis**	**Type of Problem**