AMCOT Austin
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PATIENT INTAKE: MEDICAL FORM
(To be completed by patient)

Date: _____

Name: _____DOB: _____SS# _____

Address: _____

Phone: (H)_____(C)_____EMAIL: _____

Martial Status: _____ Occupation: _____ Employer: _____

Emergency Contact/Relationship/Phone#: _____

Primary Care Physician/Phone #: _____

Date of Last Physical: _____ Date of Last Menstrual Cycle: _____

Emergency Contact/Relationship/Phone#: _____

Primary Care Physician/Phone #: _____

Date of Last Physical: _____

Childhood History (where did you grow up, # brothers & sisters): _____

_____

Educational History: _____

Employment History: _____

Relationship/Marriage: _____

Children: _____

Current Living Arrangement: _____

Criminal Justice History: _____

Reproductive History (LMP, # of pregnancies): _____

CURRENT/PAST MEDICAL CONDITIONS

(Asthma, Hypertension, Liver/Thyroid/GI Disease, STDs, Cardiovascular, Seizure Disorder, Diabetes, Head Trauma, other)

CURRENT or PAST MEDICAL CONDITION	APPROXIMATE DATE OF ONSET OR DIAGNOSIS

PAST SURGERIES

(Gall Bladder removal, Appendectomy, Hysterectomy, Heart Surgery, Angioplasty, other)

PAST SURGERIES	APPROXIMATE DATE OF SURGERY

ALLERGIES

Medical/Environmental Allergies and Reaction: (Example rash, swelling, trouble breathing)

ALLERGIC TO	REACTION

MEDICATIONS

Please list any other medications you take that are not listed in the substance abuse questionnaire (include any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia, ADD, ADHD or any other psychiatric illnesses).

MEDICATION NAME	DOSAGE/ FREQUENCY	PRESCRIBING PHYSICIAN	REASON TAKING MEDICATION

LIST PRIOR INPATIENT TREATMENT PROGRAMS INCLUDING OUTPATIENT TREATMENT PROGRAMS (IOP)

NAME OF PROGRAM	DATES	LENGTH

What is your longest period of (clean and sober) sobriety? _____

What helped you remain sober? _____

Do you have a family history of addiction? Yes No
If yes, who:_____

Do you have any current legal problems? Yes No
If yes, please describe:_____

Are you currently in a Pain Management Program? Yes No
If yes: Name of Program/Phone #:_____

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor?
If yes: Name/Phone #_____

Have you ever experienced, witnessed, or been confronted with traumatic events (abuse)? Yes No

Have you ever thought about, planned or attempted suicide? Yes No
If yes please explain (include dates): _____

Are you currently suicidal? Yes No
If yes please explain: _____

CURRENT SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

PAST SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

	HOW MUCH DAILY	HOW MANY YEARS	PAST/PRESENT
CIGARETTES			
SMOKELESS			
VAPE			

TOBACCO HISTORY

Have you ever experienced any of the following when you attempted to stop drinking or using? Please check all that apply.

	Seizures		Loss of Consciousness
	Tremors		Hot/Cold Sweats
	Nausea and Vomiting		Blackouts
	Hallucinations (DT's)		Falls

The consequences of drug use change over time. Initially, there is a "honeymoon" period in which few, if any, of the costs have time to emerge. But, as drug use continues the consequences begin to accumulate. In what way has your perception of benefits become overwhelmed by consequences?

_____

_____

_____