



San Luis Obispo Addiction Recovery Center

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(805) 541-5566 voice
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PATIENT INTAKE

Name: _____ Date _____

Address: _____

Phone (cell) _____ (home) _____ (work) _____

DOB _____ Age _____ Email _____

Emergency Contact _____ Phone _____

How can we help you today? _____

Are there any medicines you are interested in being prescribed today? _____

How did you hear of us? _____

Please list ALL medical conditions: None

_____ Physician Name _____

_____ Physician Name _____

_____ Physician Name _____

Married Single Long-term relationship Divorced/Separated Do you have children? Yes No

Are you currently employed? Yes No Where _____

What type of work do/did you do? _____ How long have/did you work (ed) there? _____

Have you ever been arrested or convicted? Yes No When? What for? _____

Do you currently have any legal problems? Yes No What? _____

DWI Drug-related Domestic violence Are you on probation / Parole? Yes No

Have you ever been abused? Yes No Physically Sexually Verbally Emotionally

Have you ever attended: None AA NA Other 12-Step When did you last attend? _____

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? Yes No (Please describe) _____

Have you ever been hospitalized? Yes No (Please explain) _____

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

Where? When? _____

Are you feeling suicidal? Yes No Have you ever attempted suicide? Yes No

Have you ever been treated for overdose? Yes No (Please describe) _____

Have you ever taken or been prescribed antidepressants? Yes No

Medication(s) and dates of use _____

Did you have any problems with antidepressants? Yes No What was the problem? _____

List **ALL** current medicines **prescribed to you by a doctor:** _____

Please list any **ALLERGIES** you have (penicillin, bees, peanuts) _____

Have previously been treated for substance misuse? Yes No When, where and for how long? _____

How long have you been using/abusing substances? _____

How old were you when you first started using drugs and alcohol? _____

What has been your longest period of abstinence/not using? _____

When/how long ago was the last time you stopped for any length of time? _____

Why did you stop using then? (Jail? Rehab? Problems?) _____

Is there anything else you feel we should know about you? _____

Patient Signature: _____ Date _____

Physician Signature: _____ Date _____

Meets dsm IV criteria dependence Anxiety Depression Bipolar PTSD ADHD

Substance Use History

Name: _____ Date : _____

HAVE YOU USED?	<u>EVER</u> <u>in your</u> <u>life!?</u>	Used in last 30 days??	How Much?	How many times a day?	When did you last use?	Route (oral, nasal, smoked, IV)
Tobacco						
Alcohol						
Marijuana						
Vicodin/Norco						
OxyContin / oxycodone						
Heroin						
Morphine						
Methadone						
Dilaudid						
Fentanyl						
Suboxone						
Tramadol/ Ultram						
Other _____						
Cocaine						
Crystal Meth- Amphetamine						
LSD mushrooms Hallucinogens						
Ecstasy						
Street Valium Ativan Xanax etc						
Soma						