Chwen-Yuen Angie Chen, MD, FACP, FASAM
Board Certified, American Board of Internal Medicine
Diplomate of the American Board of Addiction Medicine
363 Main Street #C, Redwood City, CA 94063
Phone 650-503-4115 Fax 888-755-4489 Website www.addictionmedicinemd.com

ADDICTION MEDICINE INTAKE FORM – ALL INFORMATION IS CONFIDENTIAL

Name ____ Date_______________

Address ____ Apt # ______________

City____________________________________State_________________Zip_________________

Birth date ______________________ Age ____________

Phone (with area codes):

(c) (_____)_____________________ VM message OK? ☐Yes ☐ No Preferred number? ☐ Yes ☐ No

(h) (_____)_____________________ VM message OK? ☐Yes ☐ No Preferred number? ☐ Yes ☐ No

(o) (_____)_____________________ VM message OK? ☐Yes ☐ No Preferred number? ☐ Yes ☐ No

E-mail____ OK to reach you by e-mail?* ☐Yes ☐ No
*Please note that e-mail correspondence may not encrypted and may not be confidential ________. Please initial

How do you identify your ethnicity? ☐ African-American ☐ Asian ☐ Caucasian ☐ Latino

☐ Pacific Islander ☐ Bi-racial ☐ Multi-racial ☐ Other __________________________________

Insurance Carrier ___________________________ ☐ HMO ☐ PPO Policy No.________________

Person financially responsible for your treatment (if other than you):

Name_____________________________________ __Relationship to you_______________________

Address___________________________________City______________State______Zip__________

Phone(s): ____________________________________E-mail ______________________________

Emergency Contact ____

Relationship to you _________________________________Phone (_____)____________________

*Primary care physician ______________________________ Phone (_____) __________ Referred? ____

Approximate date of most recent laboratory work _______________________Where done______________

*Psychiatrist ______________________________________ Phone (_____) __________Referred? ____

*Therapist ____ Phone (_____) __________ Referred? ____

*Name of referring MD/Therapist/Counselor, if not above________________________Phone (_____) __________

X__________________________________/_________________

Signature **Date**

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NAME______________________**DOB**____________

MEDICAL HISTORY

The following questions will help me get to know you and understand how we can work most effectively. If you don't remember, or don't want to answer particular items, that's okay. Just complete the parts that you can.

Opioid Use History

When was the first time you used an opioid (heroin or painkiller)? ____

Name of drug: ______________________________Route: ☐ Oral (by mouth) ☐ Snorted ☐ Smoked ☐ Injected

Was this prescribed by a physician? ☐ Yes ☐ No If yes, did you use as directed? ☐ Yes ☐ No

If no, please explain ____

Have you also used other types of opioid drugs? ☐ Yes ☐ No

If yes, please list them: ____

When did you when you began using an opioid every day? ____

When did you first became dependent, or get sick if you did not use regularly? _____________________________

Have you ever injected opioids or other drugs? ☐ Yes ☐ No

Since first becoming dependent, have you had any periods when you did not misuse opioids? ☐ Yes ☐ No

If yes, approximate dates when you were opioid free:____

What were the circumstances? ☐ On my own ☐ With outpatient treatment, therapy, or self-help groups

☐ Live-in program ☐ I was on methadone ☐ I was on buprenorphine (Suboxone) ☐ I was incarcerated

☐ On parole, probation, etc. ☐ Other (please explain____

Please complete this chart for all opiates you have used

Name of opioid drug	Route(s) of use (oral, snort, smoke, inject)	How much used	Dates used	Prescribed? Yes or No	Used in past 30 days? Yes or No

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Opioid Dependence Treatment History

Dates	Type of treatment (methadone, buprenorphine, counseling, residential, other)	Where did you get your treatment?	Why did you leave treatment?	How long did you remain drug free after you left treatment?

Current Opioid Use

Current opioid(s) used: ____

Route of use: ☐ Oral (by mouth) ☐ Snorted ☐ Smoked ☐ Injected

How much do you use every day? ____________How many times a day do you use? __________

When did you last use? Date:__________ Time: __________ Amount: ______________

Are you in withdrawal now? ☐ Yes ☐ No

If yes, what withdrawal symptoms do you have right now?

( ) Generalized discomfort	( ) Diarrhea	( ) Headache
( ) Hot/cold	( ) Runny nose	( ) Weakness
( ) Sweats	( ) Watery eyes	( ) Anxiety, irritability
( ) Goosebumps	( ) Sneezing	( ) Restlessness, agitation
( ) Stomach ache	( ) Yawning	( ) Tremors, shakes
( ) Nausea	( ) Muscle aches, cramps	( ) Sleep disturbance
( ) Vomiting	( ) Bone, joint aches	( ) Craving
( )	( )	( )

If 1 means "I feel fine" and 10 means "the worst withdrawal ever," rate how you feel now on a scale of 1 – 10 (Please circle a number):

1 2 3 4 5 6 7 8 9 10

I'm fine — A little sick — Moderately sick — Very sick — Worst ever

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Other Substance Use History

	No (Never used)	If Yes: Age at first use	Route	How Much	How Often	**Date/Time of Last Use**	**Quantity Last Used**
Alcohol			Oral	Per wk			
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Inhalants							
LSD or Hallucinogens							
Marijuana							
PCP							
Stimulants (pills)							
Sedatives/ Sleeping Pills							
Ecstasy							
Other							
Cigarettes							
Cigars							
Chewing tobacco							

Comments (Include inpatient, rehabilitation center, outpatient IOPs, etc):

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Past Medical History

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

( ) High blood pressure	( ) Stroke, neurologic disorder	( ) Thyroid problem
( ) Diabetes	( ) GI (stomach, intestinal)	( ) Arthritis
( ) Heart disease	( ) Pancreatic problem	( ) Chronic pain
( ) High cholesterol, lipid disorder	( ) Kidney disease	( ) Cancer
( ) Seizure disorder, epilepsy	( ) Lung disease (asthma, COPD)	( ) Nutritional problem

Hepatitis: Have you ever been tested for **Hepatitis C**? ☐ Yes ☐ No When? __________ Result______________

Have you ever had Hepatitis A? ☐ Yes ☐ No Have you ever had Hepatitis B? ☐ Yes ☐ No

Have you been vaccinated against Hepatitis A or Hepatitis B? ☐ Yes ☐ No When? ________________________

HIV: Have you been tested for HIV? ☐ Yes ☐ No When was your last test? _____________ Result___________

TB: When was your last TB skin test? _____________ Have you ever tested positive for TB? ☐ Yes ☐ No

STD: ☐ Syphilis ☐ Gonorrhea ☐ Herpes ☐ Chlamydia ☐ Other ______________________________

Do you use condoms? ☐Yes ☐ No Have tattoos? ☐ Yes ☐ No Have body piercings? ☐ Yes ☐ No

Have you ever had **surgery** or been **hospitalized overnight**? ☐ Yes ☐ No (If yes, please describe and list dates):

____

____

Have you ever experienced **trauma**, such as bone fractures or accidents? ☐ Yes ☐ No (If yes, please describe):

____

To your knowledge, have you had all required and recommended **vaccinations**? ☐ Yes ☐ No _______________

Please list any **allergies** you have (medications, bees, peanuts, environmental): ____________________________

____

Current prescribed **medications**: (Please list medication, dose and frequency) ____________________________

____

____

____

____

Please describe any medical, psychiatric, or drug and alcohol use **conditions that run in your family**: _________

____

____

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Women's Reproductive History

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many children have you had? _______ How old are your children? ____________________________

Have you had any miscarriages? ☐ Yes ☐ No If yes, how many? ________

Have you had any abortions? ☐ Yes ☐ No If yes, how many? ________

Date of last menstrual period ___________________

Date of last Pap smear ________________________

Date of last mammogram ______________________

Do you use birth control now? ☐ Yes ☐ No

If yes, what kind? ____

Comments: ____

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Male Reproductive History

Do you have children? ____

If yes, how many children do you have? ____

How old are your children? ____

Do you practice birth control? ____

Comments: ____

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Psychiatric History

Please indicate if you have you ever been diagnosed or treated for any psychiatric disorder:

☐ Depression ____

☐ Anxiety____

☐ Bipolar Disorder____

☐ Schizophrenia____

☐ Attention Deficit/Hyperactivity Disorder____

☐ Schizoaffective disorder____

☐ Eating disorder____

☐ Cutting/self-mutilation____

☐ Learning disability____

☐ Personality disorder____

☐ Ever thought about hurting myself ____

☐ Ever tried to hurt myself____

☐ Other ____

If you have never been diagnosed or treated for any of these disorders, do you feel you may have one? ☐ Y ☐ N

List any current prescribed psychiatric medications: ____

____

____

List any previously prescribed psychiatric medications: ____

____

List any prior hospitalizations for psychiatric conditions: ____

____

____

Comments: ____

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RECENT STRESSFUL EVENTS

Recent Stressful Life Events Check any of the following events that have occurred during the last 12 months	COMMENTS
Married	❐
Engaged	❐
Separated	❐
Divorced	❐
Breakup of important relationship	❐
Pregnancy	❐
New family member	❐
Child left home	❐
Death of spouse or significant other	❐
Bad health of family member	❐
Behavior problems in family member	❐
Personal injury or illness	❐
Sexual difficulties	❐
Difficulties or changes at school or work	❐
Retired or lost job	❐
Changed residence	❐
Major mortgage	❐
Foreclosure	❐
Legal difficulties	❐
Owe money	❐

OTHER COMMENTS ON STRESSORS:

____

____

____

____

GOALS AND EXPECTATIONS FOR THIS VISIT:

____

____

____

____

Thank you.

____