Chwen-Yuen Angie Chen, MD, FACP, FASAM
Addiction Medicine MD
Board Certified, American Board of Internal Medicine
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1900 O'Farrell Street, Suite 190, San Mateo, CA 94403
Phone 650-503-4115 ~ Fax 888-755-4489 ~ www.addictionmedicinemd.com

HISTORY INTAKE FORM – ALL INFORMATION IS CONFIDENTIAL

Name _____ Date_____

Address _____ Apt # _____

City_____State_____Zip_____

Birth date _____ Age _____ Gender Identity/Pronouns_____

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 (_____) _____

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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 cannot recall, or prefer not 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 begin using an opioid every day? _____

When did you first become dependent, or get sick if you did not use regularly? _____

Have you 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 ☐ Outpatient treatment, therapy, or self-help groups (NA/AA/RR)

☐ 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				
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 When? _____☐ No

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

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

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.