Patient Intake Form

VICTORY Recovery Partners

This form is completely confidential and will be a part of your medical record.

Demographic Information:

Patient Name:_____DOB: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone:_____ Is it okay to leave a message? ☐ Yes ☐ No

Gender:_____

Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Declined/Unknown ☐Other_____

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Other Preferred Language:_____

Email: _____ Can we text you appointment reminders? ☐ Yes ☐No

Emergency Contact Name:_____Emergency Contact #: _____

Emergency Contact Relationship: _____

Mothers Name/Guardian (if under 21): _____

Fathers Name/Guardian (if under 21): _____

Name of Person filling out this form if not patient: _____

Current Occupation: _____

Current Occupation Status: ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Disability

Pharmacy Information:

Pharmacy Name: _____ Address/City: _____

Health Insurance Information:

Primary Insurance Name:_____Policy #: _____

Policy Holder Name:_____Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Address:_____City:_____State:_____Zip:_____

Do you have a secondary insurance? ☐Yes ☐No

Name of Primary Care Physician: _____

How did you hear about us? ☐Walked/Drove By ☐Google Search ☐ ☐Family/Friend Referral ☐Social Media ☐ Newspaper ☐Doctor/Therapist Referral ☐Hospital/Detox ☐Legally Mandated ☐EAP/Employer ☐Other_____

Physical Health:

Medications:

List ALL Medications you CURRENTLY Take (Including Non-Prescription Medications and Herbal Supplements)		
Medication Name	**Dose**	**Times taken Daily**

Allergies: Please list all

1. Medication Allergies: _____
2. Food Allergies: _____
3. Environmental Allergies: _____
4. Latex Allergy: ☐Yes ☐No

Describe your physical health: ☐Good ☐Average ☐Poor

Are you currently under a doctor's care? ☐Yes ☐No

If yes, please provide doctor's full name: _____

Reason for care? _____

Have you been hospitalized in the past 6-12 months? If YES, please describe: _____

_____

Do you have any current concerns about your physical health? If YES, please specify: _____

_____

Do you have or have you ever had any of the following?

Aids or HIV	☐Yes ☐No	Epilepsy/Convulsions	☐Yes ☐No	Kidney Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting/Seizures	☐Yes ☐No	Liver Disease	☐Yes ☐No
Anorexia	☐Yes ☐No	Frequently Fatigued	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Arthritis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Obesity	☐Yes ☐No
Asthma	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Bulimia	☐Yes ☐No	Heart Attack	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer	☐Yes ☐No	Heart Disease	☐Yes ☐No	Swollen Ankles	☐Yes ☐No
Chest Pain	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Syphilis	☐Yes ☐No
Chlamydia	☐Yes ☐No	Hepatitis	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Diabetes	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No

Family History:

Check all that apply, Check here if history ☐Unknown

Present Health or Cause of Death	Present Age OR Age at Death		Relationship
Bleeding Disorder			☐Mother ☐Father ☐Sister ☐Brother
Clotting Disorder			☐Mother ☐Father ☐Sister ☐Brother
Diabetes			☐Mother ☐Father ☐Sister ☐Brother
Stroke			☐Mother ☐Father ☐Sister ☐Brother
Heart Disease			☐Mother ☐Father ☐Sister ☐Brother
Hypertension			☐Mother ☐Father ☐Sister ☐Brother
Cancer:_____			☐Mother ☐Father ☐Sister ☐Brother
Drug Abuse			☐Mother ☐Father ☐Sister ☐Brother
Alcohol Abuse			☐Mother ☐Father ☐Sister ☐Brother

Mental Health Data:

Are you currently under the care of a Psychiatrist, Psychologist, Therapist, or Counselor? ☐Yes ☐No

If yes, please provider their name: _____

What mental health symptoms are you seeing the above for?_____

Substance Abuse Data:

What substances are you currently or do you have a history of using: _____

When was the last time you used? _____

When is your longest period of sobriety?_____

Have you ever overdosed on a substance(s)? ☐Yes ☐No If YES, Number of times you have overdosed: _____

From what substances(s) have you overdosed?_____

Do you consume alcohol? ☐Never ☐Occasionally ☐Heavily If yes, How many drinks per week_____

If former alcohol use, when was your quit date? _____

Tobacco Use:

Do you currently smoke cigarettes? ☐Yes ☐No

If YES, How many per day_____For how many years?_____

If a former smoker when was your quit date? _____

Do you currently use smokeless tobacco products? ☐Yes ☐No

Previous Substance Abuse Treatment:

Have you ever been in treatment for Substance Use Disorder? ☐Yes ☐No

If yes, when and where? _____

For what substances? _____

When is your longest period of sobriety?_____

Legal History Data:

In the past 12 months, have you been convicted? ☐Yes ☐No

If yes, was it a felony or misdemeanor? ☐Felony ☐Misdemeanor

Reason for conviction: _____

Have you ever had any drug or alcohol related arrests? ☐Yes ☐No

Have you ever had a DWI/DUI (Driving While Intoxicated or Under the Influence)? ☐Yes ☐No

Are you currently on probation? ☐Yes ☐No Explain:_____

Do you currently have any pending charges? ☐Yes ☐No Explain: _____

CONFIDENTIALITY NOTICE: All intake information is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR Pts 160 and 164 and cannot be disclosed without written consent unless otherwise provided for in the regulations. The Federal rules prohibit any further disclosure of this information unless a written consent is obtained from the person to whom it pertains. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.