PERSONAL INFORMATION

NAME _____ _____
(first) (last)
DATE _____
HEALTH CARD #_____VERSION CODE: _____
DATE OF BIRTH _____
(year/month/day)
ADDRESS_____APT # _____
CITY_____POSTAL CODE _____
PHONE day ( )_____ evening ( ) _____

CONTACT IN CASE OF EMERGENCY (state relationship)

_____

CONTACT'S PHONE ( ) _____

WHO REFERRED YOU?_____
GENDER: ❑ male ❑ female

DRUG USE HISTORY:

OPIOIDS

Opioids used (in order of preference/frequency of use): _____

First used: _____

When use became regular or daily: _____

What route/when started using by that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

METHAMPHETAMINE

First used: _____

When use became regular or daily: _____

What route/when started that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

COCAINE

First used: _____

When use became regular or daily: _____

What route/when started that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

ALCOHOL

First used: _____

When use became regular or daily: _____

What route/when started that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

BENZODIAZEPINES

First used: _____

When use became regular or daily: _____

What route/when started that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

CANNABIS

First used: _____

When use became regular or daily: _____

What route/when started that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

TOBACCO

First used: _____

When use became regular or daily: _____

What route/when started that route: _____

Amount used currently and frequency (how often): _____

Last used: _____

Pattern of use in last 12 months: _____

Harms/consequences of use recognized (health/physical, financial, social, occupational, legal, etc):

_____

DSM-V CRITERIA:

Do you frequently take more drugs than you planned, or use them for longer than you planned to? ❑ yes ❑ no

Have you had many unsuccessful attempts to cut down on your drug use or do you often want to cut down or quit?

❑ yes ❑ no

Do you spend a lot of your day getting, using, and recovering from the effects of drugs? ❑ yes ❑ no

Do you feel cravings, or strong desires or urges to use drugs? ❑ yes ❑ no

Have you given up on work, social or other things you used to do because of your drug use? ❑ yes ❑ no

Have you had times where you haven't been able to keep up your responsibilities because of your drug use?

❑ yes ❑ no

Do you keep taking drugs, despite the harm and problems they are causing you? ❑ yes ❑ no

If so, what kinds of harms and problems have they been causing you:

_____

_____

Have you often used drugs in situations it which it may be dangerous ❑ yes ❑ no

Do you need more and more of the drug you are using to get the same effect? ❑ yes ❑ no

Describe what symptoms you experience if you suddenly stop taking the drug:

_____

_____

PRESCRIPTION MEDICATIONS:

(Any medications you regularly take or are prescribed, amount and frequency): none ❑
or, give details_____
_____
_____
_____

DRUG ALLERGIES:

none ❑ or, give details:

_____
_____

(any medications you can't take, and WHY NOT?)

PAST MEDICAL HISTORY: (circle and give year)

List all current health conditions including all conditions for which medications are taken or other treatments used

_____

_____

List all past health concerns that have since resolved, including any overnight hospitalizations or operations:

_____

_____

Ask specifically about any drug overdoses, seizures, heart problems, lung problems, hepatitis C status, HIV status.

_____

_____

Name of family doctor: _____

Is your doctor aware of your drug problem? ❑ yes ❑ no

If no family doctor, would you like a referral to a nurse practitioner:_____

For women, date of last menstrual period: _____

Current method of contraception? The Pill/condoms/other:_____

Is there any chance you might be pregnant ? ❑ yes ❑ no

EMOTIONAL HEALTH/PSYCHIATRIC HISTORY:

Have you ever been treated by a family doctor or psychiatrist for:

anxiety? ❑ depression? ❑ ADHD? ❑ PTSD? ❑ Other: _____

Have been admitted to a psychiatric facility? ❑ yes ❑ no

Were you abused? (mentally, sexually or physically?) ❑ yes ❑ no

Have you ever attempted suicide? ❑ yes ❑ no If yes, how often and when: _____

Are you currently depressed or suicidal? ❑ yes ❑ no

FAMILY HISTORY:

Is there any family history of medical problems like alcohol or drug abuse, depression, or other mental health concerns. (indicate the problem and the relationship to the client):

_____

_____

DRUG TREATMENT PROGRAMS:

List any drug treatment programs including length of stay, dates attended, length of abstinence following program (include outpatient medication treatment):

_____

_____

SOCIAL HISTORY:

Are you: married/single/separated/divorced/common-law/widowed
Children?_____Whose custody are the children in? _____

Who lives in your household? _____ Do they abuse alcohol/drugs? ❑ yes ❑ no

Are the people close to you aware of your drug problem? ❑ yes ❑ no

Usual occupation:_____Are you currently employed ? ❑ yes ❑ no
Last job held:___From when____to ____ Highest level of education: _____
Are you receiving: welfare/FBA/pension/UI/none/other? Do you drive a car? ❑ yes ❑ no

LEGAL STATUS:

1. Are you currently on probation or parole? ❑ yes ❑ no
if yes, until when ? _____

2. Is treatment a condition of your probation? ❑ yes ❑ no
if yes, when ? _____

3. Do you have any Court dates pending? ❑ yes ❑ no
if yes, when ? _____

4. Do you have previous convictions? ❑ yes ❑ no
if yes, for what ?_____

5. Have you been incarcerated? ❑ yes ❑ no
if yes, for what ?_____

6. How long have you been in jail for in total? _____

7. Have you been charged with impaired driving? ❑ yes ❑ no

8. Have you been charged with a crime that included a weapon or violence? ❑ yes ❑ no

TREATMENT GOALS:

Why have you come for treatment at this time? _____

What type of treatment do you feel that you need? _____

What are your goals for treatment? _____

PHYSICAL EXAM:

BP__/___
HR ____/min
PUPILS: normal/pinned/dilated
CHEST: clear/other
CVS: murmur/other
ABDO: tender enlarged liver/spleen other
SKIN: tracks abscess tattoos piercing other
LYMPHADENOPATHY: ❑ yes ❑ no

CHECKLIST:

1. Personal information complete, including accurate date of birth and valid health card information
2. Treatment agreement reviewed and signed.
3. All relevant consents (previous clinics, family doctor, pharmacy, etc.) completed and signed