PATIENT INFORMATION **DATE:** **TIME:**

Former Patient (y/n):	Referred By:	Primary Medical Doctor:
Last Name:	First:	Middle:
Date of Birth:	Sex:	Social Security #:
Street Address:	Phone:	
City, State & Zip:		
Latino/Hispanic:		Race:
Martial Status (married, single, etc..)	Primary Language:	
Religion:	Maiden Name:	Occupation:
Employer Name:		Status(FT, PT, Retired), etc.:
Employer Address:	Employer Phone#:	Effective Dates (from/to):
Home Phone:	Cell:	

INSURED INFORMATION (Complete this section if the insured is NOT the patient)

Relationship to Patient:	Last Name:	First Name:
SS#:	D.O.B:	Sex:
Address:	Phone:	Occupation:
City, State & Zip:		
Employer's Name:	Employer's Address:	
Employer's Phone:	Effective Date(from/to):	Martial Status:

NEAREST RELATIVE

Last Name:	First Name:	Phone:
Street Address:		Relationship to Patient:
City, State & Zip:		

EMERGENCY CONTACT

Last Name:	First Name:	Relationship to Patient:
Work Phone:	Personal Phone:	

Name: _____ Age: _____ Sex: ❑ M ❑ F Today's Date: _____

Reason for admission/ assessment: _____

Drug of Choice	NA	Age 1st used	How often do you use	How much	Last use	Route: Smoke, IV Inhale, etc.
Alcohol						
Marijuana						
Cocaine						
Heroin						
Demerol						
Vicodin						
Lortab/Norco						
Dilaudid						
Methadone/Suboxone						
Xanax						
Valium						
Ativan						
Klonopin						
Soma						
Barbiturates						
PCP						
Amphetamines						
Ecstasy						
Diet pills						
Ritalin						
Inhalents						
Other: Prescription Drugs						
Other: Street Drugs						

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Information Completed by the Patient

Previous Treatments:

When?	Where?	How long did you stay sober after treatment?

Allergies: Drugs:_____ Food:_____ Other:_____

Medications patient is currently taking:

Name	Dosage	Frequency	Route	Comments

Who will be involved in your treatment (Spouse, Children, EAP, etc.)?

Name	Relationship	Phone Number

Are you active in AA/ NA? _____ Do you have a Sponsor? _____

Primary Care Doctor:_____ Psychiatrist:_____

Therapist:_____

Any other pertinent information you want to share with your physician/ staff: _____

Review By:_____ Date:_____ Time:_____

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Information Completed by the Patient