The Fresh Start Program
Waterstone Counseling Center

Dr. Thomas Abbenante, MD • Dr. Richard Goulding, MD
Dr. Marc F. Bono, Psy.D

Please complete the form and submit to a confidential fax at (203) 245-0572

PLEASE READ: IMPORTANT NOTE FOR FEMALE PATIENTS

We are currently unable to take in new patients who are already pregnant. However, should you become pregnant during your treatment at CCR, please alert us immediately and we will discuss your options with you. Pregnancy tests will be performed during your first visit, and then on the first week of every month at CCR. If you suspect that you may be pregnant before the first week of the following month, please alert your providers so a pregnancy test can be performed sooner.

Name of Person Completing Form:_____

Relationship to Patient:_____

Primary Care Physician:_____ **Referring/Specialty Dr:**_____

Pharmacy:_____ **Location (Street & City):**_____

Employer Name:_____
(We will not contact your employer without a signed consent from you)

Will this be your first treatment program? Yes No

What do you consider to be your primary addiction?
Please list that first in the sections below, to the best of your ability. Please include alcohol, addictive prescription medications and street drugs. For the chronic pain patient, please be sure to include all prescription narcotic and benzodiazepine medications.

Name of Drug	Quantity/Dosage Daily	How Long	Last Used

Are there any nonsubstance addictions you need help with? Yes No

If yes, please describe:_____

Please list any prior treatment programs you have attended, including outpatient treatment programs. This includes alcohol, drug and/or psychiatric treatment programs over the past 10 years:

Name of Program	Date	Purpose of Treatment

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What is your longest period of (clean and sober) sobriety?_____

_____

What helped you remain sober?_____

_____

Do you have a family history of addiction? Yes No If yes, please describe:

_____

Do you have any Current legal problems? Yes No If yes, please describe:

_____

Do you have any current medical problems? Yes No If yes, please describe:

_____

_____

_____

Are you currently in a Pain Management Program? Yes No If yes, please describe:

_____

Name of Program:_____

Telephone #:_____ **May we contact them?** Yes No

Please list any other medications you take that are not listed in the substance abuse questionnaire above.
Include name of medication, dosage, what frequency and the name of the prescribing doctor:

_____

_____

Have you ever experienced any of the following when you attempted to stop drinking or using or while drinking and/or using? Please check all that apply.

☐ Seizure ☐ Tremors ☐ Nausea/Vomiting ☐ Hallucinations

☐ Loss of Consciousness ☐ Hot/Cold Sweats ☐ Blackouts ☐ Falls

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? May we contact them?
Name:_____ **Telephone #:**_____

Name:_____ **Telephone #:**_____

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Name:_____ **Telephone #:**_____

Have you ever thought about, planned or attempted suicide? Yes No If yes, please describe:

_____

_____

Are you currently suicidal? Yes No If yes, please describe:

_____

_____

Are you Currently taking any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia or other psychiatric illnesses? Yes No If yes, please describe:

_____

_____

Have you ever been treated for or do you need treatment for an eating disorder? Yes No

If yes, please describe:

_____

_____

Is there any other important information you would like to provide at this time? Yes No

_____

_____

_____

_____

Allergies:

_____ Reaction:_____ ☐ Mild ☐ Moderate ☐ Severe

_____ Reaction:_____ ☐ Mild ☐ Moderate ☐ Severe

_____ Reaction:_____ ☐ Mild ☐ Moderate ☐ Severe

Significant & Systemic illnesses (Please mark all that apply)

☐ No history of illnesses	☐ Anemia COPD	☐ High Cholesterol	☐ Polymyalgia
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Migraine	☐ Asthma
☐ Hepatitis	☐ Lupus	☐ Arrhythmia	☐ Fibromyalgia
☐ Lung Disease	☐ Arthritis	☐ Eczema	☐ Kidney Disease
	☐ Diabetes	☐ HIV	☐ Psychiatric Disorder

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☐ Bleeding Disorder	☐ Skin Cancer	☐ Liver Disease
☐ Headache	☐ Cancer	☐ Stroke
☐ Kidney Stones	☐ Hearing Loss	☐ Thyroid Disease

Other:_____

17 Wall Street Madison, CT 06443 www.ccrfreshstart.com Phone (203) 245-0412 Fax (203)245-0572

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_____

_____

General Surgeries/Operations (Please list all): _____

_____

_____

Other Current Medications (Please list all): _____

_____

_____

Do you have any other specific questions or requests?_____

_____

_____

_____

Thank you very much for the time you have taken to complete this questionnaire. We will respond to your inquiry in a timely manner and look forward to working with you!
Sincerely,

17 Wall Street, Madison, CT 06443
p:203-245-0412 f: 203-245-0572

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Intake Staff at The Center For Compassionate Recovery:

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