WATERSTONE
Counseling Centers

Addiction Medicine and Psychotherapy

PLEASE READ: IMPORTANT NOTE FOR FEMALE PATIENTS
If you are currently pregnant, to trying to become pregnant please let our Patient Liaison Coordinator know immediately.

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)

Are you seeking treatment in our Substance Abuse Program Circle Response YES NO

If NO, PLEASE SKIP TO SECTION B

IF YES, PLEASE FILL OUT SECTION A

SECTION A – SUBSTANCE ABUSE QUESTIONNAIRE

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

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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

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

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

Please continue to Section B

SECTION B

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:

_____

_____

_____

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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:

_____

_____

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

Name:_____ **Telephone #:**_____

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:

_____

_____

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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	☐ Arthritis	☐ Polymyalgia	☐ Kidney Stones
☐ Congestive Heart Failure	☐ Diabetes	☐ Asthma	☐ Skin Cancer
☐ Hepatitis	☐ High Cholesterol	☐ Fibromyalgia	☐ Cancer
☐ Lung Disease	☐ Migraine	☐ Kidney Disease	☐ Hearing Loss
☐ Anemia COPD	☐ Arrhythmia	☐ Psychiatric Disorder	☐ Liver Disease
☐ High Blood Pressure	☐ Eczema	☐ Bleeding Disorder	☐ Stroke
☐ Lupus	☐ HIV	☐ Headache	☐ Thyroid Disease

Other:_____

General Surgeries/Operations (Please list all): _____

_____

_____

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, 45CFR 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. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message

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