TriState Health

SUBOXONE PROGRAM INTAKE FORM

Patient Information

Patient Name ______________________________ Date of Birth ____/____/_____ ❑ Male ❑ Female

Mailing Address ______________________________ City ________________ State _____ Zip ________

Phone # ________________ Phone Type ________ Alt Phone # ________________ Phone Type ________

Email ______________________________________ Social Security # ____________________

Race ❑ African American ❑ Alaska Native ❑ American Indian ❑ Caucasian ❑ Hispanic or Latino

❑ Native American ❑ Other ____________________________ Preferred Language ______________

Emergency Contact Information

Name ______________________________ Phone # ________________ Phone Type __________

Relationship to Patient ______________________________

Employer Information

Employer Name ______________________________ Position Title ____________________

Current Occupation Status ❑ Full-Time ❑ Part-time ❑ Self-employed ❑ Student ❑Unemployed

If employed, how long have you been at your current job? ❑ 30 days ❑ 90 days ❑ 6 months ❑ 1 year ❑ >2 years

If not employed, when was your last job? ____________________

Social History

Highest Education Level ❑ GED ❑ High School ❑ Associates Degree ❑ Bachelor's Degree

❑ Master's Degree ❑ Doctorate ❑ Other ______________________________________

Were you in the military? ❑ Yes ❑ No If yes, which branch? ❑Active Duty ❑Reserves ❑ National Guard

❑ Air Force ❑ Army ❑ Coast Guard ❑ Marines ❑ Navy

What is your relationship status? ❑ Single ❑ Married (# of marriages _____) ❑ Separated ❑ Divorced ❑ Widowed

Do you have children? ❑ Yes ❑ No If yes, how many and their ages? ______________________

What is your current living situation? ❑ Rent ❑ Own ❑ Friend's home ❑Relative's home ❑ Homeless

Do you feel that you live in a health and safe place? ❑ Yes ❑ No

Have you had difficulty meeting your basic needs (rent, clothing, shelter, etc.) in the last 12 months? ❑ Yes ❑ No

Do you collect disability income? ❑ Yes ❑ No

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Mental Health

Have you ever been hospitalized for psychiatric/behavioral health problems? ❑ Yes ❑ No

If yes, please explain ______________________________

In the past twelve months:

Have you felt sad, down, depressed? ❑ Yes ❑ No

Have you felt anxious or suffered a panic attack? ❑ Yes ❑ No

Have you had suicidal thoughts? ❑ Yes ❑ No

Have you attempted suicide? ❑ Yes ❑ No

In the past 30 days, have you felt that your mental health negatively impacted your ability to complete daily activities?

❑ Yes ❑ No

Please check any of the following behaviors that apply to you.

❑ Can't keep a job
❑ Compulsions
❑ Crying
❑ Eating problems
❑ Impulsive reactions
❑ Insomnia lack of motivation
❑ Nervous tics
❑ Odd behavior
❑ Overeating
❑ Procrastination
❑ Sleep disturbance
❑ Take too many risks
❑ Vomiting
❑ Withdrawal
❑ Work too hard

Are there any major stressors in you life? ❑ Yes ❑ No If yes, complete table below.

Stressors	Severity			How long?	
	Mild	Moderate	Severe	Recent	>1 year
Marriage/relationship					
Friends/social					
School-related					
Work-related					
Housing					
Financial					
Legal					
Death/grief					
Health problems					

Legal History

In the past 12 months, have you been convicted of a crime? ❑ Yes ❑ No

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

Have you even had any drug or alcohol related arrest? ❑ Yes ❑ No If yes, when was the most recent? __________

Have you ever been convicted of Driving While Intoxicated (DWI)? ❑ Yes ❑ No if yes, how many times? __________

Are you currently on probation? ❑ Yes ❑ No If yes, please explain ______________________________

Do you have any current pending charges? ❑ Yes ❑ No If yes, please explain ______________________________

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Chemical Dependency Information

Have you even been in treatment for chemical dependency or addiction? ❑ Yes ❑ No

If yes, where ______________________________

What was the treatment for? ______________________________

Are you involved in a recovery program? ❑ Yes ❑ No Do you attend meetings? ❑ Yes ❑ No

Have you completed a 12-step program? ❑ Yes ❑ No If yes, when? ______________________________

The following questions relate to the recovery support you currently have available to you.

In the last 30 days before you entered this program:

- How many times did you attend a self-help group meeting (AA, NA, MA)? ____________ meetings
- How many of those meeting were religious or faith affiliated? ____________ meetings
- Do you have a sponsor from any the self-help groups (AA, NA, MA)? ❑ Yes ❑ No
- Did you have family/friends in support of your recovery? ❑ Yes ❑ No
- How many people could you count on for recovery support when you need it? ____________

Currently, how many people can you count on for recovery support? ____________

Who are your supports? ______________________________

Besides substance abuse treatment and opiate replacement medication, what are the two most useful things you believe will help you in getting/staying off of substances? Please check any of the following that apply to you.

- ❑ Change in environment (staying away from certain people, places, etc.)
- ❑ Children
- ❑ Counseling
- ❑ Employment
- ❑ My faith or religion
- ❑ Other people in recovery
- ❑ Remembering the past/ consequences
- ❑ Staying busy/keeping occupied
- ❑ Support from a partner
- ❑ Support from family
- ❑ Support from friends
- ❑ The need to stay out of jail/prison
- ❑ Will power
- ❑ Other ______________________

Please complete the following chart.

Substance	Was this your drug of choice?	Age first used	Route (Oral, nasal, IV, etc.)	How much?	How Often	Date/time of last use
Alcohol	❑ Yes ❑ No					
Cocaine	❑ Yes ❑ No					
Ecstasy	❑ Yes ❑ No					
Heroin	❑ Yes ❑ No					
Inhalants	❑ Yes ❑ No					
LSD, PCP, hallucinogens	❑ Yes ❑ No					
Marijuana	❑ Yes ❑ No					
Methamphetamine	❑ Yes ❑ No					
Prescription pain killers	❑ Yes ❑ No					
Other prescription drugs (methadone, xanax, etc)	❑ Yes ❑ No					
Prescription stimulants (adderall, etc.)	❑ Yes ❑ No					
Other ________________	❑ Yes ❑ No					

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Health History (check all that have been present/diagnosed)

- ❏ AIDS/HIV
- ❏ Anemia
- ❏ Anorexia
- ❏ Arthritis
- ❏ Asthma
- ❏ Bulimia
- ❏ Cancer, type? ____________________
- ❏ Cardiac pacemaker
- ❏ Chest pain
- ❏ Chlamydia
- ❏ Chronic fatigue
- ❏ Easily winded/shortness of breath
- ❏ Emphysema
- ❏ Epilepsy/convulsions
- ❏ Fainting/seizures
- ❏ Glaucoma
- ❏ Hay fever
- ❏ Heart attack
- ❏ Heart disease
- ❏ Heart murmur
- ❏ Hepatitis
- ❏ High blood pressure
- ❏ Joint replacement
- ❏ Kidney disease
- ❏ Luekemia
- ❏ Liver disease
- ❏ Low blood pressure
- ❏ Mitral valve replacement
- ❏ Obesity
- ❏ Radiation therapy
- ❏ Recent weight loss
- ❏ Respiratory problems
- ❏ Rheumatic fever
- ❏ Stroke
- ❏ Swollen ankles
- ❏ Syphilis
- ❏ Thyroid problems
- ❏ Tuberculosis
- ❏ Ulcer/stomach issues

Physical Review (mark any which have been present to a significant degree, especially those present in the last 2-3 months)

- ❏ Back pain
- ❏ Blackouts
- ❏ Bowel disturbances
- ❏ Burning/itchy skin
- ❏ Chest pains
- ❏ Dizziness
- ❏ Don't like being touched
- ❏ Dry mouth
- ❏ Excessive sweating
- ❏ Fainting spells
- ❏ Fatigue
- ❏ Flushes
- ❏ Headaches
- ❏ Hearing problems
- ❏ Hearing things
- ❏ Muscles spasms
- ❏ Nervous tics
- ❏ Numbness
- ❏ Palpitations
- ❏ Rapid heart beat
- ❏ Sexual disturbances
- ❏ Skin problems
- ❏ Stomach issues
- ❏ Tension
- ❏ Tingling
- ❏ Tremors
- ❏ Twitches
- ❏ Unable to relax
- ❏ Visual disturbances
- ❏ Watery eyes

How would you descirbe your physical health? ❏ Poor ❏ Avergage ❏ Good ❏ Excellent

Do you currenlty have a primary care provider? ❏ Yes ❏ No If yes, who? ____________________

Reason for care ____________________

Have you been hospitalized in the past? ❏ Yes ❏ No If yes, please explain ____________________

____

Have you had any recent major illnessess or surgerys? ❏ Yes ❏ No If yes, please explain ____________________

____

Do you have any concerns about your physical health? ❏ Yes ❏ No If yes, please explain ____________________

____

Current Medications - Include all prescription and non-prescription (over-the-counter) medications

Medication Name	Dose (mg, mcg, %)	How Often?	Managed By

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Family History

Where were you born? ____

Were you adopted? ❑ Yes ❑ No If yes, what was your age at the time of adoption? ______________________

Father: If living, current age ________ If deceased, their age at death _________ Cause of death ________________

Mother: If living, current age ________ If deceased, their age at death _________ Cause of death ________________

Do your parents live together? ❑ Yes ❑ No Are they divorced? ❑ Yes ❑ No

Do you a family history of any of the following? (check all that have been present/diagnosed)

- ❑ AIDS/HIV
- ❑ Allergies
- ❑ Anemia
- ❑ Anorexia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bulimia
- ❑ Cancer, type? ____________________
- ❑ Cardiac pacemaker
- ❑ Chest pain
- ❑ Chlamydia
- ❑ Chronic fatigue
- ❑ Easily winded/shortness of breath
- ❑ Emphysema
- ❑ Epilepsy/convulsions
- ❑ Fainting/seizures
- ❑ Glaucoma
- ❑ Hay fever
- ❑ Heart attack
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- ❑ Radiation therapy
- ❑ Recent weight loss
- ❑ Respiratory problems
- ❑ Rheumatic fever
- ❑ Stroke
- ❑ Swollen ankles
- ❑ Syphilis
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Ulcer/stomach issues

Allergies - Please list any allergy or intolerance you have to medications or environment (i.e. dust, nuts, animals)

Medication or Environmental Issue	Reaction