New Patient Packet

Welcome, you are in the right place.

Our purpose at Addiction Angels of America is to deliver the best individualized comprehensive outpatient treatment for drug and alcohol addiction in Columbus, Ohio.

By completing the following forms, you are declaring that you are ready to be free from the challenges, pain and problems that brought you to us.

Please answer each form completely and honestly so that we can fully support you with the plan that best serves you without the fear of judgment.

This is your time. You deserve the best. Our team is here to be sure you get it.

Addiction Angels of America New Patient Packet ▸ Medical History Intake

(To be completed by patient)

Use the opposite side of the page complete your answers if needed. Please print legibly.

Name: _____

DOB: _____ Age: _____ SS#:_____

Address:

_____

City: _____ State: _____ Zip Code:_____

Phone: (w) _____ (home) _____ (cell)_____

Emergency Contact:

_____

Relationship to patient: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Date of last physical: _____
Have you ever had an EKG? N ( ) Y ( ) Date:_____

Current of past medical conditions (check all that apply): If there is a family history of the illnesses listed please put an "F" next to that illness.

( ) Asthma/ respiratory	( ) Cardiovascular (heart attack, high cholesterol, angina)	
( ) Hypertension	( ) Epilepsy or seizures disorder	( ) GI disease
( ) Head trauma	( ) HIV/AIDS	( ) Diabetes
( ) Liver problems	( ) Pancreatic problems	( ) Thyroid disease
( ) STDs	( ) Abnormal Pap smear	( ) Nutritional deficiency

Other (Please describe):

_____

_____

Is there a family history of anything NOT listed here? N ( ) Y ( ) Please explain below.

_____

_____

_____

Have you ever had surgery or been hospitalized? N ( ) Y ( ) (please describe)

_____

_____

_____

Childhood Illnesses

Measles N ( ) Y ( ) Mumps N ( ) Y ( ) Chicken Pox N ( ) Y ( )

Have you or a family member even been diagnosed with psychiatric or mental illness? N ( ) Y ( )

(Please describe)

_____

_____

Have you ever taken or been prescribed antidepressants? N ( ) Y ( )

For what reason?

_____

_____

Medication(s) and dates of use:_____

_____

Why discontinued? _____

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day)

DO NOT include medications you may be currently misusing (that information is needed later):

_____

_____

_____

Please list all herbal medications, vitamin supplements, etc. and how often you take them:

_____

_____

_____

Have you ever been diagnosed with a Seizure? No ( ) Yes ( )

If Yes, when? _____ and by whom?_____

Do you recall the name given to your type of seizure?

_____

What medications were you given?

_____

Are you still using those medications? No ( ) Yes ( )

If No, why not?_____

Please list any allergies you have (e.g., penicillin, bees, and/or peanuts):

_____

Substance Abuse History:

I originally started my use of narcotics in (month/year) _____ at age _____

I started using opioids like oxycodone: To Get High ( ) To treat pain ( ) After surgery ( )

Fill out all that apply ((Please write (C) for current and (P) for past))

SUBSTANCE (Current or Past)	HOW INGESTED	AMOUNT & FREQUENCY (grams, packs, joints, mg, etc.)	LAST USE
Heroin			
Cocaine			
Opioid			
Marijuana			
Alcohol			
Tobacco			
Buprenorphine(Suboxone)			
Other drugs			

Substance Abuse Counseling (SAC) History: (Check what applies)

I am not attending SAC currently ( )

I am trying to set up SAC currently ( )

I am attending SAC currently at:

_____

How Many Times per Week do you Attend?

I attend _____/ week for individual counseling

I attend _____/week for group counseling

I have attended SAC in the past.
Last attended (mo./yr.): _____/_____ at _____

I have NEVER attended any kind of SAC

Have you ever been to Individual Counseling: N ( ) Y ( )

If you are not currently in counseling what made you stop attending and/or attend originally?

_____
_____
_____
_____

Living Arrangements: (Circle one of the following)

I live in: An Apartment, House, Trailer, Car, Other_____

I live with: Spouse, My Children, Significant Other, Friend, Other_____

I live with "users" currently I do NOT live with "users" currently

Employment History ▸

I am currently working FT PT at_____

I am not working now but I will be seeking: Employment Disability

I am already disabled due to

_____

Relationship Status ▸ (Circle one of the following)

Married Single Long-term Relationship Divorced Separated

Years married/ in long-term relationship:____ Times Married: ____ Times Divorced: ____

Children? N ( ) Y ( ) Current ages (please list)

_____

Residing with you? N ( ) Y ( ) If no, where?

_____

Where are you currently living?

_____

Do you have family nearby? N ( ) Y ( ) (please describe)

_____

Education (check most recent degree):

( ) Graduate School ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Have you ever been arrested or convicted? N ( ) Y ( ) (Check all that apply)

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) other _____

Have you ever been abused? N ( ) Y ( )

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

By signing this document, I am agreeing that the information I provided is correct.

_____ _____ _____

Signature Print Date