ADVANCED PAIN CARE

OPIOID STEWARDSHIP NEW PATIENT INTAKE

Patient Name: _____ DOB: _____

Please take a few minutes to fill out this medical intake to facilitate your appointment today

Past Psychiatric History

Past Outpatient Treatment? ☐ Yes | ☐ No
If yes, please describe:

When	By Whom	Nature of Treatment

Past Psychiatric Hospitalization? ☐ Yes | ☐ No
If yes, please describe:

When	Where	Reason

Past Psychiatric Medications? ☐ Yes | ☐ No
If yes, please describe:

Name of Medication	Dose	How often do you take it	What is it for	Who prescribes it

Are you currently seeing a Mental Health Provider? ☐ Yes | ☐ No

Provider Name: _____

Diagnosis: _____

What brings you to counseling currently? Is there something specific, such as a particular event?
Be as detailed as you can: _____

Are you having any thoughts of hurting yourself? ☐ Yes | ☐ No

Symptoms Checklist:

	Y	N		Y	N
Depressed Mood	○	◉	Change In Appetite	○	○
Racing Thoughts	○	○	Excessive Energy	○	○
Excessive Worry	○	○	Excessive Guilt	○	○
Unable to Enjoy Activities	○	○	Increased Irritability	○	○
Impulsivity	○	○	Fatigue	○	○
Anxiety Attacks	○	○	Crying Spells	○	○
Sleep Patter Disturbance	○	○	Decreased Libido	○	○
Increase Risky Behavior	○	○			
Avoidance	○	○			
Loss of Interest	○	○			
Increased Libido	○	○			
Hallucinations	○	○			
Concentration / Forgetfulness	○	○			
Decrease Need for Sleep	○	○			
Suspiciousness	○	○			

Have you been treated for depression, anxiety, bipolar illness, or ADD? ☐ Yes | ☐ No

Do you have any history of substance abuse (such as alcohol, marijuana, cocaine, methamphetamine, heroin, pain medications, and/or other)? ☐ Yes | ☐ No

Do you use illicit substances? ☐ Yes | ☐ No

Do you have gambling problems? ☐ Yes | ☐ No

Have you ever been to a substance abuse treatment program (either inpatient or outpatient)? ☐ Yes | ☐ No

Have you ever been arrested for DWI, public Intoxication, and/or possession of controlled substance? ☐ Yes | ☐ No

Any tobacco use? ☐ Yes | ☐ No | ☐ Prior Use

If yes, packs per day _____ for _____ years. If prior user, year quit? _____

Do you have a family history of substance abuse or psychiatric illness? ☐ Yes | ☐ No

Have you ever had an adverse reaction to opioid pain medication including overdose, tolerance, or withdrawal?
☐ Yes | ☐ No

Allergies (Please list all medication/drug allergies with the reaction):

Name of Medication:	Reaction:

Current Medication (Please list all the medications you are currently taking):

Name of Medication	Dose	Directions	What is it for	Who prescribes it

Preferred Pharmacy: ◯ Advanced Rx ◯ Other: _____

***Advanced Rx pick up or mail next day available (Shipping and Handling included) ***

Please Provider Your Past Medical Conditions/Diagnosis

Condition/Diagnosis	Details	Treating Physician

Please Provider Your Past Surgical History

Date of Surgery	Type of Surgery	Hospital	Performed By

Hospitalization other than surgery (include dates): _____

Family Medical History:

Has your mother ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Has your father ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Have any of your siblings ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Have any of your children ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Has your mother's parents ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Has your mother's siblings ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Has your father's parents ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____
Has your father's siblings ever had:	☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Other_____

Any other family history and relation to you: _____

Patient Signature:_____ Employee's Initials:_____ Provider's Initials: _____