

Fair Start

Patient History

Date: _____

Name: _____

City/State: _____

Gender: Male Female

Occupation: _____

Birth Date: _____

Ethnicity/Race: _____

Marital Status: Single Married Separated Divorced Widowed Living with partner

How old were you when you first used alcohol/drugs? _____

How old were you when you first started using opiates? _____

<u>OPIATES</u>	<u>Usage</u>	<u>How Often:</u> Daily(D), Weekly(W), Occasionally(O)	<u>Date of Last Use</u>	<u>Quantity Used</u>
Percocet	Current <input type="checkbox"/> Past <input type="checkbox"/>			
Vicodin	Current <input type="checkbox"/> Past <input type="checkbox"/>			
Oxycontin	Current <input type="checkbox"/> Past <input type="checkbox"/>			
Oxycodone	Current <input type="checkbox"/> Past <input type="checkbox"/>			
Heroin	Current <input type="checkbox"/> Past <input type="checkbox"/>			
Methadone	Current <input type="checkbox"/> Past <input type="checkbox"/>			
<u>Other Opiates</u>				
_____	Current <input type="checkbox"/> Past <input type="checkbox"/>			
_____	Current <input type="checkbox"/> Past <input type="checkbox"/>			

Do you currently drink alcohol? Yes No If yes, how often do you drink and how much?

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OTHER DRUGS:

DRUG	USAGE	DATE OF LAST USE
Marijuana/Spice/K2/Hash	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Amphetamines	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Cocaine	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Tranquillizers Sleeping Pills Ambien, Xanax, Valium, etc	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Hallucinogens	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Ecstasy	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Inhalants	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Nicotine	Current <input type="checkbox"/> Past <input type="checkbox"/>	
Other Drugs	Current <input type="checkbox"/> Past <input type="checkbox"/>	

Has your drug/alcohol use created problems in your life? Yes No

If yes, what areas of your life have been impacted: Health Relationships Legal
Social Employment Motivation Education Finances

Please describe the impacts _____

Have you experienced any of the following withdrawal symptoms?

Nausea Vomiting Sweats Chills Headaches Body Aches Shakes
Insomnia Seizure Anxiety Depression Loss of Appetite Difficulty
Concentrating Paranoia Psychosis

Any other family members who have problems with alcohol/other drugs?

Yes No Adopted/Unknown

If yes, please identify from the list:

Mother Father Siblings Grandmother Grandfather Aunts Uncles
Cousins

Is your Mother: alive deceased Briefly describe your relationship: _____

Is your Father: alive deceased Briefly describe your relationship: _____

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Are your parents married divorced separated never married
 Do you have stepparents? Yes No Briefly describe your relationship with them.

Do you have any siblings? Yes No If yes, how many brothers: ____ sisters ____
 Describe your relationship with them: _____

Do you have any children? Yes No If yes, how many? _____
 How old are your children: _____

Are you currently having any thoughts or plans of suicide? Yes No If yes, please describe: _____

Are you currently seeing any of the following? Psychiatrist Psychologist Counselor
 Have you experienced any abuse in your lifetime? Yes No
 If yes, did you experience: Verbal Physical Sexual Emotional
 Please describe: _____

Were you or are you in the military? Yes No (If no continue to next section)
 Branch of service? _____
 Dates: From _____ To _____
 Type of discharge: _____
 Did you experience combat? Yes No If yes, please describe: _____

What don't you like about your alcohol/drug use? _____

On a scale of 1 to 10, how would you rate your ability to change? _____

Have you previously been detoxed? Yes No If yes, how many times? _____
 Have you had prior treatment for addiction? Yes No If yes, please list the names of the program(s) you have attended:

Program Name	Year	Outpatient	Residential	Completed
		<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Have you participated in any recovery support groups (AA,NA,etc)? Yes No If yes, which groups have you attended? _____

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Have you had periods of abstinence from all alcohol/drugs? Yes No If yes, what was the longest period of abstinence you've had? _____

Are you aware of the things that might trigger you to drink or use other drugs? Yes No If yes, what are your triggers? _____

Past Medical History (check conditions that apply to you or blood relatives):

	Self	Family		Self	Family
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Seizure History	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Type _____			Location _____		
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		
Packs/Day _____					
# Years _____					

Other Current Medical History: _____

Hospitalizations: (Include Mental Health, Medical/Surgical and Emergency Room Visits)

MEDICATIONS:	DOSE	LENGTH OF USE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug allergies _____

What is your height? _____ Weight? _____