



# HUNTSVILLE EMOTIONAL WELLNESS CENTER

## NEW PATIENT INFORMATION

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex:  Male  Female | Marital Status:  Married  Single  Other | Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Education Level: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Race:  Asian  Black  Native American  White  Other | Ethnicity:  Hispanic  Non-Hisp.

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Person: \_\_\_\_\_

### SPOUSE/PARTNER INFORMATION *(if applicable)*

Spouse/Partner Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

Responsible Party: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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Secondary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## PHARMACY INFORMATION:

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

## SIGNATURE and DATE

Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_



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## SUBSTANCE ABUSE HISTORY

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

What brings you to treatment: \_\_\_\_\_

### OPIOID USE HISTORY:

Age of first use: \_\_\_\_\_ Age it became a problem: \_\_\_\_\_ Last Use: \_\_\_\_\_

Average Amount Used: \_\_\_\_\_ Route: , Oral , Nasal , Injection

Current Symptoms: \_\_\_\_\_

Have you ever tried to quit on your own? , Yes , No Details: \_\_\_\_\_

Previous Treatment for Opioid Dependence: \_\_\_\_\_

Other Substance Abuse Treatment (Dates & Locations): \_\_\_\_\_

Have you ever had a drug overdose? , Yes , No Date(s) and details: \_\_\_\_\_

Has your drug use ever resulted in legal problems? , Yes , No Date(s) and details: \_\_\_\_\_

### OTHER SUBSTANCE ABUSE HISTORY:

#### ALCOHOL: (includes beer, wine, hard liquor)

#### SEDATIVES (benzodiazepines, barbiturates, Z-drugs)

Substance: \_\_\_\_\_

Substance(s): \_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_

Beginning Problem Use: \_\_\_\_\_

Beginning Problem Use: \_\_\_\_\_

Recent Average Use: \_\_\_\_\_

Recent Average Use: \_\_\_\_\_

Max Use: \_\_\_\_\_

Max Use: \_\_\_\_\_

Treatment Tried: \_\_\_\_\_

Treatment Tried: \_\_\_\_\_



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## STIMULANTS: (Cocaine, Amphetamines)

Substance: \_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_

Beginning Problem Use: \_\_\_\_\_

Recent Average Use: \_\_\_\_\_

Max Use: \_\_\_\_\_

Treatment Tried: \_\_\_\_\_

## MARIJUANA, SPICE, SYNTHETIC MARIJUANA

Substance(s): \_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_

Beginning Problem Use: \_\_\_\_\_

Recent Average Use: \_\_\_\_\_

Max Use: \_\_\_\_\_

Treatment Tried: \_\_\_\_\_

## HALLUCINOGENS, LSD, MUSHROOMS

Substance: \_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_

Beginning Problem Use: \_\_\_\_\_

Recent Average Use: \_\_\_\_\_

Max Use: \_\_\_\_\_

Treatment Tried: \_\_\_\_\_

## INHALANTS (glues, anesthetics, etc.)

Substance(s): \_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_

Beginning Problem Use: \_\_\_\_\_

Recent Average Use: \_\_\_\_\_

Max Use: \_\_\_\_\_

Treatment Tried: \_\_\_\_\_

## OTHER DRUGS:

\_\_\_\_\_

First use: \_\_\_\_\_ Last Use: \_\_\_\_\_ Recent Average Use: \_\_\_\_\_

### SUBSTANCE ABUSE TREATMENT HISTORY: *include dates and locations*

Inpatient Treatment: \_\_\_\_\_

\_\_\_\_\_

Outpatient Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Parent/Guardian Signature if under 18

\_\_\_\_\_

Date

\_\_\_\_\_

Date



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## MEDICAL AND PSYCHIATRIC HISTORY

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Therapist: \_\_\_\_\_

### PAST PSYCHIATRIC HISTORY:

Outpatient Treatment:  Yes  No If yes, describe when and by whom

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Psychiatric Hospitalization:  Yes  No If yes, describe for what reason, when and where:

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### Have you ever been diagnosed or treated for:

Bipolar Disorder	<input type="radio"/> Yes	<input type="radio"/> No	Schizophrenia	<input type="radio"/> Yes	<input type="radio"/> No
Depression	<input type="radio"/> Yes	<input type="radio"/> No	PTSD	<input type="radio"/> Yes	<input type="radio"/> No
Anxiety	<input type="radio"/> Yes	<input type="radio"/> No	ADHD	<input type="radio"/> Yes	<input type="radio"/> No
Suicide	<input type="radio"/> Yes	<input type="radio"/> No	Anger/Violence	<input type="radio"/> Yes	<input type="radio"/> No

Past Psychiatric Medications			
Name	Dates	Dosage	Response/Side Effects



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## PAST MEDICAL HISTORY

**Medication Allergies:** \_\_\_\_\_

**List ALL current prescription medications:** *(bring attached copy of medications if more space needed)*

Medication Name	Total Daily Dose	Start Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Over the Counter Medications or Supplements:** \_\_\_\_\_

### Current Medical Problems:

- Thyroid Disease • Anemia • Liver Disease • Kidney Disease • Diabetes • Asthma/Respiratory Problems
- Cancer • Stomach Problems • Fibromyalgia • Heart Disease • Seizures • Chronic Pain
- High Blood Pressure • High Cholesterol • Head Trauma

Details: \_\_\_\_\_

**Pertinent Family History** (Medical & Psychiatric): \_\_\_\_\_

**When your mother was pregnant with you, were there any complications during pregnancy or birth?**

### FOR WOMEN ONLY:

Date of last menstrual period: \_\_\_\_\_ Birth Control Method: \_\_\_\_\_

Are you currently pregnant, think you might be pregnant, or breastfeeding? • Yes • No

Are you planning to get pregnant in the near future? • Yes • No



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## SOCIAL HISTORY

**EXERCISE:** Do you exercise regularly?  Yes  No How many days per week? \_\_\_\_\_

**CAFFEINE:** How many caffeinated beverages do you drink per day? \_\_\_\_\_

**TOBACCO:** Packs per day \_\_\_\_\_ How many years? \_\_\_\_\_

In the past?  Yes  No How many years did you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**ALCOHOL:** How often? \_\_\_\_\_ Type: \_\_\_\_\_

### EDUCATION AND WORK HISTORY:

Highest Grade/Degree Completed: \_\_\_\_\_ Where: \_\_\_\_\_

Are you currently:  Working  Student  Unemployed  Disabled  Retired

Occupation: \_\_\_\_\_ Where do you work? \_\_\_\_\_

Did you ever serve in the military?  Yes  No If so, what branch and when? \_\_\_\_\_

Honorable discharge?  Yes  No Details \_\_\_\_\_

### RELATIONSHIP HISTORY:

Relationship status:  Married  Partnered  Divorced  Widowed  Single | How long? \_\_\_\_\_

Any prior marriages?  Yes  No | If so, how long \_\_\_\_\_

If not married, are you in a relationship?  Yes  No | If yes, how long? \_\_\_\_\_

Are you sexually active?  Yes  No | Sexual Orientation:  Heterosexual  Homosexual  Bisexual  
 Transsexual  Asexual  Prefer not to answer  Other \_\_\_\_\_

Children:  Yes  No | List ages and genders: \_\_\_\_\_

List everyone who current lives with you: \_\_\_\_\_

### LEGAL HISTORY:

Have you ever been arrested?  Yes  No | Do you have any pending legal problems?  Yes  No

### SPIRITUAL LIFE:

Do you belong to a religion or spiritual group?  Yes  No | If so, which one? \_\_\_\_\_



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## **FAMILY AND CHILDHOOD BACKGROUND:**

Were you adopted? , Yes , No At what age? \_\_\_\_\_ Where did you grow up? \_\_\_\_\_

List siblings and their ages: \_\_\_\_\_

What was your father's occupation? \_\_\_\_\_ Mother's occupation? \_\_\_\_\_

Did your parents divorce? , Yes , No How old were you? \_\_\_\_\_ Who did you live with? \_\_\_\_\_

Trauma history: History of being abused emotionally, sexually, physically or by neglect? , Yes , No

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/Guardian Signature if under 18

\_\_\_\_\_

Date