Valley View Health Services Inc
Addiction Treatment Center
Internal Medicine
1001 9th Ave, Suite 2
Brackenridge, PA. 15014-1107
(724) 393-1756

Substance Use Disorder Intake:

Please complete all information on this form and bring it to the first visit.

It may seem long, but most of the questions require only a check, so it will go quickly.

You may need to ask family members about the family history. Thank you!

Today's Date:

Name:

Date of Birth:

Primary Care Physician:

Do you give permission for ongoing regular updates to be provided to your Primary care physician? ( ) Yes ( ) No

What are the problem(s) for which you are seeking help?

1.

2.

3.

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood

( ) Unable to enjoy activities

( ) Sleep pattern disturbance () Loss of interest

( ) Concentration/forgetfulness ( ) Change in appetite

( ) Excessive guilt

( ) Fatigue

( ) Racing thoughts

( ) Impulsivity

( ) Increase risky behavior () Increased libido

( ) Decrease need for sleep

( ) Excessive energy

( ) Increased irritability

( ) Crying spells

( ) Excessive worry ( ) Anxiety attacks () Avoidance () Hallucinations

( ) Suspiciousness

( ) Decreased libido

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

Current medical problems:

Past Medical History:

- Thyroid Disease
- Anemia
- Liver Disease
- Chronic Fatigue
- Kidney Disease
- Diabetes
- Asthma/respiratory problems
- Stomach or intestinal problems

- Cancer (type)
- Fibromyalgia
- Heart Disease
- Epilepsy or seizures
- Chronic Pain
- High Cholesterol
- High blood pressure
- Head trauma
- Liver problems
- Other

Past Psychiatric History:

Past Surgical History:

Social History:

Family Medical History:

- Thyroid Disease
- Anemia
- Liver Disease
- Chronic Fatigue
- Kidney Disease
- Diabetes
- Asthma/respiratory problems
- Stomach or intestinal problems
- Cancer (type)
- Fibromyalgia
- Heart Disease
- Epilepsy or seizures
- Chronic Pain
- High Cholesterol
- High blood pressure
- Head trauma
- Liver problems
- Other

Non-psychiatric hospitalization:

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Is there any additional personal or family medical history? ( ) Yes ( ) No
If yes, please explain:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do:

Family Psychiatric History:

- Has anyone in your family been diagnosed with or treated for:
- Bipolar disorder
- Depression
- Anxiety
- Anger
- Suicide
- Schizophrenia
- Has any family member been treated with psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?

Substance Use:

- Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
- If yes, for which substances?
- If yes, where were you treated and when?
- How many days per week do you drink any alcohol?
- What is the least number of drinks you will drink in a day?
- What is the most number of drinks you will drink in a day?
- In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
- Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
- Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
- Do you think you may have a problem with alcohol or drug use? () Yes () No
- Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
- If yes, which ones?
- Have you ever abused prescription medication? ( ) Yes ( ) No

- If yes, which ones and for how long?
- Check if you have ever tried the following:
- Methamphetamine
- Cocaine
- Stimulants (pills)
- Heroin
- LSD or Hallucinogens
- Marijuana Yes No
- If yes, how long and when did you last use?
- Pain killers (not as prescribed)
- Methadone
- Tranquilizer/sleeping pills
- Alcohol
- Ecstasy
- How many caffeinated beverages do you drink a day? Coffee
- Sodas
- Tea

Tobacco History:

- How have you ever smoked cigarettes? ( ) Yes ( ) No
- Currently? ( ) Yes ( ) No
- How many packs per day on average?
- How many years?
- In the past? ( ) Yes ( ) No
- How many years have you smoked?
- When did you quit?
- How often per day on average?
- Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? () Yes ( ) No What kind?
- How many years?

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No List your siblings and their ages:

- Where did you grow up?
- What was your father's occupation?
- What was your mother's occupation?
- Did your parents' divorce? ( ) Yes () No If so, how old were you when they divorced?
- If your parents divorced, who did you live with?
- Describe your father and your relationship with him:
- Describe your mother and your relationship with her:
- How old were you when you left home?
- Has anyone in your immediate family died?
- Who and when?

Trauma History:

• Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No. Please describe when, where and by whom:

Educational History:

• Highest Grade Completed?
• Did you attend college?
• What is your highest educational level or degree attained?

Occupational History:

• Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
• How long is the present position?
• What is/was your occupation?
• Where do you work?
• Have you ever served in the military?
• If so, what branch and when?
• Honorable discharge ( ) Yes ( ) No Other type discharge

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long?
If not married, are you currently in a relationship? ( ) Yes () No If yes, how long?
Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation?

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? ( ) Yes ( ) No. How long? If so, how many?

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:

Describe your relationship with your children: List everyone who currently lives with you:
Where do you live? Who is your support? Family, Friends, State?

Legal History:

• Any trouble with the law?
• Have you ever been arrested?
• Any imprisonment before and how long?

- Do you have any pending legal problems?

Spiritual Life:
- Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
- If yes, what is the level of your involvement?
- Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

- Is there anything else that you would like us to know?

For women only: Date of last menstrual period:

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.

How many live births?

Allergies:

List ALL current prescription medications and dosages and how often you take them:
(if none, write none)

Current over-the-counter medications or supplements:

Date and place of last physical exam:

_____

Signature of patient

_____

Patient full name

_____

Date: