San Luis Obispo Addiction Recovery Center
K. Dane Howalt, M.D.
1223 Higuera Street, Suite 101
San Luis Obispo, CA 93401
(805) 541-5566 voice
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PATIENT INTAKE

Name: ____ Date: ______________________________

Address: ____

Phone (cell) _______________________(home) _____________________ (work) ______________________

DOB _________________________ Age _____________ Email __________________________________

Emergency Contact ____ Phone _______________________

How can we help you today? ____

____

Are there any medicines you are interested in being prescribed today? _________________________________

How did you hear of us? ____

Please list ALL medical conditions: ❒ **None**

____ Physician Name _________________________________

____ Physician Name _________________________________

____ Physician Name _________________________________

❒ Married ❒ Single ❒ Long-term relationship ❒ Divorced/Separated Do you have children? ❒ **Yes** ❒ **No**

Are you currently employed? ❒ **Yes** ❒ **No** Where ____

What type of work do/did you do? _____________________ How long have/did you work (ed) there? _______

Have you ever been arrested or convicted? ❒ **Yes** ❒ **No** When**?** What for**?** _________________________

Do you currently have any legal problems? ❒ **Yes** ❒ **No** What? ____________________________________

❒ DWI ❒ Drug-related ❒ Domestic violence Are you on probation / Parole? ❒ **Yes** ❒ **No**

Have you ever been abused? ❒ **Yes** ❒ **No** ❒ Physically ❒ Sexually ❒ Verbally ❒ Emotionally

Have you ever attended: ❒ None ❒ AA ❒ NA ❒ Other 12-Step When did you last attend? ____________

If you are not currently attending meetings, what factors led you to stop? ______________________________

Have you ever been in counseling or therapy? ❒ **Yes** ❒ **No** (Please describe) _________________________

Have you ever been hospitalized? ❒ **Yes** ❒ **No** (Please explain) ___________________________________

Have you ever been diagnosed with a psychiatric or mental illness? ❒ **Yes** ❒ **No**

What diagnosis**?** ________________Where? ______________________When? _______________

Are you feeling suicidal? ❒ **Yes** ❒ **No** Have you ever attempted suicide? ❒ **Yes** ❒ **No**

Have you ever been treated for overdose? ❒ **Yes** ❒ **No** (Please describe) _________________________

____

Have you ever taken or been prescribed antidepressants? ❒ **Yes** ❒ **No**

Medication(s) and dates of use ____

Did you have any problems with antidepressants? ❒ **Yes** ❒ **No** What was the problem? ______________

List ALL current medicines prescribed to you by a doctor:____________________________________

____

Please list ALL **ALLERGIES** you have (drugs, penicillin, bees, peanuts) ___________________________

____

Have previously been treated for substance misuse? ❒ **Yes** ❒ **No** When, where and for how long?__________

____

How long have you been using/abusing substances? ______________________________________

How old were you when you first started using drugs and alcohol? _____________________________

What has been your longest period of abstinence/not using?___________________________________

When/how long ago was the last time you stopped for any length of time?__________________________

Why did you stop using then? (Jail? Rehab? Problems?) ______________________________________

Is there anything else you feel we should know about you? ____________________________________

Patient Signature: _______________________________________ Date ______________________

Physician Signature: _____________________________________ Date _____________________

❒ Meets dsm IV criteria dependence ❒ Anxiety ❒ Depression ❒ Bipolar ❒ PTSD ❒ ADHD

Substance Use History

Name: ____ Date :_________________________

HAVE YOU USED?	***EVER? In your life? Even once?***	Used in last 30 days?	How Much?	How many times a day?	When did you last use?	Route (oral, nasal, smoked, IV)
Tobacco						
Alcohol						
Marijuana						
Vicodin/Norco						
OxyContin / oxycodone						
Heroin						
Morphine						
Methadone						
Dilaudid						
Fentanyl						
Suboxone						
Tramadol/Ultram						
Inhalants: Glue, Paint, Solvents. Aerosols						
Cocaine						
Crystal Meth- Amphetamine						
LSD mushrooms Hallucinogens						
Ecstasy						
Street Benzo's Valium Ativan Xanax						
Soma						
Other? _______________						

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