



PRINCE WILLIAM Hospital

INTENSIVE OUTPATIENT PROGRAM PATIENT HISTORY FORM

Patient Label

3-Hole 1/4 4 1/4 c-to-c

Patient Name:				Date:															
DOB:	AGE:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Sep <input type="checkbox"/> D <input type="checkbox"/> W	Ethnicity:															
Address:																			
Phone (H):		Phone (W):		OK leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No															
SS#:		Cell #:																	
Emergency Contact Name:			Phone #:																
REFERRED BY: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Physician</td> <td><input type="checkbox"/> Outpatient</td> </tr> <tr> <td><input type="checkbox"/> Family</td> <td><input type="checkbox"/> Psychiatrist</td> <td><input type="checkbox"/> Attorney</td> </tr> <tr> <td><input type="checkbox"/> Friend</td> <td><input type="checkbox"/> Employer</td> <td><input type="checkbox"/> ASAP</td> </tr> <tr> <td><input type="checkbox"/> Clergy</td> <td><input type="checkbox"/> Probation Officer</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Employment Assistance Program</td> <td><input type="checkbox"/> Inpatient</td> <td></td> </tr> </table>					<input type="checkbox"/> Self	<input type="checkbox"/> Physician	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Family	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Attorney	<input type="checkbox"/> Friend	<input type="checkbox"/> Employer	<input type="checkbox"/> ASAP	<input type="checkbox"/> Clergy	<input type="checkbox"/> Probation Officer	<input type="checkbox"/> Other	<input type="checkbox"/> Employment Assistance Program	<input type="checkbox"/> Inpatient	
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1) MAJOR REASON(S) FOR SEEKING HELP AT THIS TIME: _____																			

2) HOW LONG HAVE YOU HAD THESE PROBLEMS OR SYMPTOMS? _____																			

<u>PERSONAL HISTORY</u>																			
SEXUAL ORIENTATION: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other: _____																			
With whom do you now live? <input type="checkbox"/> spouse/partner <input type="checkbox"/> children <input type="checkbox"/> parents <input type="checkbox"/> friends <input type="checkbox"/> self <input type="checkbox"/> others: _____																			
EDUCATION & OCCUPATION: Highest education achieved? _____																			
Present position / employment? _____																			
Previous job? _____																			
Do you have current vocational concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes - if so, please list _____																			

RELIGION: _____																			
Church/Faith Affiliation: _____																			
Do you have any specific cultural needs? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, explain: _____																			

SPECIAL NEEDS: Do you have a developmental disability? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, describe: _____																			

Will you require special assistance during your visit? <input type="checkbox"/> No <input type="checkbox"/> Yes - what type? _____																			

MEDICAL HISTORY

READ THE FOLLOWING AND (✓) ANY THAT YOU HAVE HAD:

- Stroke
- Muscle Disease or Weakness
- Chronic Back Disease
- Arthritis or Gout
- Bone or Joint Disease
- Bladder or Kidney Disease
- Kidney Disease or Stones
- Herpes / Chlamydia
- Meningitis or Polio
- Gonorrhea or Syphilis
- Recurrent Bronchitis
- Recurrent Pneumonia
- Asthma
- Tuberculosis (TB)
- Ulcer Disease
- Chronic Bowel / Colon Disease
- Pancreatis
- Gallbladder Disease
- Hepatitis and/or Cirrhosis
- Drug Abuse or Alcoholism
- Severe Depression
- Nervous Breakdown
- Bleeding Disorder
- Sickle Cell Disease
- Vision Impairment
- Hearing Impairment
- Chronic Skin Disease
- Recurrent Boils
- Recurrent Skin Infections
- Anemia
- Severe Headaches
- Broken or Cracked Bones
- Severe Sprains or Dislocations
- Severe Lacerations
- Concussion or Head Injury
- Diabetes
- Thyroid Disease
- Cancer
- High Blood Pressure
- Heart Disease
- Rheumatic Fever
- Seizures
- Blood Clots
- Elevated Cholesterol
- DES Exposure: (Did your mother take while she carried you to prevent miscarriage?)
- AIDS / AIDS Related Disease
- Other: _____

IMMUNIZATION HISTORY: HAVE YOU HAD:

	YES	NO	DATE OF LAST
Hemophilus Influenzae Vaccine (HIB)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia / Influenzae Shot	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles & Mumps Shots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus Shot	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria Shot	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB Skin Test (pos / neg)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis Shots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella Shot or Blood Test	<input type="checkbox"/>	<input type="checkbox"/>	_____

LIST ALL ALLERGIES: None Known

MEDICATION:

LIST ALL MEDICATIONS TO INCLUDE VITAMINS, OVER THE COUNTER MEDICATIONS AND HERBAL PREPARATIONS

NAME	AMOUNT/DOSE	FREQUENCY

Patient Label

DIET, EXERCISE & HABITS:

Do you follow a special diet? _____

Weight? Current: _____ Desired: _____ 1 yr. ago: _____

Exercise? What kind of exercise do you do? _____

PAIN: Do you have any physical pain? No Yes

If yes, on scale from 1-10 (10 worst) how is to now? _____

Cause of pain: _____

PAST MEDICAL HISTORY:

LIST ANY SURGERY YOU HAVE HAD, SUCH AS: TONSILS, APPENDIX, DENTAL, GALLBLADDER

DATE	SURGERY	REASON

LIST ANY SERIOUS ACCIDENTS OR INJURIES:

DATE	NATURE OF THE PROBLEM

VIOLENCE / ABUSE:

Is the violence at home or work a concern for you? No Yes

If Yes, describe: _____

Have you ever been abused? No Yes

By whom? _____

Physical Abuse Sexual Abuse Emotional Abuse

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PATIENT HISTORY FORM**

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PSYCHIATRIC HISTORY

PLEASE CHECK OFF IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- Anxiety Suicidal Assaultive Delusions Fatigued Mood Swings Racing Thoughts
 Depressed Restlessness Hallucinations Withdrawn Self-abusive Agitation

Do you have any present suicide thoughts? Yes No

Have you ever made a suicide attempt? Yes No

If Yes, describe such attempts:

Date: _____ Describe: _____

Date: _____ Describe: _____

PSYCHIATRIC TREATMENT:

Describe any history of treatment with a psychiatrist, psychologist, therapist or hospitalization you may have had for conditions such as schizophrenia, bipolar disorder, depression, anxiety, relationship problems or suicide attempts, etc.:

<i>When</i>	<i>Where</i>	<i>Why</i>	<i>Improvement noted</i>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Who is your therapist? _____ Phone #: _____

Who is your Psychiatrist? _____

Address: _____

Phone #: _____

Have you ever been treated, or are you presently being treated with medicine for any psychiatric condition?

<i>Medicine</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Last Use</i>	<i>Reason prescribed</i>	<i>Prescribed by</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Describe any side effects that you experience from your medications: _____

Do you take medication while using drugs or alcohol? Yes No

LEGAL HISTORY

Do you have an Advanced Directive? Yes No

LEGAL HISTORY: Pending charges: None _____

Past history of illegal activities or criminal charges: None _____

Probation Officer: None Name: _____

DWI / DUIs: 1) Date: _____ County: _____

DWI / DUIs: 2) Date: _____ County: _____

DWI / DUIs: 3) Date: _____ County: _____

DWI / DUIs: 4) Date: _____ County: _____

Do you have an attorney representing you? Yes No

Additional Legal Information: _____

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SUBSTANCE ABUSE HISTORY (continued)

DRUGS: What drugs have you snorted? _____
 What drugs have you smoked? _____
 What drugs have you injected with a needle? _____
 What drugs have you taken in pill form? _____

SUBSTANCES	Last Use	First Use	Frequency	Amount	Years Abused
PAIN KILLERS:					
Oxycontin/Percocet (Oxycodone)					
Vicodin (Hydrocodone)					
Lyrica					
Dilaudid (Hydromorphone)					
Darvon					
Codeine					
Paregoric					
Methadone					
Fioricet					
MS-Contin					
Other					
ANTI-ANXIETY:					
Xanax					
Ativan					
Klonopin (Clonazepam)					
Other					
STIMULANTS:					
Ritalin					
Concerta					
Adderall					
Ephedra					
OTHER:					
Ultram / Ultracet (Tramadol)					
Soma					
Stacker					
Ambien					
Other:					
MARIJUANA					
COCAINE					
CRACK					
AMPHETAMINE					
Methamphetamine					
Ecstasy/MDMA					

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SUBSTANCE ABUSE HISTORY (continued)

Patient Label

SUBSTANCES	Last Use	First Use	Frequency	Amount	Years Abused
HEROIN					
Roofies					
HALLUCINOGEN					
PCP,					
LSD					
Mushrooms					
OTHER:					
OTCs,					
Steroids,					
Rx,					
Gambling,					
Shopping					

GENERAL QUESTIONS:

- Do you think about drinking or using drugs often? Yes No
- Do you quickly or urgently take the first drink or drug? Yes No
- Do you need to use more to get the effect you want? Yes No
- Do you drink or use drugs to get rid of withdrawal symptoms? Yes No
- Do you plan to use a little and end up using a lot? Yes No
- Have you ever had a hangover from alcohol or crashed from drugs? Yes No
- How often do you call in sick or not really work all day because of hangovers or crashes? # _____ Days called in sick to work
- Have you ever been fired because of drinking or drugs? # _____ Times fired
- Have you ever been told the next day about something you did, that you didn't remember, when you were drinking or taking drugs? Yes No
- Has your family said that they're worried about your drinking or drug use? Yes No
- Have you tried to quit, but then started using again? Yes No
- Do you spend a lot of time using or recovering from alcohol or drugs? Yes No
- Have you lost friends because of your drinking or drugging? Yes No
- Do you drink or drug before driving or operating machinery? Yes No
- Have you continued to drink or drug even after experiencing significant legal, family, or other problems? Yes No
- What is the current amount of debt you are in from credit cards and personal loans (not counting mortgage and car loans)? \$ _____
- What is your total household income from all sources? \$ _____

SUBSTANCE ABUSE TREATMENT HISTORY

List below any and all treatment you received for alcoholism, other drugs, gambling or eating disorders. Include rehabilitation units, alternative sentencing, drinking driver programs, detoxes and emergency room visits.

Dates	Facility	Type of Program	How long attended?
_____	_____	<input type="checkbox"/> Inpt <input type="checkbox"/> Residential <input type="checkbox"/> Detox <input type="checkbox"/> IOP	_____
_____	_____	<input type="checkbox"/> Inpt <input type="checkbox"/> Residential <input type="checkbox"/> Detox <input type="checkbox"/> IOP	_____
_____	_____	<input type="checkbox"/> Inpt <input type="checkbox"/> Residential <input type="checkbox"/> Detox <input type="checkbox"/> IOP	_____
_____	_____	<input type="checkbox"/> Inpt <input type="checkbox"/> Residential <input type="checkbox"/> Detox <input type="checkbox"/> IOP	_____
_____	_____	<input type="checkbox"/> Inpt <input type="checkbox"/> Residential <input type="checkbox"/> Detox <input type="checkbox"/> IOP	_____

Have you ever attended meetings of any Twelve-Step Programs? Yes No

If you were a member of a Twelve-Step program, did you have a sponsor? Yes No

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____