PATIENT HISTORY

rev: 6/16

Patient Name:_____

Date_____Date of Birth _____

Sex_____ Marital Status _____

Telephone Numbers/Home ( )_____Work( )_____

Email:_____

HomeAddress_____

Street_____

City_____ State _____ Zip_____

SOBER SOLUTIONS OF NORWALK

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

Surgical History (**unrelated** to continuing pain; such as appendectomy)

Surgical History (**related** to continuing pain; such as laminectomy)

Allergies (include medication and food allergies)

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

Current Medications (include vitamins and birth control pills, if applicable):

(over)

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Do you have any of the following? (Check all that apply) Headaches____ Stomach Pain____ Chest Pain____ Vision Problems Nausea_____? Shortness of Breath_____ Hearing Problems_____ Vomiting____ Urinary Problems____ Dizziness____ Constipation____ Rashes____ Difficulty Swallowing____ Diarrhea_____ Swollen Joints____ Chronic Fatigue____?

Domestic Situation

With whom do you live?
_____ Are there any substance abuse issues in the household? Yes_____ No_____ If yes, please explain
_____ Are you able to take care of yourself? Yes_____ No_____ If not, please enter name of caregiver
_____

Work History

Job Years worked Why did you leave?

Legal Matters

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

Substance Use

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply) Next to each drug or substance that you've circled, indicate if you currently use it ("C"), or used it in the past("P")?

Alcohol _____ Barbiturates _____ Cocaine _____ Heroin _____
Amphetamines_____ Marijuana _____ Other _____ Other
_____ Other _____

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____.

If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_____
How many packs do (did) you smoke a day? _____ For how many years? _____.
Other type of tobacco use? Snuff_____? Dip_____? E cigarettes____?

Ever undergo treatment for tobacco use? Patch_____? Losenge_____? Gum_____?
Wellbutrin_____? Chantrix_____?

_____ X_____

NAME / DATE SIGNATURE