lanier treatment center
OUTPATIENT ADDICTION RECOVERY

Application for Admission

Patient ID_____ Date_____

Name: _____ SSN#: _____ - _____ - _____

Phone: _____ DOB: _____ Sex: (M or F) _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Referred By:_____

Please Circle One:

Race: White ☐ Black ☐ Multi-Racial ☐ Other ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐

Height:_____Weight:_____Hair Color:_____Eye Color:_____

Driver's License #:_____ State:_____ Exp. Date_____

Emergency Contact:_____Relationship to Patient:_____

Emergency Contact Phone:_____(in the event of a medical emergency involving the patient on the clinic premises, Clinic Policy, requires that 911 emergency services be called. In addition to 911, Clinic Staff may contact the person listed to notify them of the emergency)

Primary Care Physician_____Phone:_____

Hospital Preference:_____Food/Drug Allergies_____

Female Patients: Are you pregnant? Select Yes ☐ No ☐ OB/GYN:_____

Employed: Select Yes ☐ No ☐ What is your occupation?_____

What is your highest grade level of completed education?_____

Are you over the age of 18? Select Yes ☐ No ☐

Which program are you interested in? Select Methadone ☐ Buprenorphine (Suboxone) ☐

What is your drug of choice?_____

Do you abuse other drugs, with or without a prescription? Select Yes ☐ No ☐
If so, what?_____

How much do you use at one Time?_____

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When did you last use?_____ How much?_____

How much do you spend on drugs per day?_____

Have You Ever Detoxed From Illicit Drugs Before? Select Yes ☐ No ☐

If so, when? _____

Have You Ever Received Treatment for Addiction? Select Yes ☐ No ☐

If so, when and where?_____

Do You Have a History of Chronic Reoccurring Pain? Select Yes ☐ No ☐

If so, please explain. _____

Have you ever been to a pain clinic Select Yes ☐ No ☐

If yes, what was diagnosis_____

Are you currently a patient at a pain clinic? Select Yes ☐ No ☐

If yes, please provide name of pain clinic_____

Have You Ever Thought of Hurting Yourself or Others? Select Yes ☐ No ☐

Are You Currently Having Those Thoughts? Select Yes ☐ No ☐

If so, please explain. _____

Applicant Signature: _____ Date: _____

Staff Signature:_____ Date:_____

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Intake Questionnaire

Patient Name_____ Patient ID: _____ Date: _____

Age of first Opiate use_____ How long have you used/abused Opiates_____

Current daily Opiate use_____ Last Opiate Use_____

How are you currently getting Opiates_____ Amount spent daily _____

Other illicit use _____

Past attempts to withdraw _____Yes _____No Longest period w/o Opiates_____

Have you ever been in drug treatment _____Yes _____ No

Details_____

Have you ever been in Methadone/Buprenorphine treatment _____Yes _____ No

Details_____

Are you experiencing any medical problems _____Yes _____ No

Details_____

Medications taken by prescription_____

OTC medications_____

Are you experiencing any psychiatric problems _____Yes _____ No

Details_____

Have you overdosed _____ Yes _____No Details_____

Have you attempted suicide _____ Yes _____ No

If yes, details_____

Current suicidal thoughts _____Yes _____No Current Homicidal Thoughts _____Yes _____No

How did you find out about our clinic _____

TRANSFER PATIENTS ONLY:

Current clinic_____ Dose_____ Date of Last Dose_____

WithdrawalSymptoms:_____
_____
_____

_____ _____ _____ _____

Intake Counselor **Date** **Patient** **Date**

Patient ID:_____ (office use only)

Lanier Treatment Center
Intake Medical Exam

Please complete the front and back of form.

Patient Name:_____ Date _____
(print name)
Age _____ Gender: _____Male _____Female

Occupation _____ Currently employed? ☐ Yes ☐ No

Primary Care Physician _____

Allergies to medications _____

Do you have allergies (example: pollen, food, stinging insects) ☐ Yes ☐ No
If yes, please explain_____

Do you have any current skin problems (example: itching, rashes) ☐ Yes ☐ No
If yes, please explain_____

Do you cough, wheeze, or have trouble breathing during or after an activity? ☐ Yes ☐ No
If yes, please explain_____

Have you had any problems with your eyes or your vision? ☐ Yes ☐ No
If yes, please explain_____

Do you currently smoke? ☐ Yes ☐ No How many per day? _____

Do you drink alcohol? ☐ Yes ☐ No How much per day/week/month: _____

Date of last physical? _____ Any medical problems_____

Are you currently having any medical problems that you are seeing a doctor about?
☐ Yes ☐ No Explain _____

Have you had a medical illness or injury since your last physical? _____Yes _____No
If yes, please explain_____

Have you ever been treated for any emotional or psychiatric problems _____Yes _____No
If yes, please explain _____

Have you ever had or do you currently have any of the following? *(Check all that apply and explain below)*
☐ Allergies ☐ Anemia ☐ Arthritis ☐ Diabetes ☐ Epilepsy ☐ Gout ☐ TB
☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Surgery ☐ Hepatitis ☐ Asthma

Patient ID:_____ (office use only)

☐ Kidney Trouble ☐ Emphysema ☐ Hernia
Explain _____

Have you ever been hospitalized? If yes, please explain_____
_____

Have you ever had any surgeries? If yes, please explain _____
_____

List all prescription medications that you are currently taking_____
_____

Per state regulations the PDMP (Prescription Drug Monitoring Program) will be checked and monitored on a regular basis. Please initial here that you have read this statement. _____ (Patient Initials)

List all over the counter medicals or herbal supplements _____
_____

Do you now or have you ever used benzodiazepines (example Xanax or Valium) ☐ Yes ☐ No
If yes, please explain_____

Do you have pain at present or chronic pain problems? ☐ Yes ☐ No
If yes, please explain_____

Have you been evaluated by a physician for your pain? ☐ Yes ☐ No
Diagnosis _____

Are you presently a patient in a pain clinic? ☐ Yes ☐ No Have you been treated in a pain clinic in the past? ☐ Yes ☐ No If yes, when? _____

Have you ever been diagnosed Hepatitis C positive? ☐ Yes ☐ No Are you undergoing treatment for Hepatitis C? ☐ Yes ☐ No

Have you ever been tested for HIV (Aids)? ☐ Yes ☐ No If yes, when? _____
HIV status: ☐ Positive ☐ Negative

Female Patients Only: Are you pregnant? ☐ Yes ☐ No
Do you use any form of birth control or contraception (condoms, pill, diaphragm, IUD, etc.)?
☐ Yes ☐ No If yes, what do you use?_____
Have you had a tubal ligation (tubes tied)? ☐ Yes ☐ N

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge.

_____ _____
Patient Signature Date