Fair Start

Patient History

Date: _____

Name: _____

City/State: _____

Gender: Male ☐ Female ☐

Occupation: _____

Who do you live with? Alone ☐ Roommate ☐ Parents ☐ Other: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner ☐

How old were you when you first used alcohol/drugs? _____

How old were you when you first started using opiates? _____

Opiates	**Usage**	**How Often? Daily (D), Weekly (W), Occasionally (O)**	**Date of Last Use**	**Quantity Used**
Percocet	Current ☐ Past ☐			
Vicodin	Current ☐ Past ☐			
Oxycontin	Current ☐ Past ☐			
Oxycodone	Current ☐ Past ☐			
Heroin	Current ☐ Past ☐			
Methadone	Current ☐ Past ☐			
Kratum	Current ☐ Past ☐			
Other Opiates	Current ☐ Past ☐			

Do you currently drink alcohol? **Yes ☐** **No ☐** If yes, how often do you drink and how much?

_____

Do you currently smoke cigarettes? **Yes ☐** **No ☐** If yes, how many per day? _____

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OTHER DRUGS:

DRUG	USAGE	DATE OF LAST USE
Marijuana/Spice/K2/Hash	Current ☐ Past ☐	
Amphetamines	Current ☐ Past ☐	
Cocaine	Current ☐ Past ☐	
Tranquilizers, Sleeping Pills Ambien, Xanax, Valium, Etc	Current ☐ Past ☐	
Hallucinogens	Current ☐ Past ☐	
Ecstasy	Current ☐ Past ☐	
Inhalents	Current ☐ Past ☐	

Has your drug/alcohol use created problems in your life? Yes ☐ No ☐

If yes, what areas of your life have been impacted ? Health ☐ Relationships ☐ Legal ☐

Social ☐ Employment ☐ Motivation ☐ Education ☐ Finances ☐

Please describe the impacts

_____

_____

Have you experienced any of the following withdrawal symptoms?

Nausea ☐ Vomiting ☐ Sweats ☐ Chills ☐ Headaches ☐ Body Aches ☐ Shakes ☐ Insomnia ☐ Seizure ☐ Anxiety ☐ Depression ☐ Loss of Appetite ☐ Difficulty Concentrating ☐ Paranoia ☐ Psychosis ☐

Have you previously been detoxed? Yes ☐ No ☐ If yes, how many times? _____

Any other family members who have problems with alcohol/other drugs?

Yes ☐ No ☐ Adopted/Unknown ☐

If yes, please identify from the list:

Mother ☐ Father ☐ Siblings ☐ Grandmother ☐ Grandfather ☐ Aunts ☐ Uncles ☐ Cousins ☐

Is your Mother: Alive ☐ Deceased ☐ Briefly describe your relationship:

_____

Is you Father: Alive ☐ Deceased ☐ Briefly describe your relationship:

_____

Are your parents: Married ☐ Divorced ☐ Separated ☐ Never Married ☐

Do you have stepparents? Yes ☐ No ☐ Briefly describe your relationship with them:

_____

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Do you have any siblings? Yes☐ No ☐ If yes, how many **Brothers**: _____ **Sisters:** _____
Describe your relationship with them:

_____

_____

Do you have any children? Yes ☐ No ☐ If yes, how many? _____ Gender: _____
How old are your children?

_____

Are you currently having any thoughts or plans of suicide? Yes ☐ No ☐ If yes, please describe: _____

_____

Are you currently seeing any of the following? Psychiatrist ☐ Psychologist ☐ Counselor ☐

Have you experienced any abuse in your lifetime? Yes ☐ No ☐

If yes, did you experience: Verbal ☐ Physical ☐ Sexual ☐ Emotional ☐

If yes, have you had counseling for this? Yes ☐ No ☐ Please describe:

_____

_____

Were you or are you in the military? Yes ☐ No ☐ (If no continue to next section)
Branch of service? _____
Dates: From: _____ To _____
Type of Discharge: _____

Did you experience combat? Yes ☐ No ☐ If yes, please describe:

_____

What don't you like about your alcohol/drug use?

_____

_____

Have you had prior treatment for addiction? Yes ☐ No ☐ If yes, please list the names of the program(s) you have attended:

Program Name	Year	Outpatient	Residential	Completed
		☐	☐	Y ☐ N ☐
		☐	☐	Y ☐ N ☐
		☐	☐	Y ☐ N ☐
		☐	☐	Y ☐ N ☐

Have you participated in any recovery support groups (AA, NA, etc)? Yes ☐ No ☐ If yes, which groups have you attended? _____

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Have you had periods of abstinence from all alcohol/drugs? Yes ☐ No ☐ If yes, what was the longest period of abstinence you've had? _____
What year? _____

Are you aware of the things that might trigger you to drink or use other drugs? Yes ☐ No ☐
If yes, what are your triggers?

_____

Past Medical History (Check all conditions that apply to you or blood relatives):

	Self	Family		Self	Family
Recent Weight Loss	☐	☐	Migraines/Headaches	☐	☐
Seizure History	☐	☐	Chest Pain	☐	☐
Heart Attack	☐	☐	Hypertension	☐	☐
Stroke	☐	☐	High Cholesterol	☐	☐
Irregular Heart Beat	☐	☐	Lung Disease/Asthma	☐	☐
Liver Disease/Hepatitis	☐	☐	Stomach Problems	☐	☐
Constipation/Diarrhea	☐	☐	Kidney/Bladder Disease	☐	☐
Neurological	☐	☐	Chronic Pain	☐	☐
Cancer	☐	☐	Location _____	☐	☐
Type _____			Diabetes	☐	☐
Thyroid Disease	☐	☐			

Hospitalizations: (Include Mental Health, Medical/Surgical, and Emergency Room Visits)

_____
_____
_____
_____

MEDICATIONS	DOSE	LENGTH OF USE

Drug Allergies:

_____