MAGNOLIA MEDICAL

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PATIENT INTAKE FORM

Date of Admission: _____
Name (*Last, First, Middle Initial*): _____
Address/Apartment Number: _____
City/State/Zip Code: _____
Phone Number (*incl. Area Code*): _____
Date of Birth (*Month/Day/Year*): _____
Social Security Number: _____
Sex (*circle one*): M F
Do you currently have Medicaid (*circle one*): Y N
Do you have a valid driver's license (*circle one*): Y N
Employment (*circle one*): Full Time Part Time Occasional
Length at current job (*in years*): _____
If not employed, how long out of work: _____
Approximate monthly income: _____
Marital Status (*circle one*): Single Married Living Together
Children: None Number of Children _____ Single Parent
Education: Last grade completed _____ **OR** Full-time Part-time

FAMILY HISTORY (*Circle one*)
Family member(s) with alcohol or drug addiction:
None Yes; who & what _____
Family member(s) with psychiatric illness:
None Yes; who and diagnosis _____

CURRENT DRUG USE
Circle any currently using:
Heroin Alcohol Barbituates Other Sedatives Methamphetamines
Amphetamines Cocaine/Crack Marijuana PCP Hallucinogens
Non-Prescription Methadone Vicodin OxyContin Percocet Inhalants
Other Opioids (*specify*): _____
Over-The-Counter Drugs (*specify*): _____
Other (*specify*): _____

Primary Drug Use: _____
Date of Last Usage: _____
Amount Used: _____
Time Used: _____

Average Daily Amount: _____
Length of Usage Habit: _____
Method of Use (*circle one*): Oral Smoking Inhalation Injection Other

Secondary Drug Use: _____
Date of Last Usage: _____
Amount Used: _____
Time Used: _____
Average Daily Amount: _____
Length of Usage Habit: _____
Method of Use (*circle one*): Oral Smoking Inhalation Injection Other

Other medications currently using regularly: _____
Do you have a prescription for this medication (*circle one*): YES NO
Do you have any known allergies (*please explain*): _____

_____

_____

DRUG TREATMENT HISTORY
Date of last admission to rehab program: _____
Date of last discharge from rehab program: _____
Number of Prior Admissions: _____
What was the type of treatment during your last admission (*circle one*): Detox MMTP
Outcome of last admission to treatment was (*circle one*): Completed Not Completed
Are you currently transferring from another Suboxone or Methadone based program: Y N
Which program (*clinic name and location*): _____

_____

Have you ever received any other types of drug treatment (*if yes, please explain*): _____

_____

_____

Any other issues you feel your physician should know: _____

_____

_____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Physician Signature: _____ Date _____