

HILL ALCOHOL AND DRUG TREATMENT
ADOLESCENT INFORMATION SHEET

Mother's Name: _____ **Contact #:** _____
Lives with? Y N **Release Signed?** Y N **Alternate #:** _____

Father's Name: _____ **Contact #:** _____
Lives with? Y N **Release Signed?** Y N **Alternate#:** _____

Stepmother's Name: _____ **Contact #:** _____
Lives with? Y N **Release Signed?** Y N **Alternate#:** _____

Stepfather's Name: _____ **Contact #:** _____
Lives with? Y N **Release Signed?** Y N **Alternate#:** _____

Siblings: **Name:** _____ **Age:** _____
 Name: _____ **Age:** _____
 Name: _____ **Age:** _____
 Name: _____ **Age:** _____

Primary Custodial Parent: _____
Address: _____ **City:** _____ **Zip:** _____

School Name: _____ **Grade Level:** _____
Address: _____ **Phone#:** _____
Expelled? Y N **Duration?** _____

Probation? Y N **Beginning?** _____ **Ending?** _____
P/O Name: _____ **Contact#:** _____

HILL ALCOHOL AND DRUG TREATMENT

YOUNG PERSON (Age 13-17)

ASSESSMENT

Patient Name: _____

PRENATAL

1. Did Mother use prescription drugs or illicit substances during pregnancy or while breast feeding? __Y __N

If yes, describe: _____

2. Did Mother abuse alcohol during pregnancy? _____Y _____N

3. Was there any trauma to Mother during pregnancy? _____Y _____N

If yes, describe: _____

4. Were there any complications during pregnancy? _____Y _____N

If yes, describe: _____

5. Were there any medical complications at birth? _____Y _____N

If yes, describe: _____

6. What was the child's birth weight? _____

7. Was the child full-term? _____Y _____N

If not, birth was at how many months gestation? _____

8. What was the health of the child at the time of birth? (Apgar Score if you know it? _____

9. Did the Mother suffer depression during pregnancy? _____Y _____N

If yes, took Antidepressant Medication? _____Y _____N

10. Was there any significant trauma or medical issues within the first year (including severe, prolonged fever)? _____Y _____N

If yes, please describe: _____

EARLY CHILDHOOD DEVELOPMENT

11. List anything that was delayed or unusual in patient's early development: _____

Check if Within Normal Limits

- | | | | |
|------------|--------------------------|-----------------------------------|--------------------------|
| Sat up | <input type="checkbox"/> | Spoke First Word | <input type="checkbox"/> |
| Pulled up | <input type="checkbox"/> | Spoke in Sentences | <input type="checkbox"/> |
| Walked | <input type="checkbox"/> | Toilet Training | <input type="checkbox"/> |
| Off Bottle | <input type="checkbox"/> | Fed Self | <input type="checkbox"/> |
| Used Cup | <input type="checkbox"/> | Acclimated/Transitioned to School | <input type="checkbox"/> |

ACADEMIC DEVELOPMENT

12. Age child began to read: _____
13. Age child began to write: _____
14. Did child enjoy grade school? _____Y _____N
15. What learning problems were evidenced in Grade School? _____

16. What type of grades did child receive in Grade School? _____,
Middle school? _____, High School? _____
17. Did child enjoy Grade School? _____Y _____N
Middle School? _____Y _____N
High School? _____Y _____N
18. Academic areas of achievement? _____
19. Academic areas of difficulty? _____
20. Was or is child in special programming at school? _____Y _____N
If yes, what? _____

SOCIAL DEVELOPMENT:

21. Age started school: _____
22. Did child follow rules and norms in Grade School? _____Y _____N
If no, give examples: _____
23. Was there evidence of separation anxiety as a young child? _____Y _____N
In Grade School? _____Y _____N
24. As a 5 year old, who did patient feel safest with? _____

PSYCHOLOGICAL DEVELOPMENT

25. Was patient diagnosed with psychological disorders? _____Y _____N
If yes: ___ age _____Diagnosis _____Treatment Method
26. List major trauma event(s) in childhood:

Age: _____

Age: _____

Age: _____

Age: _____

GENERAL

27. School Attending? _____ Grade Level: _____
28. Current GPA: _____ Highest GPA in last two years: _____
29. Favorite Subject: _____
30. Extra-Curricular Activities (Sports, music, drama, etc.): _____
31. What do you like to do in your spare time? _____
32. Where do you spend most of your free time? _____

33. Current school related problems: _____ Y _____ N
 _____ Excessive Absenteeism _____ Failing Classes
 _____ Poor Attitude _____ Bored
 _____ Being influenced negatively by peer group
 _____ Expulsion/Suspension If so, what for? _____

34. Do you currently have a boyfriend or girlfriend? _____ Y _____ N

35. What person in your life do you feel the most bonded with? _____

36. Have you ever run away? _____ Y _____ N

When? _____ Where did you go? _____

How long were you gone? _____

Would you do it again? _____ Y _____ N

37. What types of dangerous activities do you participate in? (like riding in a car with someone under the influence) _____

38. What are your areas of weakness? _____

39. What are your areas of strength? _____

Patient Signature

Parent Signature

Date

Reviewed by Assessor – Signature

Date

Reviewed by Counselor – Signature

Date

FOR OFFICE USE ONLY

ADOLESCENT TREATMENT CONTRACT

I, _____, agree and commit to the following:

Print Patients Name

_____ *I agree to actively participate in the Hill Alcohol and Drug Treatment Program 3 times per week, beginning _____. I will call if I need to be late or absent for any reason. I understand that unexcused absences interfere with my recovery and reflect a lack of commitment.*

_____ *I agree to attend Treatment on the following days*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

_____ *I understand that a half hour individual session is available weekly at my request. I am responsible for scheduling the sessions with my counselor.*

_____ *I agree to abstain completely from the use of alcohol and other mood altering substances, except as prescribed by my doctor.*

_____ *I will inform my counselor immediately of any prescription drugs given by a physician during the course of treatment.*

_____ *I agree to voluntarily submit to a witnessed urine sample or breathalyzer test whenever asked to do so by staff. I understand that a maximum of three drug screens are included in the cost of the program. Additional screens will be billed to me and payment is my responsibility. If the breathalyzer registers positive for alcohol, I understand that the staff is obligated to protect me and others by not allowing me to drive while under the influence. I agree that I will surrender my car keys to the treatment team and call a friend or family member for a ride home.*

_____ *I agree to attend a Minimum of _____ 12 step Meetings per week.*

_____ *I agree to get a sponsor by the 2nd week of treatment.*

_____ *I understand I am in group counseling with young adults and adults. I understand the adult treatment contract requires no contact with adolescents outside of program hours. I agree to also maintain this boundary & refrain from contact with adult peers outside of program hours, unless permission is expressly given to me by my parents.*

Patient Signature: _____

Parent /Guardian Signature: _____

Staff Signature: _____

Date: _____

FOR OFFICE USE ONLY

AGREEMENT AND RELEASE FROM LIABILITY

I/we the parent/guardian of, _____
Print Patient's name

_____ *Understand Hill Alcohol and Drug Treatment is not responsible for my child if he/she does not arrive at or remain during the entire scheduled treatment session.*

_____ *Understand that it is my responsibility to ensure that my child arrives at the treatment session and is properly checked in for each session.*

_____ *Understand that there is a break between the educational segment or treatment sessions and the group segment of treatment sessions during which no employee of Hill Alcohol and Drug Treatment is directly monitoring or otherwise supervising the activities of my adolescent.*

Print Parent/Guardian's Name

Date

Parent/Guardian's Signature

Print Parent/Guardian's Name

Date

Parent/Guardian's Signature

Staff Signature

Date

FOR OFFICE USE ONLY

PARENT/GUARDIAN CONTRACT

I/We as parents of _____
Print Child's Name

agree and commit to the following:

_____ ***I/ we as parent/guardians or at least one parent /guardian will present and participate in the Family Group Sessions every Monday Night throughout Primary Phase (8 weeks) of our child's treatment.***

_____ ***It is detrimental to the goal of my/our child's early sobriety to have alcohol and/or other illicit substances in the home or to have these substances used by us, as parents/guardians and role models.***

_____ ***Chemical dependency is an illness that impacts the family. As such, I/we agree to attend Al-Anon, meetings as recommended by Hill Alcohol and Drug Treatment Program as a support to our personal growth.***

_____ ***To provide transportation to and from Hill Alcohol and Drug Treatment programs facility during the Primary Phase of treatment, as well as during the AfterCare phase of treatment.***

_____ ***To provide transportation to and from 12-Step Meeting as recommended by the Treatment Plan.***

Print Parent/Guardian's Name

Date

Parent/Guardian's Signature

Print Parent/Guardian's Name

Date

Parent/Guardian's Signature

Staff Signature

Date

Hill Alcohol and Drug Treatment

Please completely fill out all requested information:

1. PATIENT INFORMATION

Patient Last Name _____ First Name: _____ MI: _____

How Were You Referred To Us? _____

Home Phone: _____ Cell: _____ Email: _____

Physical Address: _____ Apt # _____ City: _____ Zip: _____

Mailing Address If Different: _____

SSN: _____ (Required)

Birth Date: _____ Gender: _____ Age: _____ Height _____ Weight _____

(Required if driving to treatment) Vehicle: _____ Year: _____ Model: _____

Color: _____ License Plt. #: _____ DL # _____

Marital Status: _____ Married _____ Single _____ Separated _____ Divorced

Spouse Name _____ Spouse Cell: _____

Primary Care Physician/ First and Last Name: _____

Address: _____ Phone#: _____

2. EMPLOYER INFORMATION OF INSURED

Employer Name: _____ Phone: _____

Address: _____ City _____ St. _____ Zip _____

3. INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____

Insured's Last Name: _____ First Name: _____

Relationship to the Patient: _____ Birth Date: _____ SSN: _____

Insured Address: _____ City: _____ Zip: _____

ALTERNATIVE EMERGENCY CONTACT

I _____ give my permission for the staff of Hill Alcohol and Drug to contact the following person, as staff deems necessary.

1ST CONTACT NAME: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

2ND CONTACT NAME: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Patient/Responsible Party Signature

Relationship to the Patient

Date

HILL ALCOHOL AND DRUG TREATMENT

ASSESSMENT

TO BE COMPLETED BY
PATIENT And/Or MINOR'S FAMILY

Patient ID: _____
Referral Source: _____
Assessment Date: _____

Name: _____ Nickname: _____

D.O.B. _____ Age: _____ Marital Status: _____

Number of Children: _____ Ages: _____

Who do you live with? _____

What language is spoken at home? _____

Where do you consider home? (Country, State, Region) _____

How would you describe your cultural background? _____

What groups or organizations do you belong to? _____

What do we need to understand about your beliefs, culture, or traditions to better help you in treatment? _____

Are you afraid to talk about yourself in a group? (Choose One)

- Huge fear Significant fear Some anxiety Not fearful at all

How can we help you deal with your anxiety? _____

What, *specifically*, has happened that brings you here today? _____

1. LEGAL

Have you ever been arrested for any of the following?

- a. Drinking and Driving? _____ BAC N Y _____ Yr
(BAC=Blood Alcohol Content)
How Many DUIs? _____ When? _____
- b. Domestic Violence? N Y _____ Yr
- c. Alcohol or Drug Intoxication? N Y _____ Yr
- d. Possession of Drugs or Paraphernalia? N Y _____ Yr
- e. Sale of Drugs? N Y _____ Yr
- f. Prescription Forgery? N Y _____ Yr
- g. Doctor Shopping? N Y _____ Yr
- h. Any Offense? N Y _____ Yr

Are you currently on Probation or Parole? N Y _____ Yr

Officer's Name: _____

* Reminder: Release to be signed to Officer.

Do you have an immediate family member that is currently incarcerated or having legal issues?

N Y

2. EMPLOYER

How do you financially support yourself? _____

Job Title: _____ Length of time on job? _____

If working, what is your work schedule? _____

Who helps you financially? _____

Does your employer suspect that you have a problem
with substances?

N Y

Did your Employer Mandate Treatment?

N Y

If yes, please explain: _____

Does your Employer need reports from us?

N Y

Have you ever been disciplined or counseled at work for:

- a. Absenteeism? N Y
- b. Tardiness? N Y
- c. Intoxication? N Y
- d. Theft? N Y
- e. Positive Urinalysis? N Y
- f. Other? N Y

If other, please describe? _____

If unemployed, reason for unemployment: _____

Is your employer supportive of treatment? N Y

3. HEALTH

Has a Health Care Professional ever:

- a. Expressed concerns over your Alcohol or Drug use? N Y
- b. Recommended that you reduce or discontinue use? N Y
- c. Recommended Treatment or Detox? N Y
- d. If yes, please describe: _____

4. FAMILY

Has a Family Member ever:

- a. Expressed concerns over your Alcohol or Drug use? N Y
- b. Made excuses for your behavior? N Y
- c. Had to drive you because of intoxication? N Y
- d. Been to Al-Anon or therapy to improve coping with a loved one's drug use? N Y
- e. Who will attend Family Program?

Name: _____ Relationship _____
Phone: _____

Does anyone in your home abuse substances? N Y

Who? _____ What Substance? _____

5. GENERAL

- a. Do most of your friends drink or use drugs? N Y
- b. Have you ever attended AA or NA meetings?
Did you find them helpful? N Y
- c. Have you ever attempted to stop or cut down use? N Y
- d. Has Substance Use interfered with enjoyment
of leisure activities? N Y
- e. Do you think about or plan for getting high frequently? N Y
- f. Do you utilize community resources (support groups,
social services, school-based services)? N Y

- g. Last grade completed in school? _____
- h. Degree, certifications, or licenses you hold? _____
- i. Specialized training that you have had? _____
- j. Military History: _____

6. SPIRITUALITY ASSESSMENT

- a. Is religion or spirituality important in your life? N Y
- b. What do you feel is your purpose in life? _____
- c. Do you affiliate with a particular church or religion now? N Y
If yes, which? _____
- d. Were you raised in a particular belief or religion? N Y
If yes, which? _____
- e. What is your perception of a "Higher Power" or "Power greater than yourself"? _____
- f. Is Prayer or Meditation something you are comfortable with? N Y

7. DISCHARGE PLANNING

- a. How motivated are you to achieve sobriety?
 Extremely Very Fairly Hardly Not at all
- b. Where do you plan on living following treatment?
 My Home Friend or Relative Sober Living Unsure
 Other: _____

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Reviewed by: _____
 Assessor's Signature _____ Date _____

HILL ALCOHOL AND DRUG TREATMENT HEALTH QUESTIONNAIRE

Name: _____

Date: _____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

Section 1 Please answer Yes or No. If YES, please give dates and details.

1. Do you **currently** have any **contagious** health problems or illnesses (such as tuberculosis or active pneumonia).

N Y

a. When did the condition start? _____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

2. Are you running a fever today?

N Y

a. When did the condition start? _____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

3. Do you have a rash or skin lesions with drainage now?

N Y

a. When did the condition start? _____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

Section 2 Please answer Yes or No. If YES, please give dates and details.

4. Have you ever had a stroke?

N Y

- a. When did the condition occur? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

5. Have you ever had a head injury that resulted in a period of loss of consciousness?

N Y

- a. When did the condition occur? _____
- b. How long were you unconscious? _____
- c. Do you still have problems such as dizziness or loss of memory? _____
- d. Who is the treating health care provider? _____
- e. What medication do you take for this condition? _____
- f. What else are you doing to help this condition? _____
- g. How is the medication and/or other interventions working? _____

6. Have you experienced or suffered any chest pains recently? N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

7. Have you ever been diagnosed with MRSA? N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

Section 3 Please answer Yes or No. If YES, please give dates and details.

8. Have you ever had a heart attack or any problem associated with the heart?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

9. Have you ever had blood clots in the legs or elsewhere that required medical attention?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

10. Have you ever had high-blood pressure or hypertension?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

11. Do you have a history of cancer?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

Section 4 Please answer Yes or No. If YES, please give dates and details.

12. Do you have a history of any other illness that may require frequent medical attention?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

13. Do you have any allergies to medications, foods, animals, chemicals, or any other substance?

N Y

- a. What are you allergic to? _____
- b. What is your specific allergic reaction? _____
- c. Who is the treating health care provider? _____
- d. What medication do you take for this condition? _____
- e. What else are you doing to help this condition? _____
- f. How is the medication and/or other interventions working? _____

14. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation?

N Y

- a. What is the specific condition? _____
- b. When did the condition occur? _____
- c. Who is the treating health care provider? _____
- d. What medication do you take for this condition? _____
- e. What else are you doing to help this condition? _____
- f. How is the medication and/or other interventions working? _____

15. Have you ever been diagnosed with diabetes?

N Y

- a. When was the condition diagnosed? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

Section 5 Please answer Yes or No. If YES, please give dates and details.

16. Have you ever been diagnosed with any type of hepatitis or other liver illness?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

17. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for any type of glandular disease?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

18. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

19. Do you use nicotine? N Y

- a. _____ packs/day for _____ years.
- b. Do you desire to quit? N Y
- c. Have you quit before? N Y
- d. How long did you quit for? _____
- e. What method did you use to quit? _____

Section 6 Please answer Yes or No. If YES, please give dates and details.

20. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with kidneys or bladder?

N Y

- a. When did the condition start? _____
- b. Who is the treating health care provider? _____
- c. What medication do you take for this condition? _____
- d. What else are you doing to help this condition? _____
- e. How is the medication and/or other interventions working? _____

21. Do you have any of the following:

- Arthritis N Y When did the condition start? _____
- Back Problems N Y When did the condition start? _____
- Bone Injuries N Y When did the condition start? _____
- Muscle Injuries N Y When did the condition start? _____
- Joint Injuries N Y When did the condition start? _____

- b. Who is the treating health care provider? _____
- c. What medication(s) do you take for the condition(s)? _____
- d. What else are you doing to help the condition(s)? _____
- e. How is the medication and/or other interventions working? _____
- f. Additional info: _____

22. Have you had any surgeries or hospitalizations due to illness or injury? N Y

Date of incident: _____ Please describe: _____

Date of incident: _____ Please describe: _____

Date of incident: _____ Please describe: _____

Date of incident: _____ Please describe: _____

Section 7 Please answer Yes or No. If YES, please give dates and details.

23. When was the last time you saw a physician including a psychiatrist? _____
What was the purpose of the visit? _____

24. Do you take any prescription psychiatric medications?

N Y

Type: _____ Dosage: _____
Frequency: _____ Is it helping? _____

Type: _____ Dosage: _____
Frequency: _____ Is it helping? _____

25. Do you wear or need to wear glasses, contact lenses, or hearing aids?

N Y Details: _____

26. Do you have difficulty hearing?

N Y Details: _____

27. Do you have difficulty reading?

N Y Details: _____

28. When was your last dental exam? Date: _____

29. Are you in need of dental care?

N Y Details: _____

a. What has prevented you from getting care? _____

30. Do you wear or need to wear dentures or other dental appliances?

N Y Details: _____

31. Are you pregnant? N Y

Section 8**DETOX RISK ASSESSMENT**

32. State of General Health Excellent Good Fair Poor

33. Have withdrawal symptoms occurred when you have become abstinent in the past?

N Y Details: _____
 How many withdrawal episodes have you experienced? _____

34. Have you ever had a seizure or DT's?

N Y Date: _____

a. Cause of seizure: _____

35. Last date that substance was used?

Alcohol: _____ Tranquilizers: _____

Painkillers: _____ Sleeping Medications: _____

36. Are you currently experiencing any of the following?

- | | | | |
|---------------------------|---|----------------------------|---|
| 1. Extreme Anxiety | <input type="checkbox"/> N <input type="checkbox"/> Y | 7. Visual Distortions | <input type="checkbox"/> N <input type="checkbox"/> Y |
| 2. Tremors | <input type="checkbox"/> N <input type="checkbox"/> Y | 8. Auditory Hallucinations | <input type="checkbox"/> N <input type="checkbox"/> Y |
| 3. Diaphoresis (sweating) | <input type="checkbox"/> N <input type="checkbox"/> Y | 9. Tactile Hallucinations | <input type="checkbox"/> N <input type="checkbox"/> Y |
| 4. Nausea/Vomiting | <input type="checkbox"/> N <input type="checkbox"/> Y | 10. Insomnia | <input type="checkbox"/> N <input type="checkbox"/> Y |
| 5. Diarrhea | <input type="checkbox"/> N <input type="checkbox"/> Y | 11. Loss of appetite | <input type="checkbox"/> N <input type="checkbox"/> Y |
| 6. Muscle Cramps | <input type="checkbox"/> N <input type="checkbox"/> Y | 12. Cravings | <input type="checkbox"/> N <input type="checkbox"/> Y |

Section 9**HIV ASSESSMENT**

1. Have you ever used IV drugs? N Y

2. If you are currently using IV drugs...
 Is the injection area infected or abscessed? N Y

3. Have you ever participated in unsafe or unprotected sex? N Y

4. Have you had a blood transfusion? N Y

5. Have you been sexually active with an IV drug user? N Y

6. Have you been tested for HIV? N Y

When: _____ Results: _____

Referral for HIV Test to: _____

7. Do you identify self as part of LBG T Community? N Y

Section 10

FAMILY MEDICAL HISTORY

37. Has a 1st degree relative had the following:

- | | | | | | |
|----------------------------|----------------------------|----------------------|----------------------------|----------------------------|-------------------|
| <input type="checkbox"/> N | <input type="checkbox"/> Y | Addiction | <input type="checkbox"/> N | <input type="checkbox"/> Y | Depression |
| <input type="checkbox"/> N | <input type="checkbox"/> Y | Asthma | <input type="checkbox"/> N | <input type="checkbox"/> Y | Bi-Polar Disorder |
| <input type="checkbox"/> N | <input type="checkbox"/> Y | Cancer | <input type="checkbox"/> N | <input type="checkbox"/> Y | Heart Disease |
| <input type="checkbox"/> N | <input type="checkbox"/> Y | Diabetes | <input type="checkbox"/> N | <input type="checkbox"/> Y | Lupus |
| <input type="checkbox"/> N | <input type="checkbox"/> Y | Stroke | <input type="checkbox"/> N | <input type="checkbox"/> Y | Blood clots |
| <input type="checkbox"/> N | <input type="checkbox"/> Y | Rheumatoid Arthritis | | | |

If yes to any of the above, please complete the following:

Condition	Family Member	Type of Medication Prescribed/Used	Response to Medication
<i>Example</i> Depression	Mom	Prozac	Good

Section 11

FOR OFFICE USE ONLY

Level of Detox Risk

- ___ None Assessed
- ___ Mild
- ___ Moderate
- ___ Severe

Cows Score (Opiates) ___ CIWA Score (Alcohol/Benz) ___

Initial Drug Screen: (12 Panel) Dip Test Only - Positives go to Lab

Dip Test Results: ___ Neg. ___ Pos. For: _____

Vital Signs:

Blood Pressure: _____ Pulse: _____

Moderate to Severe Withdrawal Risk Safety Plan:

(Required for Moderate to Severe Risk Only)

___ Refer To: _____
Doctor/Facility

___ Release Signed to: _____ for Referral/Coordinator
MD/Facility

___ Obtain Medical Clearance by: _____
MD

___ Staff Consulted w/Nurse

___ Patient and Family to Sign Ambulatory Detox Safety Agreement

___ Place on Detox Monitoring

___ Hill MD Consult _____
Date

___ Nurse Home Contact _____ for Re-Assessment
Date

___ Emergency Safety Advisement Given

I have reviewed the Health Questionnaire.

Patient referral to an MD prior to admission IS IS NOT required.

Staff Signature

Date

Section 12**FOR OFFICE USE ONLY**

Page # _____

Medication Record - Initial and Ongoing

Name: _____

DOB: _____

Allergies: _____

1 st Presc. Date	Prescribing MD	OTC	Medication	Dosage	Freq.	Special Use Instructions	Purpose	Discontinued	
								Date	By Whom

The information is true and correct to the best of my knowledge

Client Signature_____
Parent/Guardian (under age of 18)_____
Nurse Signature

Medication validated by review of medication prescription or pharmaceutical labeling.

Medication Record Medical Director Review - Date _____

Date _____

Date _____

MDSignature