NewTampa interventional pain & sports medicine
2014 Ashley Oaks Circle Wesley Chapel, FL 33544 813.999.3030ph 813.333.0453fx

ADDICTION PACKET

Today's Date _____ **PLEASE PRINT *CLEARLY*** **Provider performing:** _____

Patient Name _____ **Social Security #** _____-_____-_____ DOB _____

Gender: ☐ **Male** ☐ **Female** Address _____

City _____ State _____ Zip_____

Home Phone # _____ Cell # _____ E-Mail _____

May we leave detailed messages at the above listed numbers? ☐ **Yes** ☐ **No** **Email** _____

Race: _____ Ethnicity: _____ Language spoken: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Other: _____

Employer: _____ Employer address: _____

Drivers License Number: _____ ☐ **Copy of License given to staff Y N**

_____ Initial Here Agreement statement to copy DL picture and / Insurance I.D./ and or other Photo I.D. (fill in blanks here)

Pharmacy Name _____ **Pharmacy address/ phone #**_____

Primary care provider: _____ **Phone of primary care provider:** _____

Referral source: ☐ **Primary care name** _____ ☐ **Insurance listing / or on internet**

☐ **Specialist (list name)** _____ ☐ **Friend** _____ **Other:**_____

☐ **Addiction program or rehabilitation program** **If yes which one?** _____

☐ **Newspaper or other direct mail (circle one)** **How did you hear about us?** _____

☐ **Addiction web site SAMSA / or NAABT or Suboxone chat room**

In Case of an Emergency please contact: Spouse name: _____ Phone # _____

Emergency Contacts:
Name _____ Relationship _____ Phone # _____

Primary Ins Co _____ Policy # _____ Group # _____

Policy Holder _____ Relationship _____ DOB (if different from patient) _ _____

Secondary Ins. Co_____ Policy # _____ Group # _____

Policy Holder _____ Relationship _____ DOB (if different from patient) _____

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ADDICTION PACKET INFORMATION:

General Information: Patient name: _____ Date: _____

ALLERGIES: __MEDICATIONS _____

__ FOODS OR OTHER _____

__ DYE OR CONTRAST MATERIAL FOR RADIOLOGY OR SPECIAL IMAGING PROCEDURES_____

1.Chief Complaint: What is the reason for your visit today?

_____

_____

Age of Patient:_____ ☐ Male ☐ Female

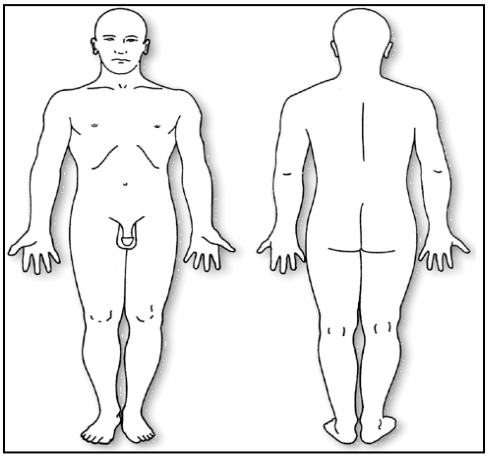
2.Addiction (HPI): Describe how it started (tell us your story) _____

_____

_____

3. If pain was originally a cause of your addiction? Answer the next set of questions please.

a.) Do you still have pain while addicted? __ Yes __ No
b.) And where is the pain?
_____
c.) Please draw on the drawing to your right. (Mark area of pain)



4. How long ago did your addiction begin? _____
5. Were you ever prescribed what you abused?_____
6. Do you still have access to the prescribed drugs that you abused?
__ Yes If yes whom? _____
__ No I do not still have access.

7. What was your longest period of abstinence? _____
What do you attribute your success to with that abstinence?
_____

8. Have you ever taken Suboxone before? __ Yes __ No If yes where did you get it? _____
Why did you stop taking it? _____

9. What caused you to contact us for addiction treatment this time? _____

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10. Have you ever been treated for addiction before? __ Yes __ No
11. Was the treatment in a hospital? __Yes __ No
12. What was the total time you were in the hospital for the treatment: _____

13. Was the treatment in an outpatient clinic setting? __Yes __ No if yes where? _____

14. Have you ever been diagnosed with Attention Deficit Disorder?__ Yes __ No If yes when? _____
15. Have you ever been told you had Attention Deficit Disorder but never officially diagnosed? __Yes __ No

16. What other treatment have you received for this problem:

Treatment Modality	Y / N	When?	Effectiveness
Psychiatric treatment			
Psychological treatment			
Medication treatments			
Accupunture for addiction			
Hypnosis			
Other			

17. LIST ALL OTHER MEDICATIONS

Medication		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.

18. REVIEW OF SYSTEMS:

GENERAL
Y N
☐ ☐ FEVERS
☐ ☐ CHILLS
☐ ☐ NIGHT SWEATS
☐ ☐ MALAISE
☐ ☐ DIZZINESS
☐ ☐ WEIGHT GAIN
☐ ☐ WEIGHT LOSS
☐ ☐ LOSS OF SLEEP

EYE, EAR, NOSE, THROAT
Y N
☐ ☐ EYE PROBLEMS
☐ ☐ DOUBLE VISIONS
☐ ☐ HAY FEVER
☐ ☐ LOSS OF HEARING
☐ ☐ SNORING
☐ ☐ SINUS PROBLEMS
☐ ☐ EARACHE

CARDIOVASCULAR
Y N
☐ ☐ CHEST PAIN
☐ ☐ HIGH BLOOD PRESSURE
☐ ☐ RAPID HEARTBEAT
☐ ☐ SWELLING OF ANKLES
☐ ☐ POOR EXERCISE ABILITY

GASTROINTESTINAL
Y N
☐ ☐ CONSTIPATION
☐ ☐ BLOATING
☐ ☐ DIARRHEA
☐ ☐ RECTAL BLEEDING
☐ ☐ STOMACH BLEEDING
☐ ☐ STOMACH PAIN
☐ ☐ NAUSEA/VOMITING
☐ ☐ HEARTBURN

GENITO-URINARY
Y N
☐ ☐ BLOOD IN URINE
☐ ☐ FREQUENT URINATION
☐ ☐ INCONTINENCE
☐ ☐ PAINFUL URINATION

SKIN
☐ ☐ CANCER
☐ ☐ DISEASE

MUSCLE/BONE/JOINTS
Y N
☐ ☐ MUSCLE SPASM(S)
☐ ☐ NECK PAIN
☐ ☐ ARM PAIN
☐ ☐ BACK PAIN
☐ ☐ LEG PAIN
☐ ☐ JOINT PAIN
☐ ☐ PELVIC PAIN

NEUROLOGICAL
Y N
☐ ☐ NERVE DAMAGE
☐ ☐ SEIZURES (ACTIVE)
☐ ☐ NUMBNESS/TINGLING
☐ ☐ LIGHTHEADEDNESS
☐ ☐ MUSCLE WEAKNESS
☐ ☐ POOR CONCENTRATION

CANCER
☐ ☐ PROSTATE/COLON
☐ ☐ BREAST
☐ ☐ LUNG

HEMATOLOGICAL
Y N
☐ ☐ BLOOD DISORDER
☐ ☐ BLEEDING PROBLEMS
☐ ☐ BLEEDING GUMS

DO YOU TAKE:
☐ ☐ COUMADIN
☐ ☐ LOVENOX
☐ ☐ PLAVIX
☐ ☐ HEPARIN
☐ ☐ AGGRENOX
☐ ☐ PRADAXA

PSYCHIATRIC
Y N
☐ ☐ FEELING SAD/UNHAPPY
☐ ☐ SUICIDAL IDEATION
☐ ☐ ADDICTION
☐ ☐ NERVOUSNESS

ENDOCRINE
☐ ☐ SEVERE THIRST
☐ ☐ SEVERE FATIGUE
☐ ☐ TAKE CORTISONE
☐ ☐ ROUGH SKIN/ELBOWS
☐ ☐ DECREASED SEX DRIVE

RESPIRATORY
Y N
☐ ☐ PERSISTENT COUGH
☐ ☐ COUGHING BLOOD
☐ ☐ CHRONIC BRONCHITIS
☐ ☐ SLEEP APNEA
☐ ☐ USE OXYGEN
☐ ☐ USE CPAP
☐ ☐ SHORTNESS OF BREATH

ALLERGY/IMMUNOLOGY
☐ ☐ SHELLFISH ALLERGY
☐ ☐ ENVIRONMENTAL ALLERGIES

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19.PAST MEDICAL HISTORY: DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING MEDICAL CONDITIONS?

A. ☐ NONE
B. ☐ THYROID DISORD
C. ☐ OVERWEIGHT
D. ☐ LUNG DISEASE (EMPHYSEMA)
E. ☐ ASTHMA/TUBERCULOSIS
F. ☐ CORONARY ARTERY DISEASE (CHEST PAIN)
G. ☐ PRIOR HEART ATTACK if yes WHEN? _____
H. ☐ HIGH BLOOD PRESSURE / HYPERTENSION
I. ☐ HEART DISEASE (CONGESTIVE HEART FAILURE)
J. ☐ HIGH CHOLESTEROL _____
K. ☐ PERIPHERAL VASCULAR DISEASE
L. ☐ STOMACH ULCERS
M. ☐ DIABETES MELLITUS
N. ☐ HEPATITIS, TYPE: _____
O. ☐ LIVER DISEASE
P. ☐ KIDNEY DISEASE
Q. ☐ IMMUNE DISORDER
R. ☐ SEIZURE DISORDER
S. ☐ MULTIPLE SCLEROSIS/ OR OTHER BRAIN DISEASE
T. ☐ STROKE / CVA
U. ☐ OSTEOARTHRITIS/ OSTEOPOROSIS
V. ☐ RHEUMATOID ARTHRITIS *** LIST ALL OTHER:
W. ☐ ENDOMETRIOSIS/ OR PELVIC PAIN
X. ☐ DEPRESSION/ ANXIETY DISORDER
Y. ☐ MENTAL DISORDER(S) / ☐ ADD or ADHD?
Z. ☐ CANCER/TUMOR, TYPE: _____

20. PAST SURGICAL HISTORY HAVE YOU HAD ANY SURGERIES? (INCLUDE PRIOR PAIN INECTIONS)

A. NONE B. IF YES *(LIST BELOW)*

DATE	SURGERY	PHYSICIAN

21. FAMILY HISTORY: __ Adopted __ Any adoption medical history? __ Yes __ No
If yes then What history do you know about birth parents ? _____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING? (*CIRCLE ALL THAT APPLY)*

A. NONE
B. DIABETES
C. CANCER
D. HYPERTENSION
E. HEART DISEASE/ before age 50
F. BACK/NECK PROBLEMS
G. STROKE
H. ASTHMA
I. OSTEOARTHRITIS
J. BLEEDING DISORDERS
K. RHEUMATOID ARTHRITIS
L. Y☐ N☐ADDICTION HISTORY who? _____
M. Y☐ N☐ALCOHOLISM if yes who? _____
N. Other _____

Mother:__ living __ deceased (why?) _____
Father : __ living __ deceased (why?) _____

22. SOCIAL HISTORY: **Marital Status**:☐ Married ☐ Remarried ☐ Single ☐ Divorced ☐ Widowed
23. Members of household: who lives with you? ☐Spouse☐Kids ☐Parents Other _____

24. Highest level of education: __ less then high school/GED, __ High School, __Vocational tech / business __ Junior College, __ College, __ Graduate or professional (type?) _____ Other _____

25. Occupation/ Employment/ Do you work currently? __Yes __N __ Retired __ On Unemployment?
If you answered yes: Full time_____ Part time_____ Other _____

26. Do you drink alcohol? __Yes __ No __ Socially? How much? _____

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Do you think you or others think you have a drinking problem ? __Yes __No

27. Do you smoke? __ No __Yes I smoke _____ packs per day?

Have you tried to quit? __Yes __ No

I quit smoking ____ (time) years ago.

Have you been counseled on smoking cessation before: Yes No NA

28. Present Source of financial support: ☐ Disability ☐ Workman's Comp ☐ Insurance

☐ Personal Earnings ☐ Spouses Earnings ☐ None Other:_____

29. Sexual History: (optional questions)Do you have loss of libido or interest in sex Yes No

Have you been tested for Hormone deficiency Yes No

30. DETAILED ADDICTION HISTORY:

Have you ever taken a pain pill from a family member or a friend? Yes No
Have you had **prior treatment for drug abuse**? Yes No if yes where? _____

How many times have you been **previously** treated for addiction?__ One __ Two __ Three __ Other _____
Where was the treatment: __ in patient facility __ Out-patient facility __ in a doctor's office-setting
How long have you been using or abuse drugs? _____
Why did you first start using drugs or abusing drugs? _____

31. DETAILS ON SUBSTANCES ABUSED: Circle or mark the answers that match your use

DRUG NAME	Yes/ No	Past/ Now	Route/ IV / pills/ snort- (circle one)	How much/ or biggest amount used	How often or times per day	Last used - DATE	Last used Quantity
Pain pills any type	Y N	Past / Now	IV/ Pills / snorting				
Cocaine	Y N	Past / Now	IV/ Pills / snorting				
Meth Amphentamine	Y N	Past / Now	IV/ Pills / snorting				
Heroin	Y N	Past / Now	IV/ Pills / snorting				
Inhalants or huffing	Y N	Past / Now	IV/ Pills / snorting				
LSD or hallucinogens	Y N	Past / Now	IV/ Pills / snorting				
Marijuana	Y N	Past / Now	IV/ Pills / snorting				
Synthetic Marijuana or "incense"	Y N	Past / Now	IV/ Pills / snorting				
Methadone	Y N	Past / Now	IV/ Pills / snorting				
PCP	Y N	Past / Now	IV/ Pills / snorting				

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Stimulants/ pills	Y N	Past / Now	IV/ Pills / snorting				
Sleeping pills/ Xanax or tranquilizers	Y N	Past / Now	IV/ Pills / snorting				
Ecstasy	Y N	Past / Now	IV/ Pills / snorting				
GHB or date rape drug	Y N	Past / Now	IV/ Pills / snorting				

Other history you think is important to your treatment today: _____
_____

32. PLEASE LIST THE NAMES OF ALL OF YOUR CURRENT PHYSICIANS:

PHYSICIAN	SPECIALTY

CERTIFICATION

- TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH INFORMATION.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL AND AGREE TO PAY ALL CHARGES FOR SERVICES AND ITEMS PROVIDED TO ME.
- **I PERMIT A COPY OF THIS TO BE USED IN PLACE OF THE ORIGINAL.**

_____ _____
SIGNATURE OF BENEFICIARY, GUARDIAN, OR PERSONAL REPRESENTATIVE **DATE**

_____ _____
PLEASE PRINT NAME OF PATIENT, PARENT, OR GUARDIAN **RELATIONSHIP**