Preparing For Your Visit

Print out this 3-page form, fill it out and bring it with you to your first visit. Please write legibly (use the opposite side of the pages to complete your answers, if necessary).

ASSISTED RECOVERY CENTERS OF AMERICA MID-ATLANTIC

1. Personal Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone Number: _____ Date of Birth: _____ Current Age: _____

SS#: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of last physical (if known): _____ Date of last lab work (if known): _____

2. General Medical History

Current or past medical conditions (please check all that apply):

- ◯ Low Back Pain
- ◯ Other Pain Problems
- ◯ Migrane Headaches
- ◯ Hepatitis B/C
- ◯ HIV
- ◯ STDs
- ◯ Liver Problems
- ◯ Pancreatic Problems
- ◯ Nutritional deficiency
- ◯ Hypertension
- ◯ Head Trauma
- ◯ GI Disease
- ◯ Diabetes
- ◯ Asthma/Respiratory
- ◯ Thyroid Disease
- ◯ Cardiovascular (heart attack, high cholesterol)
- ◯ Epilepsy/seizures
- ◯ Other: _____

Have you ever been diagnosed with a psychiatric or mental illness? ◯ YES ◯ NO

If YES, please describe: _____

_____

_____

Have you ever taken prescribed anti-depressants or anti-anxiety medications? ◯ YES ◯ NO

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Please list all current prescription medications and how often you take them (example: Dilantin 3x daily; Adderall; Valium; Klonopin; Vyvanse; Concerta)

_____

_____

Please list any allergies you have (example: Penicillin, Sulfa drugs):

_____

Tobacco History: Do you smoke? ◯ YES ◯ NO Do you smoke e-cigs? ◯ YES ◯ NO

Have you ever been treated for substance dependence? ◯ YES ◯ NO

If YES, please describe when, where and for how long: _____

_____

_____

How long have you been using substances? _____

Have you ever been in counseling or therapy? ◯ YES ◯ NO

Are you currently employed? ◯ YES ◯ NO

If YES, your occupation: _____

Have you ever been arrested or convicted? ◯ YES ◯ NO

If YES, please check all that apply:

◯ DUI/DWI

◯ DRUG RELATED

◯ DOMESTIC VIOLENCE

◯ OTHER: _____

_____

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3. Substance Use History

	NO	YES	ROUTE	How Much	How Often	Date of Last Use	Quantity Last Used
Alcohol		❍ PAST ❍ NOW					
Cocaine		❍ PAST ❍ NOW					
Crystal Meth		❍ PAST ❍ NOW					
Heroin		❍ PAST ❍ NOW					
Inhalants		❍ PAST ❍ NOW					
LSD/Hallucinogens		❍ PAST ❍ NOW					
Marijuana		❍ PAST ❍ NOW					
Methadone		❍ PAST ❍ NOW					
Pain Killers		❍ PAST ❍ NOW					
PCP		❍ PAST ❍ NOW					
Stimulants		❍ PAST ❍ NOW					
Tranquilizers/Sleep pills		❍ PAST ❍ NOW					
Ecstasy		❍ PAST ❍ NOW					
Other:		❍ PAST ❍ NOW					