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

Patient ID: _____

Referral Source: _____

Assessment Date: _____

ASSESSMENT

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

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? ☐ N ☐ Y
   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	☐ N	☐ Y	7. Visual Distortions	☐ N	☐ Y
2. Tremors	☐ N	☐ Y	8. Auditory Hallucinations	☐ N	☐ Y
3. Diaphoresis (sweating)	☐ N	☐ Y	9. Tactile Hallucinations	☐ N	☐ Y
4. Nausea/Vomiting	☐ N	☐ Y	10. Insomnia	☐ N	☐ Y
5. Diarrhea	☐ N	☐ Y	11. Loss of appetite	☐ N	☐ Y
6. Muscle Cramps	☐ N	☐ Y	12. Cravings	☐ N	☐ 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 LBGT Community? ☐ N ☐ Y

Section 10 FAMILY MEDICAL HISTORY

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

- ☐ N ☐ Y Addiction
- ☐ N ☐ Y Asthma
- ☐ N ☐ Y Cancer
- ☐ N ☐ Y Diabetes
- ☐ N ☐ Y Stroke
- ☐ N ☐ Y Rheumatoid Arthritis
- ☐ N ☐ Y Depression
- ☐ N ☐ Y Bi-Polar Disorder
- ☐ N ☐ Y Heart Disease
- ☐ N ☐ Y Lupus
- ☐ N ☐ Y Blood clots

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

Condition	Family Member	Type of Medication Prescribed/Used	Response to Medication
Example 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:

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