PINNACLE
WELLNESS GROUP
Outpatient Medication Therapy

Patient Medical Information

Patient Name: _____ Date: _____

Date of Birth: _____ Gender: M_____ F_____ SSN: _____

Home Address: _____

Phone Number: _____ E-Mail:_____

Marital Status: ____ Single ____ Married____ Divorced____ Widowed____

Occupation: _____ Full Time: [ ] Part Time: [ ]

Address Of employment: _____

Medical History

Allergies to medication: [ ] Penicillin [ ] Novocain/ xylocaine [ ] other _____

_____

Medication Please list with dosage and frequency: _____

_____

PCP: _____ **Date** of Last Physical: _____

Have you ever been diagnosed with a psychiatric disorder? Please Describe: _____

_____

Do you have a medical history of chronic pain? **YES** **NO**

Has your chronic pain contributed to your addiction issues? **YES** **NO**

Please provide any other pertinent information regarding your addiction issues: _____

_____

Are there any other life events currently contributing to you addiction (trauma, abuse, death/illness of relatives, friend, ETC.)?_____

Do you currently use any of these? [ ] Tranquilizers [ ] Marijuana [ ] Sedatives [ ] Steroids [ ] Stimulates

Cocaine [ ] Opioids [ ] Hallucinogens [ ] Inhalants [ ] Heroin [ ] Xanax [ ] Other Drugs (please Describe):____

_____

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Serious Illnesses

Yes	No	Yes	No	Yes	No
[ ]	[ ] Glucose	[ ]	[ ] Pneumonia	[ ]	[ ] Prostate Problems
[ ]	[ ] Heart disease/ attack	[ ]	[ ] Stroke/ Seizures/ Fainting	[ ]	[ ] Bleeding
[ ]	[ ] High blood pressure	[ ]	[ ] Diabetes	[ ]	[ ] Cancer
[ ]	[ ] Angina	[ ]	[ ] Thyroid Disease	[ ]	[ ] Psychiatric
[ ]	[ ] Irregular heartbeat	[ ]	[ ] Ulcers/ Indigestion		
[ ]	[ ] Emphysema/ bronchitis	[ ]	[ ] Jaundice		
[ ]	[ ] Asthma	[ ]	[ ] Gall Bladder Disease		
[ ]	[ ] Colitis/ Diverticulitis	[ ]	[ ] Bladder/ Kidney Disease		
[ ]	[ ] Weakness	[ ]	[ ] Numbness		
[ ]	[ ] Shortness of breath	[ ]	[ ] Stiffness of Joints		
[ ]	[ ] Nausea	[ ]	[ ] Easy Bruising		
[ ]	[ ] Vomiting	[ ]	[ ] Abdominal Pain		
[ ]	[ ] Change in Bowel habits	[ ]	[ ] Diarrhea		
[ ]	[ ] Constipation	[ ]	[ ] Are you Pregnant?		
[ ]	[ ] Irregular Heart Beat/Palpitation	[ ]	[ ] Bleeding since Menopause		

[ ] [ ] Have you ever been to a psychiatrist or psychologist? If yes, Why? _____

_____

In the Past Month have you had?

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Yes	No		Yes	No	
[ ]	[ ]	Weight loss	[ ]	[ ]	Blood in stool
[ ]	[ ]	Fever/ Chill	[ ]	[ ]	Black Stool
[ ]	[ ]	Hear or cold intolerance	[ ]	[ ]	Frequent Urination
[ ]	[ ]	Vision Damage	[ ]	[ ]	Burning with urination
[ ]	[ ]	Dry eyes	[ ]	[ ]	Blood in Urine
[ ]	[ ]	Excessive Tearing	[ ]	[ ]	Chest Pain

Please indicate what drugs are involved in your addiction problem

Primary drug of choice: _____ How Often: _____

How are the drugs introduced to your body? [ ] Intravenous [ ] Smoking [ ] Snorting [ ] Pills [ ]

What other drugs are you currently using, or have abused in the past? _____

Have you previously have undergone addiction treatment **YES** **NO**

What is the longest you have remained sober after treatment? _____

SOCIAL

Tobacco use: If yes, how many years: _____ Packs a day: _____

Drug use/ History: _____

Alcohol use: [ ] None [ ] rarely [ ] Social [ ] Daily: _____oz. per day [ ] Beers _____ per day

In the last 30 days have you been incarcerated/ in a mental health institution, if yes how long? _____

Who suggested that you seek therapy? Is your family aware and supportive? _____

Until Now, what has prevented you from receiving help with your addiction? _____

_____

What level of impact has your addiction had on your daily activities?

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[ ] None [ ] Mild [ ] Moderate [ ] Serious [ ] Severe

When did you start using drugs? _____ At what age? _____

Family History

Diseases that run in the family (father, mother, siblings): _____

_____

I (Print Name) _____ to the best of my knowledge, certify that all the information provided above is accurate and complete.

I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Patient Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____