Medical History and Physical Examination

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Patient Name: _____ Case Number: _____

Date: _____ Male: _____ Female: _____ Date of Birth: _____

Reason for Treatment and Concerns: _____

_____

Present Illness

Last Drink: _____

Type of Alcohol: _____

Amount and Frequency: _____

Last Drug Use: _____

_____

_____

Previous Withdrawals

Tremors: Yes ____ No ____

Hallucinations: Yes ____ No ____

DT's: Yes ____ No ____

Detoxification: _____

_____

_____

Length and Time Using Drugs: _____

Longest Period of Abstinence: _____

History of Hospitalization: _____

_____

History of Surgery: _____

_____

Current Medications: _____

_____

Tobacco/Nicotine History: Yes _____ No _____ Use per Day _____ How Long _____

Drug and Food Allergies: Yes _____ No _____ What _____

_____

Infectious and Internal Disease History

YES	NO		YES	NO	
____	____	Hepatitis	____	____	Thyroid Disease
____	____	Rheumatic Fever	____	____	Diabetes
____	____	Malaria	____	____	Anemia
____	____	Tuberculosis	____	____	Hypertension
____	____	Pneumonia	____	____	Seizure Disorder
____	____	Asthma	____	____	Ulcers
____	____	Syphilis Date _____	____	____	Gout
		Treatment _____	____	____	Cancers/Tumors
____	____	Gonorrhea Date _____	____	____	Pancreatitis
		Treatment _____	____	____	Other

Family members with Alcohol/Drug Problems? YES _____ NO _____

	Alive	Deceased		NO	YES	Please specify kind:
Mother	_____	_____	Health Problems:	_____	_____	_____
Father	_____	_____	Health Problems:	_____	_____	_____
Brothers	_____	_____	Health Problems:	_____	_____	_____
Sisters	_____	_____	Health Problems:	_____	_____	_____

Review of Systems YES _____ NO _____

Weight Change?	YES _____ NO _____	_____
Fever?	YES _____ NO _____	_____
Weakness or Fatigue?	YES _____ NO _____	_____
Sleep Disturbance?	YES _____ NO _____	_____

	Negative	Positive
Central Nervous System	_____	_____
Respiratory	_____	_____
Gastrointestinal	_____	_____
Bones and Joints	_____	_____
Psychiatric	_____	_____
Reproductive	_____	_____
Breast	_____	_____
Genitourinary	_____	_____

Menstrual History _____

Physical Examination

Height _____ Ft _____ In _____ Weight _____

General Description _____

Pulse _____ Respiration _____ Temperature _____ BP _____

Hydration

Normal _____ Dehydrated Mild _____ Moderate _____ Severe _____

Head: _____
Nose: _____
Eyes: _____
Ears: _____
Throat: _____
Lymph Nodes: _____
Thorax and Lungs: _____

Heart Rate: _____ Rhythm: Regular _____ Abnormal _____ Other _____

Murmurs: Positive _____ Negative _____ Type _____

Other: _____

Abdomen Symmetry: _____

Neurological Exam

Alert _____ Lethargic _____ Obtuned _____ Stuporous _____

Orientation: Time _____ Place _____ Person _____

Cranial Nerves: _____
Sensorium: _____
Gait: _____
Reflexes: _____
Motor Control: _____
Extremities: _____

History of Physical Problems Associated with Abuse/Dependence: _____
_____

Diagnosis:

_____ Code _____

RECOMMENDATION

Outpatient _____ Intensive Outpatient _____

Residential _____ Inpatient _____

Length of Stay

_____ 6-9 months
_____ 9-12 months
_____ 12-15 months
_____ other _____

Weekly Visits

_____ 1 time per week
_____ 2 times per week
_____ Other _____

Referral to Ancillary Services

_____ AA _____ Other _____

Lab Services Yes _____ No _____

Comments:

_____
_____
_____
_____

_____ _____
Physician Signature Date

_____ _____
Clinician Signature Date