WATERSTONE
Addiction & Recovery Services
A Division of Waterstone Health
90 Whitney Ave, Hamden | 32 Wall St, Madison | 400 Bayonet St, New London

PLEASE READ: IMPORTANT NOTE FOR FEMALE PATIENTS
If you are currently pregnant, to trying to become pregnant please let our Patient Liaison Coordinator know immediately.

Name of Person Completing Form:_____

Relationship to Patient:_____

Primary Care Physician:_____ **Referring/Specialty Dr:**_____

Pharmacy:_____ **Location (Street & City):**_____

Employer Name:_____
(We will not contact your employer without
a signed consent from you)

Are you seeking treatment in our Substance Abuse Program Circle Response **YES** **NO**

If NO, PLEASE SKIP TO SECTION B

IF YES, PLEASE FILL OUT SECTION A

SECTION A – SUBSTANCE ABUSE QUESTIONNAIRE

What do you consider to be your primary addiction?
Please list that first in the sections below, to the best of your ability. Please include alcohol, addictive prescription medications and street drugs. For the chronic pain patient, please be sure to include all prescription narcotic and benzodiazepine medications.

Name of Drug	Quantity/Dosage Daily	How Long	Last Used

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Please list any prior treatment programs you have attended, including outpatient treatment programs. This includes alcohol, drug and/or psychiatric treatment programs over the past 10 years:

Name of Program	Date	Purpose of Treatment

Have you ever experienced any of the following when you attempted to stop drinking or using or while drinking and/or using? Please check all that apply.

□ Seizure □ Tremors □ Nausea/Vomiting □ Hallucinations
□ Loss of □ Hot/Cold Sweats □ Blackouts □ Falls

Consciousness

What is your longest period of (clean and sober) sobriety?

_____

What helped you remain sober? _____

Do you have a family history of addiction? Yes No

Please continue to Section B

SECTION B

Do you have any Current legal problems? Yes No If yes, please describe:

_____

Do you have any current medical problems? Yes No If yes, please describe:

_____

_____

_____

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Are you currently in a Pain Management Program? Yes No If yes, please describe:

_____

Name of Program:_____

Telephone #:_____ **May we contact them?** Yes No

Please list any other medications you take that are not listed in the substance abuse questionnaire above.
Include name of medication, dosage, what frequency and the name of the prescribing doctor:

_____

_____

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? May we contact them?
Name:_____ **Telephone #:**_____

Name:_____ **Telephone #:**_____

Name:_____ **Telephone #:**_____

Have you ever thought about, planned or attempted suicide? Yes No If yes, please describe:

_____

_____

Are you currently suicidal? Yes No If yes, please describe:

_____

_____

Are you Currently taking any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia or other psychiatric illnesses? Yes No If yes, please describe:

_____

_____

Have you ever been treated for or do you need treatment for an eating disorder? Yes No

If yes, please describe:

_____

_____

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Is there any other important information you would like to provide at this time? Yes No

_____

_____

_____

_____

Allergies:

_____ Reaction:_____ ☐ Mild ☐ Moderate ☐ Severe

_____ Reaction:_____ ☐ Mild ☐ Moderate ☐ Severe

_____ Reaction:_____ ☐ Mild ☐ Moderate ☐ Severe

Significant & Systemic illnesses (Please mark all that apply)

- □ No history of illnesses
- □ Congestive Heart Failure
- □ Hepatitis
- □ Lung Disease
- □ Anemia COPD
- □ High Blood Pressure
- □ Lupus
- □ Arthritis
- □ Diabetes
- □ High Cholesterol
- □ Migraine
- □ Arrhythmia
- □ Eczema
- □ HIV
- □ Polymyalgia
- □ Asthma
- □ Fibromyalgia
- □ Kidney Disease
- □ Psychiatric Disorder
- □ Bleeding Disorder
- □ Headache
- □ Kidney Stones
- □ Skin Cancer
- □ Cancer
- □ Hearing Loss
- □ Liver Disease
- □ Stroke
- □ Thyroid Disease

Other:_____

General Surgeries/Operations (Please list all): _____

_____

_____