DISCOVERY180 INTEGRATIVE SOLUTIONS, PLLC

NEW PATIENT INFORMATION FORM

(Please complete and return at or prior to first appointment.)

Patient Demographic Information:

Patient Name: _____ *Date of Birth:* _____

Address: _____*City*_____*State*_____*Zip*_____

Preferred Contact Number (home/work/cell): _____

Email Address: _____

Occupation, if employed: _____

Referred by: _____

Authorized Emergency Contact (Name/Address/Phone): _____

Chief Complaint: What is your **primary reason for seeking treatment?**

_____

_____

_____

Medical History:

Medical Hospitalizations / Surgeries: _____

_____

Known Drug Allergies:

_____

_____

Primary Care Physician (Name, Address, Phone): _____

_____

Last Physical Exam (Date /Provider Name): _____

_____

Current Medications:

Name of Medications	Dose Taken	Reason for Medication	Prescribing Physician	Comments: (Helpfulness / Side Effects)

Please Comment on any Substance Misuse (drugs / alcohol):

Name of Substance (drugs/alcohol)	When did you start?	How much do you use and how often?	**Date of Last Use?**	Method of Use (pills, smoking, intravenous)

Are you now or have you ever been **treated for chronic pain?** _____. If yes, who was / is your treating physician? _____

Have you ever been treated for alcohol or substance abuse? _____. If yes, please explain:

_____

_____

Have you ever experienced **any complication from withdrawal** (e.g., seizures, blood pressure elevation, etc.)?_____. If yes, please explain: _____

_____

Have you ever been treated with buprenorphine (Subutex, Suboxone, Zubsolv) or naloxone? _____.

If yes, please describe your experience from any complications:

_____

_____

_____

Please circle /describe any current or past **medical problems**:

- Head Injury / Loss of Consciousness / Other Neurological Problems
- **Seizures / Convulsions**
- Heart problems
- **Liver problems**
- Kidney problems
- Joint / Limb problems
- Asthma / Breathing problems
- Endocrine (Thyroid, etc.) problems
- Gastrointestinal problems
- **Other Medical Problems**

_____

_____

_____

Mental Health History:

Please circle / describe any current or past relevant **psychological problems**:

- Anxiety
- Depression
- Bipolar Disorder
- Schizophrenia
- ADD/ADHD
- Thoughts of Self Harm or Harm to Others
- Other

_____

_____

Please circle / describe any recent or current problems related to alcohol or substance use:

- Health
- Employment
- Legal
- Financial
- Family relationships
- Other

_____

_____