# Welcome to Our Practice

**Our goal is to provide you with the highest quality care and services.**

**To Assist Us With this, Please Take Time to Fill Out Questionnaires Completely. Thank you.**

**Client's Name:** ____________________________________**DOB:** ______ / _______/ ________ ☐ Male ☐ Female

**Indicate Visit Type:** ☐ New Patient ☐ Hospital Follow-up ☐ Detox ☐ Therapy

**Are you here for Ambulatory Detox or Suboxone / Subutex Treatment?** ☐ Yes ☐ No

**What is the Reason for Your Visit Today?** _____________________________________________________

**Who Referred you to this office?** ____________________________________________________________

**Referring Physician Name:** _______________________________________ **Phone:** (______) ________________

**Address:** ________________________________________________________________________________

**Referring Therapist Name:** ______________________________ **Phone:** (______) ________________________

**Have You Been Hospitalized Recently?** ☐ Yes ☐ No **Hospital Name:** ______________________________

**Date of Hospital Discharge:** ______ / _______/ ________

**Have You had Previous Treatment for Emotional Problems?** ☐ Yes ☐ No. **If yes, please explain:**

_____________________________________________________________________________________

_____________________________________________________________________________________

**Are You Currently Troubled by Thoughts to Harm Yourself or Others?** ☐ Yes ☐ No. **If yes, please explain:**

_____________________________________________________________________________________

_____________________________________________________________________________________

**Do You Have Any Medical Problems?** ☐ Yes ☐ No **If yes, please explain:** ___________________________

_____________________________________________________________________________________

**Date of Last Physical Exam?** ___________________**with Dr.**______________________________________

**Pharmacy Name:** ______________________ **Address:** ____________________________________________

**City, State Zip Code** ______________________________**Pharmacy Phone:** (______) __________________

**Do you have any Known Drug Allergies** ☐ Yes ☐ No

**Please List:** ________________________________________ _____________________________________

***(Please Complete Required State Census Information)***

**<u>Confidential Contact Preference</u>:** ☐ Mail ☐ Phone (Main #1 # 2 ) ☐ Email
**<u>Preferred Language</u>:** _____________________ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic
**<u>Race:</u>** ☐ American Indian or Alaskan ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White
**<u>Education Level:</u>** ☐ Less than a high school diploma ☐ High school graduate, No college
☐ Some college ☐ Bachelor's degree or higher

**Were you treated courteously when you made this appointment?** ☐ Yes / ☐ No. **If no, please explain:**

_____________________________________________________________________________________