Gulf Coast Psychotherapy
250 Beauvoir Road Unit 5
Biloxi, Ms 39531
Phone: 228-388-2900

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Name ____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/in long-term relationship ________ Times Married ________ Times Divorced ________

Children? ( ) N ( ) Y Current ages (list)____

Residing with you ? ( ) N ( ) Y If no, where? ________________________________

Where are you currently living? ____

Do you have family nearby? ( ) N ( ) Y (Please describe) ____________________________

Education (check most recent degree):

( ) Graduate school ( ) College ( ) Professional or Vocational school

( ) High school Grade_______________

Are you currently employed? ( ) N Where (if "no," where were you last employed?) ____________

What type of work do/did you do? ______________ How long have/did you work(ed) there?_________

Have you ever been arrested or convicted? ( ) N ( ) Y

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N ( ) Y

( ) Physically ( ) Sexually (including rape or attempted rape)

( ) Verbally ( ) Emotionally

Have you ever attended:

AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meeting, what factors led you to stop? ____________________

Have you ever been in counseling or therapy? ( ) N ( ) Y (Please describe) ______________

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PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name ____

Address ____

Phone (w)____________________ (h)____________________ (c)____________________

DOB ____________________ Age ______________ SS# ______________

Emergency Contact ____

Relationship to patient ____________________ Phone ____________________

Primary care physician ____________________ Phone ____________________

Date of last physical ____________ Have you ever had an EKG? ( ) N Date ____________

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory ( ) Cardiovascular (heart attack, high cholesterol, angina)

( ) Hypertension ( ) Epilepsy or seizure disorder ( ) GI disease

( ) Head trauma ( ) Pancreatic problems ( ) Diabetes

( ) Liver problems ( ) Abnormal Pap smear ( ) Thyroid disease

( ) STDs ( ) HIV/AIDS ( ) Nutritional deficiency

Other (Please Describe)

____

____

____

If there is a family history of any of the illnesses listed above, **please put an F next to that illness**

MD NOTES ____

____

____

Is there a family history of anything NOT listed here? (Please explain) ____________________

____

____

MD NOTES ____

____

Have you ever had **surgery** or been **hospitalized**? (Please describe) ____________________

____

____

MD NOTES ____

____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason ____________________

Medication(s) and dates of use ____________________ Why stopped ____________________

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) __________

____

____

Please list all current **herbal medicines, vitamin supplements**, etc. and how often you take them

____

MD NOTES ____

____

____

Please list any **allergies** you have (penicillin, bees, peanuts)

____

MD NOTES ____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? ________ For how many years? ________

Pipe: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day on average? ________ For how many years? ________

Have you ever been **treated for substance misuse?** ( ) N (Please describe when, where and for how long)

____

How long have you been **using substances?** ________________________________

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							

Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? (   ) N (Please list) ____________________

____

____

What was your longest period of abstinence? ____________________

____

MD NOTES ____________________

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PATIENT TREATMENT CONTRACT

Patient Name ____ Date ________________

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointment.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any resource for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place.
9. I agree that lost medication will not be replaced regardless of why it was lost.
10. I agree not to obtain medication from any doctors, pharmacies, or other sources without telling my treating physician.
11. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).

12. I agree to take my medications my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in mu treatment plan.
14. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (exempting nicotine).
15. I agree to provide random urine samples and have my doctor test my blood alcohol level.
16. I understand that violations of the able may be grounds for termination of treatment.

Patient Signature Date

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Suboxone Program Guidelines and Expectations

I understand and agree to an initial evaluation appointment prior to seeing the Doctor for medication. __________

I understand and agree to attend weekly/monthly sessions throughout my treatment program. __________

I understand any missed appointments must be made up prior to seeing the Doctor. __________

I understand I am required to pay for any missed therapy appointments not cancelled 24 hours in advance. __________

I understand I have a 15 minute "grace period" to be late. After that, I have lost my appointment time and will have to reschedule. __________

I understand it is my responsibility to reschedule any missed appointments. __________

I agree to complete all assignments given to me by my therapist. __________

I agree to take my medication as instructed by the Doctor and to give a weekly drug screen at this office. __________

I agree to these terms and I understand failure to abide by this agreement can result in my termination from the Suboxone Program. __________

____

Signature   Date

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APPOINTED PHARMACY CONSENT

SUBOXONE (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet
SUBUTEX (buprenorphine HCl) sublingual tablet

I ____ do hereby: **(MD check all that apply)**
Patient Name (Print)

☐ Authorize ____________________________ at the above address to disclose my treatment for opioid
Physician Name (Print)
dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

☐ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the event that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This constant will expire in 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and;or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV/AIDS or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/ records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

____
Patient Signature   Date   Print Name

____
Parent/Guardian Signature   Date   Print Name

____
Witness Signature   Date   Print Name

Appointed Pharmacy: Name ______________________________ Phone ______________________