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HISTORY AND PHYSICAL

Name _____ SS# _____ Date _____

Address _____ Occupation _____

Phone (Home) _____ (Work) _____ Birth Date _____

Chief Complaint _____

DRUG ALLERGIES

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease	❑	❑	❑	❑	❑	❑
Highblood pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding disorder	❑	❑	❑	❑	❑	❑
Kidney disease	❑	❑	❑	❑	❑	❑
Mental illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

PAST MEDICAL HISTORY

- ❑ Headache
- ❑ Shortness of breath
- ❑ Heart palpitations
- ❑ Heart murmur
- ❑ Chest pain
- ❑ Dizziness/fainting
- ❑ Peripheral vascular disease
- ❑ Allergies/Hay fever
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Ulcer
- ❑ GI disorder
- ❑ Lactose intolerance
- ❑ Gall Bladder disease
- ❑ Prostate disease
- ❑ Bowel Irregularity
- ❑ Incontinence
- ❑ Sexual/Mentrual dysfunction
- ❑ Venereal disease
- ❑ Frequent infections
- ❑ Hepatitis
- ❑ Anemia
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Nervousness
- ❑ Depression
- ❑ Gout
- ❑ Scarlet fever
- ❑ Chronic rashes
- ❑ Rheumatic fever
- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Polio
- ❑ Diptheria
- ❑ Tetanus

SOCIAL MEDICAL HISTORY

- ❑ Smoke: Packs daily _____ How Long _____ When Stopped _____
- ❑ Exercise routine _____ ❑ Coffee: Cups daily ___ ❑ Other caffeines _____
- ❑ Alcohol: Type/Amt _____ ❑ Diet: Salt intake ___ ❑ Fat Intake _____
- ❑ Sleep: Difficulty falling asleep ___ ❑ Snoring _____ ❑ Early morning awakening
- ❑ Continuity disturbances
- ❑ Daytime drowsiness
- ❑ Contact with blood or body fluid at work

Form No. 006-011 (9/96)

Patient Information

Patient Name (Last, First, MI)	**Marital Status M W S D**	**M**	**F**	**D.O.B.**	**AGE**	**SS#**
Street Address	**City, State, Zip**					**Phone 1**
Employer	**Occupation (indicate if student)**					**Work Phone**
Spouse or Guardian's Name (Insurance Holder)				**D.O.B.**	**SS#**	
Street Address	**City, State, Zip Code**				**Phone**	
Spouse/ Guardian's Employer	**Occupation (indicate if student)**				**Work Phone**	
Name of Your Pharmacy:	**Name of Family Doctor**				**Other Doctors Who See You**	
In Case of Emergency Notify:	**Phone**				**Alt. Phone**	
Do You Have a Living Will? Yes / No	**Does anyone have a "Durable power of Attorney for Healthcare" for you? Yes / No**				**Name and Phone if 'Yes'**	
Primary Insurance Company	**Secondary Insurance Company**				**Third Insurance Company**	
Which Employer Carries the Above Insurance?	**Which Employer Carries the Above Insurance?**				**Which Employer Carries the Above Insurance?**	

Workman's Compensation / Auto Accident Information

Where you injured on the job? Yes / No	**Date of Injury**	**Workman;s Comp. Claim #**
Workman's Comp. Ins. Company	**Street Address**	**City, State, Zip Code**
Where you injured in an auto accident? Yes / No	**Date of Accident**	**Name of Attorney**

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OutPatient Information

Place of Employment	Address	Telephone #

Have you ever participated in another detox, residential, transitional living facility or community?____ Ex: Halfway House, Mission Program, Salvation Army etc. If Yes, Please complete the following grid.

Facility	Date(s)	Completion. Yes or No

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

What is the main problem, as you see it in your life?_____
_____
_____
_____
_____

What have you attempted to do about this problem?_____
_____
_____

Describe your religious or spiritual beliefs.
_____
_____

Describe your emotional state and feelings about your current residence.
_____
_____
_____

What was happening that prompted you to seek residency at Ensemble Recovery?

Who's idea was it for you to apply to Ensemble Recovery?

What issues/problems would you like to work on while at Ensemble Recovery?

Describe any short-term goals.

Describe any long-term goals.

Where and with whom were you living before your present living situation?

Where would you live now if not accepted at Ensemble Recovery?

Do you have any health problems that require special care on your part?_____ If yes, please explain_____
_____
_____
_____

Are you, to your knowledge, medically stable at the time?_____ If no, please explain.
_____
_____
_____

Have you ever been diagnosed with a mental illness? ___Yes ___No

If yes, what type and when_____
_____
_____
_____

Have you experienced suicidal ideations (thoughts)? __Yes__No. If yes, please explain:_____
_____

Have you ever attempted suicide?__Yes__No. If yes, please explain:_____
_____

Are your currently taking prescribed Medications?____ If so, List all prescribed medications for last year, including current Medications.

Name of Medication	Date of Diagnosis	Doctor Prescribing Medication

Have you ever been convicted of a felony? _____

If yes, please describe _____
_____

Arrests /Convictions	Date	Status of conviction/Attorney/P.O

Where any of these legal issues alcohol/drug related? _____
Do you have any court cases pending, upcoming court dates etc? _____If yes, please explain.

_____
_____
_____

Are you currently on probation or parole? Yes or No.

If yes, what type, city, county, state? _____

What is your Probation/Parole officer's Name? _____

What is you Probation/Parole officer Telephone #?_____

Have you ever drank alcohol?____ If so please answer the following questions.

How old were you when you had your first drink? _____
How old were you when you were first intoxicated? _____
How old were you when you first thought you might have a problem? _____
Drink of preference? _____
Quantity? _____ How often? _____
Where and when did you usually drink?_____
Did you drink alone?_____ If so, how often?_____
When and how long was your longest period abstained from alcohol_____

Why/how did you return to drinking?

_____

_____

Do you think you can control your drinking?_____
When was your last drink? _____
Have you been involved with any 12 Step Programs? _____
If so, Which Program(s)? _____

Have you ever used Drugs? Is so, please answer the following questions.

List all drugs used:

_____

_____

_____

_____

Drug Preference? _____

How old were you when you used your first substance? _____

How old were you when you first thought you might have a substance abuse problem? __

Drug of Choice? _____

Quantity? _____ How often? _____

Where and when did you usually use the substance?_____

Did you use drugs alone?_____ If so, how often?_____

When and how long was your longest period of abstinent from drugs?_____

Why/how did you return to using drugs?

_____

_____

Have you experienced any accidental or intentional overdoses? _____If so, when:

_____

Usual place or places of use:

_____

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_____

Longest length of sobriety: _____ Date of last use: _____

Last date you used any mood or mind altering drugs, including alcohol?_____

Do you think of yourself as an alcoholic, addict, or both? What makes you think that? (Give your own definition)

_____
_____
_____

Please list 3 References:

Name_____ Relationship _____Telephone #_____

Name_____ Relationship _____Telephone #_____

Name_____ Relationship _____Telephone #_____

I understand that the information contained in this application form will be used to determine my eligibility for residency at Ensemble Recovery. I grant consent for management to verify information contained on this form and to obtain and verify other information affecting my eligibility. I certify that all the above information is true and complete to the best of my knowledge.

_____ _____

Date Applicant's Signature