MAT Intake Assessment

Name (First, MI, Last) _____

Date of Birth: _____/_____/_____

Phone (Home): _____ Phone (Cell) _____ Phone (Work) _____

Email: _____ Primary Provider: _____ Referring Provider _____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave message ☐ Home ☐ Cell ☐ Work

Emergency Contact: _____

Relationship: _____ Phone: _____

- Do you have reliable transportation? ☐ Yes ☐ No
- If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the **Consent for Services.**

Health History Form

How willing/ready are you for change: ☐ very ready ☐ somewhat ready ☐ not ready ☐ unsure

CURRENT MEDICATIONS

Name of Medication	Strength (ex. 500mg.)	Dosing Instructions (ex. Twice a day)

ALLERGY HISTORY

☐ No known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication	**Reaction** (ex. Rash, Nausea, Respiratory, Shock, etc.)

SOCIAL HISTORY (Please circle all applicable responses)

Marital Status	Single Significant Other Married Divorced Widowed	
Living Situation	Alone Spouse/Significant other Children/Family Homeless Residential Other:	
Females are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
Education Level	9 10 11 12 Some college Associates Bachelors GED Masters PhD	
Employment	Full-time Part-time Unemployed Seeking employment Disabled Retired	
If yes, Employer:	Occupation : # of Years	
Previous work experience?	Yes / No	If yes, description:
Military History	None / Past / Current Army Navy Marines Coast Guard National Guard Air Force	
Combat?	Yes / No	If yes where?
Discharge?	Yes / No	If yes: Honorable General Dishonorable Retired Other
VA Disability?	Yes / No	If yes, due to:
Spiritual/Religion Affiliation?	Yes / No	Practicing/ Role of Faith Past & Present
Receiving Benefits?	Yes / No	APTD SSI SSDI Food Stamps Fuel Asst. Section 8 Disability Public Housing Pass Plan Workers comp Unemployment

Tobacco Use? If no have you ever?	Yes / No Yes / No	Cigarettes /Cigars / Chew Cigarettes /Cigars / Chew	Per day: Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea /Soda/ Energy Drink	Per day:

MEDICAL HISTORY (Please check any of the following that you have or have had in the past)

☐ Acid Reflux/GERD	☐ Chronic Cough	☐ Hearing Loss	☐ Seizure Disorder
☐ ADHD	☐ Chronic Pain	☐ Heart Disease	☐ Sexually Transmitted Disease
☐ Alcoholism	☐ COPD/Emphysema	☐ Hepatitis	☐ Skin Wounds/Infection
☐ Anemia	☐ Dementia	☐ High Blood Pressure	☐ Stroke
☐ Anxiety	☐ Dental Problems	☐ High Cholesterol	☐ Thyroid Disease
☐ Arthritis	☐ Depression	☐ HIV/AIDS	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Kidney Disease	☐ Other

☐ Bleeding Disorders ☐ Eating Disorder ☐ Immune Disorders

☐ Bowel Problems ☐ Glaucoma/Cataracts ☐ Liver Disease

☐ Cancer ☐ Headaches ☐ Osteoporosis

Do you have any pending surgeries? ☐ Yes ☐ No If yes, describe _____

- Are you/do you have Obsessive Compulsive Disorder? ____ Eating disorder? ____ Panic Attacks? _____
- Have you participated in high-risk sexual practices _____ If so, please describe: _____ ☐

  Have you had Hepatitis? Yes ☐ No ☐ If yes, which type _____

  Last Hepatitis Test _____

  Results: _____
- Have you ever had a sexually transmitted disease ☐ Yes ☐ No If yes, which one(s) _____

  _____

  Last STD Test(s) _____ Results: _____

  Last HIV Test _____ Results: _____

- Do you now have, or have you ever had, seizures or convulsions? Yes ☐ No ☐

  If yes, when, and what condition caused them? _____ When was the last seizure or convulsions? _____
- Are there any problems that would make it hard for you to give routine urine specimens?

  Yes ☐ No ☐ If yes, describe _____

_____ ☐ Do you have any disabilities that make it hard for you to read labels or count pills?

Yes ☐ No ☐ If yes, describe _____

_____

For Women Only:

At what age did you start to menstruate? _____

Do you now have, or have you had problems with your menstrual period? Yes ☐ No ☐

If yes, please describe these problems? _____

Contraception use? Yes ☐ No ☐ If yes what type:_____ If no, what is the reason _____ Have you had any:

Pregnancies? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Miscarriages? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Abortions? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Menopausal symptoms or treatment? If yes, when? _____

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

Yes ☐ No ☐ If yes, please describe those problems: _____

_____

Family History (Please tell us about your immediate family)

CHILDREN ☐ None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SPOUSE/SIGNIFICANT OTHER ☐ None

Name	Age	Occupation	Quality of Relationship

Relationship	Age	Marital Status	Occupation	Living with?	Quality of Relationship
Mother				Yes / No	
Father				Yes / No	
Sibling:				Yes / No	

Sibling:				Yes / No	
Sibling:				Yes / No	
Other:				Yes / No	

Family is: Intact Parents are Separated/Divorced Parents Remarried

Resided with: Mother Father Adopted Orphaned Other:

Health History	**Father**	**Mother**	**Sibling**	**Children**	**Other**
Age of Death					
Cause of Death					
Heart Disease/Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Depression					
Anxiety					
Bi-Polar					
Schizophrenia					
Other:					

Contact with Family (check all that apply)

☐ Visit at least monthly
☐ Supportive
☐ Non-supportive
☐ Not satisfied with family relationship/contact
☐ Involved with treatment providers
☐ Knowledgeable about mental health
☐ Involved in National Alliance on Mental Illness (NAMI) or other support groups
☐ Family is available locally
☐ Family members not available
☐ Satisfied with family relationship/contact

What family member or significant others will be supportive to you during your treatment? _____

SUBSTANCE ABUSE HISTORY

Family Substance Abuse (Please check any family that apply, and list substance abused)

☐ None ☐ Parents _____ ☐ Siblings _____ ☐ Extended Family _____

☐ Significant other/spouse _____

Do you or your family think you have a problem with:

Shopping? ☐ Yes ☐ No Barbiturates? ☐ Yes ☐ No Internet? ☐ Yes ☐ No

Sex Addiction? ☐ Yes ☐ No Gambling? ☐ Yes ☐ No

Have you had any previous rehab or treatment for substances abuse? Yes ☐ No ☐

Where?	Reason there?	How Long?	Inpatient/Outpatient	Date

Has your significant other/spouse had any previous rehab or treatment for substance abuse? Yes ☐ No ☐

Where?	Reason there?	How Long?	Inpatient/Outpatient	Date

Have you had an adverse reaction to any substance use disorder medications? Yes ☐ No ☐

_____

Name of medication/when used/reaction

Substances	Age at first use	How often you use	How much you use	Method(s) you use	How long since last use
Alcohol					
Methamphetamine					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Hashish					
Heroin					
Methadone					
Morphine					
Opioids (Narcotics)					
Inhalants					
Marijuana					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Fentanyl					
Suboxone					
Other: _____					

Did/do you go to group meetings? _____ Do you have a sponsor? _____

Do you see a psychiatrist and if so who and how long? _____

Do you see a therapist or counselor and if so who and how long? _____

Have you ever been treated for depression if so when? _____

Do you have a Narcan Kit available at home? _____

Have you had any overdoses in the past ☐ Yes ☐ No

If yes was it accidental or planned? _____

_____

Legal History (Please report any and all illegal issues using the space provided on the following page to comment, if necessary)

Legal or Criminal Involvement?	Yes / No	*Court order Probation* *Parole* *Restraining Order*	
Found not competent to stand trial	*Homicide or attempted homicide*	*Sexual Assault* *Arson* *Assault* *Felony*	
Probation/Parole Office	Current / Past	Name:	County:
DUI (date):	**Warrants (**date):		**Violent Crime (**date):
Incarceration (date):		How long:	Reason:
Do you have firearms at home?	Yes / No	If yes, Are they locked?	Yes / No

Comments: _____

_____

_____

MENTAL HEALTH

Stressful events over the last year:

☐ Recent Hospital Discharge
☐ Death/ Divorce / Separation
☐ Relationship problems
☐ Move
☐ Educational Problems
☐ Housing Problems
☐ Access to Healthcare
☐ Witness/Victim of Violence
☐ History/Current Abuse
☐ Disability (self or family)
☐ Parent Issues
☐ Job Loss
☐ Financial Problems
☐ Legal Problems
☐ Social/Environmental Problems
☐ Other Family Problems
☐ Health Problem: _____
☐ Other: _____

Please check symptoms experienced in the last 4 weeks:

MOOD	☐ Mood Changes	☐ Overwhelming guilt/shame
☐ Depression	☐ Sadness	☐ Difficulty enjoying life
☐ Anxiety	☐ Elation (happier than normal)	☐ Irritability
☐ Hopelessness	☐ Anger/Rage	

BEHAVIORS ☐ Hurting yourself ☐ Doing the same thing repeatedly	☐ Uncontrolled spending/gambling ☐ Increased alcohol/drug use	☐ Reckless behavior ☐ Social Isolation
PHYSICAL ☐ Increased Sleep ☐ Decreased Sleep ☐ Difficult Sleeping	☐ Panic/Anxiety Attacks ☐ Increased Appetite/ weight gain ☐ Decreased Appetite/ weight loss ☐ Disturbing nightmares/dreams	☐ Agitation/Restlessness ☐ Unusual sensory experience (smell, taste) ☐ Other (specify):
THINKING ☐ Wanting to take your life ☐ Wanting to hurt someone else ☐ Seeing/Hearing things that aren't there ☐ Difficulty concentrating	☐ Intrusive negative thoughts ☐ Flashbacks ☐ Irrational fear ☐ Racing thoughts ☐ Paranoia	☐ Low self-esteem ☐ Academic/work problems ☐ Easily distracted ☐ Thinking same thoughts repeatedly ☐ Memory problems
INTERPERSONAL ☐ Increased conflict w/others ☐ Increased family conflict ☐ Difficult making/keeping friends	☐ Socially withdrawn/isolation ☐ Increased sexual problem/concerns ☐ Increased social anxiety ☐ Problems with intimacy	☐ Increased difficulty tolerating others ☐ Trouble with law/authority figures

TREATMENT QUESTIONNAIRE

Have you had any previous **psychiatric hospitalizations?** Yes ☐ No ☐

Where	**When**	**Reason**

Have you had any previous **outpatient mental health treatment?** Yes ☐ No ☐

Where	**When**	**Reason**

Have you had any previous **prescribed psychiatric medications?** Yes ☐ No ☐

Medications	**Prescribing Provider**	**Dates**

Have any family members had a history of **mental illness?** Yes ☐ No ☐

Persons	**Diagnosis of Symptoms**	**Treatments**

Have you ever experienced any **trauma?** Yes ☐ No ☐

If yes, have you been

☐ Neglected ☐ Physically Abused
☐ Emotionally Abused ☐ Sexually Abused ☐ Don't know
☐ Acts of War ☐ Witnessed/Victim of violence
☐ Serious Accidents ☐ Fire
☐ Other _____

_____

What **leisure or stress reduction activities/coping methods** do you use?

What is your **motivation for treatment?**

What **"triggers"** are you aware of that may put you at risk of a relapse?

What kind of help would you like from your counselors or nurse?

Do symptoms interfere with your ability to work or get things done? Yes ☐ No ☐ If yes, Explain

_____

_____

Additional Comments/Information:

The above information is thorough and accurate to the best of my knowledge.

_____ _____

Patient Signature (or Guardian) **Date**