Patient name_____ ACTUAL RECOVERY SERVICES (ARS)

DOB_____ Date_____ 608 Easton Rd Suite A

Willow Grove PA 19090

PATIENT NAME: _____

DOB: _____ Today's date_____

The staff and management here at ARS are dedicated to providing the best medical care. We follow the best practice recommendations/guidelines set forth by licensing agencies for the safety of our patients and clinicians. These include:

Counseling the patient on treatment goals, expectations, benefits, and risks. Ensuring the patient understands the prescriber and patient treatment responsibilities and the prescribing policies of the practice. To that end, if you violate any part of this agreement, you may be subject to immediate discharge from the practice.

The provider has advised me of possible side effects of controlled medications and the risk of overdose. We also talked about what to do if this happens, which includes having Narcan available at all times _____

All patients who are currently prescribed controlled substances to treat their medical conditions are subject to drug testing for compliance. _____

I will keep (and be on time for) all of my scheduled appointments with the medical provider and other members of the treatment team. I understand that I will be charged for cancelling an appointment when less than 24 hours' notice is given_____

I will keep the medicine safe, secure and out of the reach of children. **If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.** _____

I will not sell this medicine or share it with others. I understand that if I do, I will be discharged from ARS immediately _____

I will not use illegal drugs such as heroin, meth, crack, cocaine, fentanyl or xylazine, including nonprescribed benzos or amphetamines. I understand that if I do, my treatment may be stopped.
_____

I understand that I am expected to treat all staff with the same courtesy that I would like to be

treated_____

I understand that all non-appointment refill requests can take up to 48 hours and return phone calls will be answered within 24 hours _____

I understand that I may lose my right to treatment in this office if I break any part of this agreement.
_____

Pt name_____ PT signature_____

Provider's signature_____ Date_____

ACTual

Addiction Recovery Services

Patient Intake Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (last, first, M.I.): _____

Date of Birth: _____

Address: _____

_____

_____

Email: _____

Primary Phone Number: (_____) _____

Alternate Phone Number: (_____) _____

Occupation & Employer: _____

Marital Status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Do you have any children? ☐ **Yes** ☐ **No**

If yes, how many and how old are they? _____

When was your last Physical? _____

How Did you hear about us? _____

If you are here by referral, who referred you? _____

Relevant Medical History *(check only those relevant to you)*:

General Information:	Weight Changes: Baseline Weight (if able to obtain): Blood Pressure:
Cardiovascular/ Respiratory Health:	☐ Chest Pain ☐ Hypertension ☐ Hypotension ☐ Palpitation ☐ Smoking
Genital/Urinary/Bladder:	☐ Incontinence ☐ Nocturia ☐ Urinary Tract Infection ☐ Retention ☐ Urgency
Gastrointestinal/Bowel:	☐ Heartburn ☐ Diarrhea ☐ Constipation ☐ Nausea ☐ Vomiting ☐ Ulcers ☐ Laxative Use ☐ Incontinence
Nervous System:	☐ Headaches ☐ Dizziness ☐ Seizures ☐ Memory ☐ Concentration
Musculoskeletal:	☐ **Back Pain** ☐ **Stiffness** ☐ **Arthritis** ☐ **Mobility/Ambulation**
Gynecology (if it applies):	☐ **Pregnant** ☐ **Pelvic Inflammation Disease** ☐ **TBI/LOC** ☐ **Menopause**
Skin:	☐ **Scar** ☐ **Lesion** ☐ **Lice** ☐ **Dermatitis** ☐ **Cancer** ☐ **Itching** ☐ **Rash** ☐ **Hives**
Endocrine:	☐ **Diabetes** ☐ **Thyroid** ☐ **Other:**

Respiratory:	☐ **Bronchitis** ☐ **Asthma** ☐ **COPD** ☐ **Other:**

Have you had any surgeries? ☐ **Yes** ☐ **No**

If yes, please list them below:

_____

_____

_____

_____

_____

Have you ever been Hospitalized? ☐ **Yes** ☐ **No**

If yes, please list where and why below:

_____

_____

_____

Have you ever been in an accident? ☐ **Yes** ☐ **No**

If yes, please list what kind and any injuries below:

_____

_____

_____

Have you ever been to rehab? ☐ **Yes** ☐ **No**

If yes, please list where, when, and for how long below:

_____

_____

_____

_____

Please list all your prescribed and over-the-counter medications (such as vitamins and inhalers) that you are taking:

Name of Medication:	Strength:	Frequency Taken:

Please list all your allergies:

Medication Allergies:	Reaction you had:

Other Allergies:	Reaction you had:

Medical History:

Condition	Who has/had the condition?	Which Family Member(s)?
Anemia	☐ You ☐ Family Member(s)	
Asthma/Respiratory Problems	☐ You ☐ Family Member(s)	
Cancer Type:	☐ You ☐ Family Member(s)	
Chronic Fatigue:	☐ You ☐ Family Member(s)	
Chronic Pain:	☐ You ☐ Family Member(s)	
Diabetes:	☐ You ☐ Family Member(s)	
Epilepsy or Seizures:	☐ You ☐ Family Member(s)	

Fibromyalgia:	☐ You ☐ Family Member(s)	
Head Trauma/ Traumatic Brain Injury	☐ You ☐ Family Member(s)	
Heart Disease:	☐ You ☐ Family Member(s)	
High Blood Pressure:	☐ You ☐ Family Member(s)	
High Cholesterol:	☐ You ☐ Family Member(s)	
Intellectual or Developmental Disability:	☐ You ☐ Family Member(s)	
Kidney Disease:	☐ You ☐ Family Member(s)	
Liver Disease/ Problems:	☐ You ☐ Family Member(s)	
Stomach or Intestinal Problems:	☐ You ☐ Family Member(s)	
Thyroid Disease:	☐ You ☐ Family Member(s)	

Other Conditions:	☐ You ☐ Family Member(s)	

Alcohol and Drug History:

Check if you have ever Used:	Age of First Use:	None/ Denies	Current Use	Current Abuse	Current Depen-dence	In Recovery	Perceived Problem:
Alcohol:		☐	☐	☐	☐	☐	☐ Yes ☐ No
Ampheta-mines (speed/upper, crank, etc.):		☐	☐	☐	☐	☐	☐ Yes ☐ No
Cocaine/ Crack:		☐	☐	☐	☐	☐	☐ Yes ☐ No
Opiates (Heroin, Opium, Methadone, Fentanyl):		☐	☐	☐	☐	☐	☐ Yes ☐ No
Hallucien-ogens (LSD, Mushrooms, Peyote, Ecstasy):		☐	☐	☐	☐	☐	☐ Yes ☐ No

Sleeping Pills, Pain Killers, Valium, or Similar:		☐	☐	☐	☐	☐	☐ Yes ☐ No
PSP or Designer Drugs (GHB)		☐	☐	☐	☐	☐	☐ Yes ☐ No
Inhalants (Paint, Gas, Glue, Aerosols)		☐	☐	☐	☐	☐	☐ Yes ☐ No
Other:		☐	☐	☐	☐	☐	☐ Yes ☐ No

Tobacco and Caffeine:

How many caffeinated beverages do you drink a day?

Coffee _____ **Sodas** _____ **Tea** _____ **Energy Drinks** _____

Do you currently smoke? ☐ **Yes** ☐ **No**

If yes, how many years have you been smoking? _____

Do you use Pipe, Cigars, Vapes, or Chewing Tobacco? ☐ **Yes** ☐ **No**

If yes, what kind? _____

For how many years? _____

Do you use Marijuana? ☐ **Yes** ☐ **No**

For how often? _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

Name:

Date: