Patient Intake Questionnaire
PACIFIC COAST RECOVERY CENTER

Please complete the form and and submit to a confidential fax at (949) 499-7651

Name of person completing form:_____
Relationship to Patient: _____

YOUR CONTACT INFORMATION

Phone #: _____
Alternate Phone #: _____
Fax: _____ Email: _____
Mailing Address: _____
_____

May we contact you at any or all of the above? If not, be specific, please:
_____
How did you hear about Pacific Recovery Center? _____
_____

If you were referred by a physician, therapist or interventionist or other, we would appreciate you providing their contact information:

Name: _____
Address: _____
Phone Number:_____
May we contact your referral source? ☐ Yes ☐ No

PATIENT INFORMATION:

Name: _____
DOB: _____ Age: _____ Social Security #: _____
Marital Status: _____ Gender: _____
Address: _____
Telephone #: _____ Alternate Telephone #: _____

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Employer Name: _____
(We will not contact your employer without a signed consent from you)

Emergency Contact Name: _____Telephone #: _____
If necessary, may we contact your Emergency Contact? ☐ Yes ☐ No
Will this be your first treatment program? ☐ Yes ☐ No

What do you consider to be your primary addiction? Please list that first in the sections below, to the best of your ability. Please include alcohol, addictive prescription medications and street drugs. For the chronic pain patient please be sure to include all prescription narcotic and benzodiazepine medications:

Name of Drug	Quantity/Dosage per Day	How Long	Last Use

Are there any nonsubstance addictions you need help with? ☐ Yes ☐ No
If yes, please describe:

_____

Please list any prior treatment programs you have attended, including outpatient treatment programs. This includes alcohol, drug and/or psychiatric treatment programs over the past 10 years:

Name of Program	Date	Purpose of Treatment

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What is your longest period of (clean and sober) sobriety? _____
What helped you remain sober? _____
_____
Do you have a family history of addiction? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any current legal problems? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any current medical problems? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____
Are you currently in a Pain Management Program? ☐ Yes ☐ No
If yes, please describe: _____
_____
Name of program : _____
Telephone #: _____
May we contact them? ☐ Yes ☐ No

Please list any other medications you take that are not listed in the substance abuse questionnaire above. Include name of medication, dosage, what frequency and the name of the prescribing doctor:

_____
_____
_____
_____
_____

Have you ever experienced any of the following when you attempted to stop drinking or using or while drinking and/or using? Please check where apply.

	Seizures		Loss of Consciousness
	Tremors		Hot/Cold sweats
	Nausea and Vomiting		Blackouts
	Hallucinations (DT's)		Falls

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Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? May we contact them?

Name: _____ Telephone #: _____
Name: _____ Telephone #: _____
Name: _____ Telephone #: _____
Name: _____ Telephone #: _____

Have you ever thought about, planned or attempted suicide? ☐ Yes ☐ No
If yes, please explain:

_____
_____

Are you currently suicidal? ☐ Yes ☐ No
If yes, please explain:

_____
_____

Are you currently taking any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia or other psychiatric illnesses? ☐ Yes ☐ No
If yes, please describe:

_____
_____

Have you ever been treated for or do you need treatment for an eating disorder? ☐ Yes ☐ No
If yes, please explain:

_____
_____

Is there any other important information you would like to provide at this time? ☐ Yes ☐ No

_____
_____
_____
_____

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Health Insurance Information:

Please provide the following from your health insurance card

Subscriber Name (if other than patient): _____

DOB: _____ SSN#: _____

Name of Insurance:_____

Identification #: _____

Employer Group Name: _____

Insurance Provider Service Telephone#: _____

Customer Service Telephone #: _____

If applicable, Mental Health/Substance Abuse Telephone #: _____

If there is a secondary insurance please provide the same information as above

Subscriber Name (if other than patient): _____

DOB: _____ SSN#: _____

Name of Insurance:_____

Identification #: _____

Employer Group Name: _____

Employer or Insurance Group #: _____

Insurance Provider Service Telephone #: _____

Customer Service Telephone #: _____

If applicable, Mental Health/Substance Abuse Telephone #: _____

If you have Medicare insurance please provide the following:

Name, as it appears on card: _____

Medicare ID#: (include letters after the number): _____

Effective Date: _____

Do you have any other specific questions or requests? _____

_____

Thank you very much for the time you have taken to complete this questionnaire. We will respond to your inquiry in a timely manner and look forward to working with you!

Sincerely,

Intake Staff at Pacific Coast Recovery Center

St.JosephHealth℠
Mission Hospital
Mission Pacific Coast Recovery
A member of the St.Joseph Hoag Health alliance