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Tampa, Fl 33606
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PRETREATMENT SCREENING

Name _____

Phone no. _____ Best time to contact _____

Address _____

DOB _____ Age _____ Sex () M () F

Insurance co. _____

Insurance member # _____

Do you plan to submit a claim?

() Yes () No

Reason for seeking treatment

Substance _____ How long using? _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? () N _____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? (N) (Y)

(Please describe setting, length)

Have you ever tried to quit on your own? () N (Please describe) _____

Have you ever been treated by a psychiatrist? () N (Please describe treatment reason, setting, and length)

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of substance abuse? () N _____



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Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? N _____

Are you currently taking any medications to treat these conditions? N (List medication and dosage)

Are you pregnant? N/A N Y Not Sure Are there any current legal issues we should be aware of (probation, parole)? N _____

Are you currently employed? N Y How many hours/week (avg.)? _____

Please describe your current living arrangements _____

Other _____

Patient Interviewer Signature Date: _____