Medication Management Intake

Client's legal name: _____ Date of Birth: _____

Phone: _____ OK to leave voicemail? ☐ Yes ☐ No

Name of person completing this form (if not client): _____

Primary Physician and/or Clinic: _____

Phone: _____ Fax: _____ Date last seen: _____

Pharmacy Name & Address: _____

Phone: _____ Fax: _____

Mental Health Therapist Name: _____

Agency (if other than Ellie Family Services): _____

Phone: _____ Fax: _____

What concern(s) are you seeking to treat with medications, and how do you think they can help?

_____

_____

_____

List all previous diagnoses you have received (medical and/or mental health):

_____

_____

_____

Medical/Physical Health

Current prescribed medication	Dose	Dates	Purpose	Side Effects

Current over-the-counter medication	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? ☐ Yes ☐ No
If Yes, describe: _____

Most recent examinations	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			
Last hearing exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Please check conditions you have experienced or are currently experiencing:

☐ AIDS
☐ Alcoholism
☐ Abdominal pain
☐ Abortion
☐ Allergies
☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bronchitis
☐ Bed wetting
☐ Cancer
☐ Chest pain
☐ Chronic pain
☐ Colds/cough
☐ Constipation
☐ Chicken Pox
☐ Dental problems
☐ Diabetes
☐ Diarrhea
☐ Dizziness
☐ Drug abuse
☐ Epilepsy
☐ Ear infections
☐ Eating problems
☐ Fainting
☐ Fatigue
☐ Frequent urination
☐ Headaches
☐ Hearing problems
☐ Hepatitis
☐ High blood pressure
☐ Kidney problems
☐ Measles
☐ Mononucleosis
☐ Mumps
☐ Menstrual pain
☐ Miscarriages
☐ Neurological disorders
☐ Nausea
☐ Nose bleeds
☐ Pneumonia
☐ Rheumatic fever
☐ Sexually transmitted diseases
☐ Sleeping disorders
☐ Sore throat
☐ Scarlet fever
☐ Sinusitis
☐ Smallpox
☐ Stroke
☐ Sexual problems
☐ Tonsilitus
☐ Tuberculosis
☐ Toothache
☐ Thyroid problems
☐ Vision problems
☐ Vominting
☐ Whooping cough
☐ Other (describe):
_____

List any health concerns: _____

List any recent health or physical changes: _____

Have any of the following illnesses occurred among your blood relatives?

☐ Allergies ☐ Anemia ☐ Asthma ☐ Bleeding tendency
☐ Cancer ☐ Cerebral Palsy ☐ Cleft palate ☐ Deafness
☐ Diabetes ☐ Glandular problems ☐ Heart disease ☐ Kidney disease
☐ Mental illness ☐ Migraines ☐ Muscular Dystrophy ☐ Nervousness
☐ Perceptual motor disorder ☐ Mental Retardation ☐ Spinal Bifida
☐ Suicide ☐ Other (specify): _____

Comments regarding family health:

_____

_____

_____

Nutrition

			Typical amount eaten			
Meal	How often	Typical foods eaten	No	Low	Med	High
Breakfast	/week					
Lunch	/week					
Dinner	/week					
Snack	/week					

Chemical Use History

					Used in last:	
	Method of use & amount	Frequency of use	Age of first use	Age of last use	48 hrs (Y/N)	30 days (Y/N)
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						

Reason(s) for use:

☐ Addicted ☐ Build confidence ☐ Escape ☐ Self-medication

☐ Socialization ☐ Taste ☐ Other (specify): _____

Counseling/Prior Treatment History

Information about **client** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Information about **family/significant others** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Do you feel suicidal at this time? ☐ Yes ☐ No

If Yes, explain: _____

_____

Personal History

Current school or work: _____

Feelings about school/work: _____

Approach to school/work: _____

Performance at school/work: _____

Are you affiliated with a spiritual or religious group? Please describe: _____

_____

_____

Describe any recreational activities or hobbies: _____

_____

_____