WEST END RECOVERY

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Etobicoke, ON, Canada
M8V 1C6

Tel: (416) 386-4595
www.westendrecovery.ca

ADDICTION MEDICINE INTAKE FORM

Name _____ Date_____

Address _____ Apt # _____

City_____State_____Zip_____

Birth date _____ Age _____

Phone (with area codes):

(c) (_____)_____ VM message OK? ☐Yes ☐ No Preferred number? ☐ Yes ☐ No

(h) (_____)_____ VM message OK? ☐Yes ☐ No Preferred number? ☐ Yes ☐ No

E-mail_____

Note: West End Recovery does not communicate with patients via e-mail

☐ Please check receive Medeo invitation (telemedicine, secure messaging)

Emergency Contact _____

Relationship to you _____Phone (_____)_____

Family physician _____ Phone (_____) _____ Referred? Y N

Psychiatrist _____ Phone (_____) _____Referred? Y N

Therapist _____ Phone (_____) _____ Referred? Y N

Name of referring MD/Therapist/Counselor, if not above_____Phone (_____) _____

Past Medical History

Current or past medical conditions (check all that apply):

( ) High blood pressure	( ) Stroke, neurologic disorder	( ) Thyroid problem
( ) Diabetes	( ) GI (stomach, intestinal)	( ) Arthritis
( ) Heart disease	( ) Pancreatic problem	( ) Chronic pain
( ) High cholesterol, lipid disorder	( ) Kidney disease	( ) Cancer
( ) Seizure disorder, epilepsy	( ) Lung disease (asthma, COPD)	( ) Nutritional problem

Other Past Medical History:

_____

_____

_____

Previous Surgeries:

_____

_____

_____

Please list any **allergies** you have (medications, bees, peanuts, environmental):

_____

_____

Current prescribed **medications**: (Please list medication, dose and frequency)

_____

_____

_____

_____

Please describe any medical, psychiatric, or drug and alcohol use **conditions that run in your family**:

_____

_____

_____

Past Psychiatric History

Current or past psychiatric conditions (check all that apply):

☐ Depression _____

☐ Anxiety_____

☐ Bipolar Disorder_____

☐ Schizophrenia_____

☐ Attention Deficit/Hyperactivity Disorder_____

☐ Schizoaffective disorder_____

☐ Eating disorder_____

☐ Learning disability_____

☐ Personality disorder_____

☐ Ever thought about hurting myself _____

☐ Ever tried to hurt myself_____

☐ Other _____

List any current prescribed psychiatric medications: _____

_____

_____

List any previously prescribed psychiatric medications: _____

_____

List any prior hospitalizations for psychiatric conditions: _____

_____

_____

Comments: _____

_____

NAME_____DOB_____

Substance Use History

	No (Never used)	If Yes: Age at first use	Route	How Much	How Often	Comments
Alcohol			Oral	Per wk		
Cannabis						
Cocaine						
Meth-Amphetamine						
Inhalants						
Hallucinogens/ psychedelics						
Caffeine (pills or beverages)						
Other stimulants						
Benzodiazepines						
Sedatives/ Sleeping Pills						
Ecstasy/MDMA						
Tobacco						
Vaping (nicotine)						
Opiates						
Other						

Previous Addiction Treatment (Include inpatient, rehabilitation center, outpatient, etc):

_____

_____

_____

_____

_____

_____

NAME_____DOB_____

RECENT STRESSFUL EVENTS

Recent Stressful Life Events Check any of the following events that have occurred during the last 12 months	COMMENTS
Married	❒
Engaged	❒
Separated	❒
Divorced	❒
Breakup of important relationship	❒
Pregnancy	❒
New family member	❒
Child left home	❒
Death of spouse or significant other	❒
Bad health of family member	❒
Behavior problems in family member	❒
Personal injury or illness	❒
Sexual difficulties	❒
Difficulties or changes at school or work	❒
Retired or lost job	❒
Changed residence	❒
Major mortgage	❒
Foreclosure	❒
Legal difficulties	❒
Owe money	❒

OTHER COMMENTS ON STRESSORS:

Thank you *for taking the time to complete this intake form.*

Please sign below, indicating the information provided above is current and truthful and that you consent for this information to be shared with staff at West End Recovery, as per clinic privacy and confidentiality agreements.

X_____/_____

Signature **Date**