Substance Abuse Program Medical History Form

Personal Information

Full Name

Date of Birth

Phone Number

Address

Emergency Contact Name & Relationship

Emergency Contact Phone

Medical History

Have you ever been diagnosed with or treated for:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Seizures ☐ Asthma ☐ HIV/AIDS ☐ Other

If 'Other', please specify

List current medications (name, dosage, frequency):

Allergies (medications, foods, etc.):

History of hospitalizations or surgeries (please describe):

Mental Health History

Have you ever been diagnosed with or treated for mental health conditions?

☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia ☐ PTSD ☐ Other

If 'Other', please specify

Have you received counseling or psychiatric care?

Substance Use History

Substances used (alcohol, tobacco, drugs, etc.):

Age at first use:

Frequency and amount used:

Date/Time of last use:

Have you had prior substance abuse treatment?

If yes, where and when?