107 Nelson Street, Arroyo Grande, CA 93420
(805) 242-1360

RECOVERY NEW PATIENT INTAKE

Name:_____ Male/Female DOB_____

Race/Ethnicity (data collection purposes/optional)_____

(if requesting a Verification of Insurance Benefits) **Social Security Number: _____**

Cell phone: _____ Do you text at this number ( )Yes ( )No
Is it ok to leave a voice message stating who we are at this # ( )Yes ( )No

Email: _____

Home phone: _____ Cell phone: _____

Mailing Address: Street_____
City_____
Zip_____

How did you hear about us? _____

In case of an emergency please contact:

Name: _____

Relationship: _____

Phone: _____

KEN STARR MD
WELLNESS GROUP

CLIENT HEALTH QUESTIONNAIRE

Question	Yes	No	If 'yes' please explain/give details
Have you ever had a heart attack or any problem associated with the heart?			
Are you currently experiencing chest pain(s)?			
Do you have any serious health problems or illnesses (such as tuberculosis or pneumonia) that may be contagious to others around you?			
Have you ever tested positive for tuberculosis?			
Have you ever been treated for HIV or Aids?			

Question	Yes	No	If 'yes' please explain/give details
Have you ever been tested for sexually transmitted diseases?			
Have you had a head injury in the last six (6) months?			
Have you ever had a head injury that resulted in a period of loss of consciousness?			
Have you ever been diagnosed with diabetes?			

Do you have any open lesions/wounds?			
Have you ever had any form of seizures, delirium tremens or convulsions?			
Do you use a C-PAP machine or dependent upon oxygen?			
Have you ever had a stroke?			
Are you pregnant?			Trimester: Complications?: Prenatal care?:
Have you ever been pregnant?			# of pregnancies: # of live births:
Do you have a history of any other illness that may require frequent medical attention?			
Have you ever had blood clots in the legs or elsewhere that required medical attention?			

Question	**Yes**	**No**	**If 'yes' please explain/give details**
Have you ever had high-blood pressure or hypertension?			
Do you have a history of cancer?			
Do you have any allergies to medications, foods, animals, chemicals, or any other substance?			

Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation?			
Have you ever been diagnosed with any type of hepatitis or other liver illness?			
Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease?			
Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis?			
Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder?			
Do you have any of the following; arthritis, back problems, bone injuries, muscle injuries, or joint injuries?			

Question	**Yes**	**No**	**If 'yes' please explain/give details**
Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen?			
Do you take over the counter digestive medications such as Tums or Maalox?			

Do you wear or need to wear glasses, contact lenses, or hearing aids?			
Please describe any surgeries or hospitalizations due to illness or injury that you have had in the past:			
When was the last time you saw a physician and/or psychiatrist? What was the purpose of the visit?			

SUBSTANCE USE:

In the past **seven days** what types of drugs, including alcohol, have you used?
Type of Drug = _____
Route of Administration = _____

In the past **year** what types of drugs, including alcohol, have you used?
Type of Drug = _____
Route of Administration = _____

Do you take any prescription medications including psychiatric medications?
Type of Drug, Dosage = _____
_____
Route of Administration = _____

Question	**Yes**	**No**	**If 'yes' please explain/give details**

Have you received alcoholism or drug abuse recovery treatment services in the past?			Type of Recovery: ❑ Outpatient ❑ Residential ❑ Detoxification
Name of Previous Treatment Facility: Dates of Previous Treatment: Was Treatment Completed?:			
Have you ever been treated for withdrawal symptoms?			

MENTAL/EMOTIONAL

Question	**Yes**	**No**	**If 'yes' please explain/give details**
Are you currently feeling down, depressed, anxious or hopeless?			
Are you currently receiving treatment services outside of Ken Starr for an emotional/psychiatric diagnosis?			
Over the last 2 weeks, have you felt nervous, anxious, or on edge?			
Did you feel like you were unable to stop or control your worrying?			
Over the last 2 weeks, have you had thoughts of suicide or thought that you would be better off dead?			
If yes to the above question, do you have a plan for how you would harm yourself?			

Have you attempted suicide in the past two (2) years?			
Have you ever harmed yourself/others or thought about harming yourself/others?			
Are you currently feeling that you're hearing voices or seeing things?			
Have you ever been in a relationship where your partner has pushed or slapped you?			

What is your ACE score? _____ (*Please refer to attachment to calculate your score. You do not need to include your answers to the "yes" or "no" questions. If completing online, you may find the worksheet here.)*

I declare that the above information is true and correct to the best of my knowledge:

_____ _____

Client Signature Date