PATIENT DATABASE

To be complete by patient:

Name ______________________ Today's Date ______________________

Address ______________________ City/State/Zip ______________________

Phone # ______________________ Date of Birth ______________________

Driver's License # ______________________ Social Security # ______________________

Central Registry # ______________________ Height __________ Weight __________

Name of Emergency Contact ____
Name Relation Telephone #

Are you under the age of 18?	YES	NO
Are you pregnant?	YES	NO
Have you recently been institutionalized/incarcerated?	YES	NO
Have you ever received drug treatment before?	YES	NO

Age at which you first began to use opiates? __________ Which drug type? ______________

Did you ingest/snort/IV use this drug? YES NO Have you shared needles? YES NO

Approximate date of your last physical examination? ______________________

Approximate date of your last TB test? ______________________

Approximate date of your last HIV/AIDS tests? ______________________

Do you require special accommodation because of a disability? YES NO

Describe impairment ______________________

Are you currently enrolled in another maintenance treatment program? YES NO

Why are you transferring? ______________________

Were you required to pay a $25.00 transfer fee at this clinic? YES NO NOT SURE

Have you ever been a patient at Counseling And Recovery Services? YES NO

Approximate Date? ______________________ Which location: ______________________

How did you hear of our clinic? ______________________

To be completed by Program Staff

Patient No. ______________________ Date of Admission ______________________

I. Eye Color: Brown (1) Blue (2) Green (3) Hazel (4) Gray (5) Other (6)

II. Date of Birth ______________________

III. Gender: Male (1) Female (2)

IV. Race: White (1) Black (2) Hispanic (3) Asian (4) Native American (5) Other (6)

Previous Patient? YES NO Chart # ________ Admission Date ________ Anniversary Date ________

Length Time in Program ________ Dosage @ Discharge ________ Level at Discharge ________

Discharge Date ________ Reason for Discharge ______________________

Is the patient eligible for re-admission? YES NO Did patient complete the detox process? YES NO

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