Counseling And Recovery Services

# 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 _____
(See below to formulate #)

Name of Emergency Contact _____
Name Relation Telephone #

| | | | |
|---|---|---|---|
| Circle one: | 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 (circle one) 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? _____

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**To be completed by Program Staff**

Patient No. _____ Date of Admission _____

**Central Registry #:**

I. First Initial: _____

II. Date of Birth: _____

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

IV. Race: White (1) Black (2) Hispanic (3) Other (4)

V. Last 4 of SS#: _____

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