



UF Health Florida Recovery Center

4001 S.W. 13th street
Gainesville, FL 32608

We look forward to seeing you on _____ at _____ with Dr. _____.

You are scheduled with our **Addiction Clinic, located at 4001 S.W 13th street, Gainesville, FL 32608 Building 6 room 11**. Please plan to **arrive 15** minutes before your scheduled appointment to allow for traffic, finding our building, parking, and our intake process. If you arrive late, we may need to reschedule you for a later date in order to be fair to our other patients.

Please bring with you the following items: 1) a completed assessment form (enclosed), all of your medication bottles with all of your medication in them, and your insurance card. If you fail to bring in any of these items, your appointment may need to be rescheduled.

For your convenience, we have enclosed directions to our office. If you have any questions, please call us at **(352) 265-4357**. If you find that you cannot keep this appointment, you must cancel at least **24** hours prior to your scheduled appointment. If you fail to do this, you may not be permitted to reschedule your appointment. We look forward to meeting you and participating in your care.

Addiction Medicine



UF Health Physicians
Department of Psychiatry
4001 S.W. 13th Street
Gainesville, FL 32608
PH: 352-265-4357

AGREEMENT FOR BEHAVIOR STANDARDS REQUIREMENTS DURING CLINIC VISIT

I understand that I am personally responsible for my behavior while being treated by UF Health Physicians. Speaking in a loud voice, shouting, rude behavior, and/or use of profanity are disrespectful, disrupt the physician-patient relationship, interfere with efficient clinic operations and, therefore will not be tolerated in the clinic or by any type of communication (i.e. phone, email, mychart). If I fail to adhere to this policy, I understand I may be discharged from this clinic and/or from all UF Health Clinics.

Patient's Name

Patient's MRN

Patient's Signature

Date

Provider's Signature

Date

MR# _____
(For office use only)

Date __/__/____

New Patient Self-Report Questionnaire

Demographics

Name (last, first, mi): _____

Age: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Date of appointment: _____ Who referred you? _____

Have you been treated here before? _____

What problem/s brings you to Florida Recovery Center Clinic?

Please describe the major stressor(s) in your life now:

Are you currently having any of the following problems?

<input type="checkbox"/> Irritability, anger	<input type="checkbox"/> Trembling or shaking	<input type="checkbox"/> Intrusive memories
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Excessive worrying	<input type="checkbox"/> Fear in social/public situations
<input type="checkbox"/> Euphoric or elevated mood	<input type="checkbox"/> Grunts, tics, jerks	<input type="checkbox"/> Obsessive or intrusive thoughts
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Compulsive or repetitive behaviors	<input type="checkbox"/> Recurring memories or dreams of past trauma
<input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Concerns about your health
<input type="checkbox"/> Overspending money	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Death of someone close
<input type="checkbox"/> Loss of interest in things	<input type="checkbox"/> Hearing or seeing things that others cannot	<input type="checkbox"/> High level of stress
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fear for your safety	<input type="checkbox"/> Poor school work or performance
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Violence toward you/self	<input type="checkbox"/> Physical abuse
<input type="checkbox"/> Phobias or fears	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Excessive guilt
<input type="checkbox"/> Memory problems	<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Feelings of worthlessness
<input type="checkbox"/> Feelings of hopelessness	<input type="checkbox"/> Thoughts of death	<input type="checkbox"/> Pressure to keep talking
<input type="checkbox"/> Difficulty in making decisions	<input type="checkbox"/> Poor concentration	
<input type="checkbox"/> Fear of losing control	<input type="checkbox"/> Thoughts of harming yourself	
<input type="checkbox"/> Low self-esteem		

Psychiatric History

Have you received any *inpatient or outpatient* psychiatric care, counseling, therapy, or psychiatric medication management? *Please describe below.*

Date	For what problem?	What type of treatment?

Have you been treated with any of the following medications? *Check all that apply.*

<input type="checkbox"/>	Abilify	<input type="checkbox"/>	Eskalith	<input type="checkbox"/>	Naltrexone	<input type="checkbox"/>	Serzone
<input type="checkbox"/>	Adderall	<input type="checkbox"/>	Gabitril	<input type="checkbox"/>	Namenda	<input type="checkbox"/>	Sonata
<input type="checkbox"/>	Ambien	<input type="checkbox"/>	Geodon	<input type="checkbox"/>	Nardil	<input type="checkbox"/>	Stelazine
<input type="checkbox"/>	Antabuse	<input type="checkbox"/>	Haldol	<input type="checkbox"/>	Navane	<input type="checkbox"/>	Strattera
<input type="checkbox"/>	Aricept	<input type="checkbox"/>	Imipramine	<input type="checkbox"/>	Neurontin	<input type="checkbox"/>	Suboxone
<input type="checkbox"/>	Ativan	<input type="checkbox"/>	Inderal	<input type="checkbox"/>	Parnate	<input type="checkbox"/>	Tegretol
<input type="checkbox"/>	Buspar	<input type="checkbox"/>	Keppra	<input type="checkbox"/>	Pamelor	<input type="checkbox"/>	Topamax
<input type="checkbox"/>	Campral	<input type="checkbox"/>	Klonopin	<input type="checkbox"/>	Paxil	<input type="checkbox"/>	Thorazine
<input type="checkbox"/>	Celexa	<input type="checkbox"/>	Lamictal	<input type="checkbox"/>	Pristiq	<input type="checkbox"/>	Trazodone
<input type="checkbox"/>	Chloral Hydrate	<input type="checkbox"/>	Lexapro	<input type="checkbox"/>	Prolixin	<input type="checkbox"/>	Trileptal
<input type="checkbox"/>	Clozaril	<input type="checkbox"/>	Librium	<input type="checkbox"/>	Prozac	<input type="checkbox"/>	Tranxene
<input type="checkbox"/>	Cogentin	<input type="checkbox"/>	Lithium/Lithobid	<input type="checkbox"/>	Remeron	<input type="checkbox"/>	Valium
<input type="checkbox"/>	Concerta	<input type="checkbox"/>	Loxitane	<input type="checkbox"/>	Reminyl	<input type="checkbox"/>	Vistaril
<input type="checkbox"/>	Cymbalta	<input type="checkbox"/>	Lunesta	<input type="checkbox"/>	Restoril	<input type="checkbox"/>	Vyvanse
<input type="checkbox"/>	Dalmane	<input type="checkbox"/>	Luvox	<input type="checkbox"/>	Risperdal	<input type="checkbox"/>	Wellbutrin
<input type="checkbox"/>	Depakote	<input type="checkbox"/>	Mellaril	<input type="checkbox"/>	Ritalin	<input type="checkbox"/>	Xanax
<input type="checkbox"/>	Effexor	<input type="checkbox"/>	Methadone	<input type="checkbox"/>	Serax	<input type="checkbox"/>	Zoloft
<input type="checkbox"/>	Elavil	<input type="checkbox"/>	Miltown	<input type="checkbox"/>	Seroquel	<input type="checkbox"/>	Zyprexa

Which of these medications were particularly helpful, or problematic?

Have you ever attempted suicide, or intentionally injured yourself? *Please describe.*

Substance Use History

Substance	Type	Age started	Last Use	Amount	Frequency
Nicotine					
Alcohol					
Marijuana					
Cocaine					
LSD					
Mushrooms					
Inhalants					
Ecstasy					
Heroin					
Opiates/ Painkillers					
Benzodiazepines/ (Xanax, Ativan, etc.)					
Barbiturates					
Sleeping Pills					
Soma/muscle relaxers					
Amphetamines					
Stimulants-other					
PCP/Ketamine					
Designer Drugs					
Cold/Allergy Meds					

Have you ever had treatment for substance abuse/dependence?

Outpatient treatment Yes No

Inpatient treatment Yes No

If yes, please describe (type, when, where) _____

Regarding substance(s) listed above, have you ever experienced:

	Yes	No
Recurrent failure to fulfill duties at work/school/home?		
Using in situations that could be dangerous (e.g. driving a car)?		
Legal problems (arrest, DUI, etc.)?		
Recurrent social or relationship problems (e.g. arguments with spouse)?		
Needing more and more to get the same effect? Less effect on same dose?		
Withdrawal symptoms when you stopped or reduced your dose?		
Taking more, or for a longer time, than you planned?		
Wanting, or trying unsuccessfully, to cut back or quit?		
Spending a great deal of time in activities surrounding the substance?		
Reducing important social/occupational/recreational activities because of the substance?		
Knowing that it was harming your physical or mental health and taking it anyway?		
Doing things that violate your own personal code of ethics (e.g. lying, stealing, etc.)?		

Medical History

Do you currently have a primary care doctor? Name _____

Are you presently being treated for medical problems? If yes, for what problem and who is treating you? _____

When was your last physical examination? _____

Where and by whom? _____

What major illnesses have you had in the past?

What surgeries have you had?

Have you had any serious injuries, including head injuries? Please explain.

List all medications you are currently taking, including over the counter and herbal/natural preparations:

Medication	Dosage and times per day	Why do you take it?	Who prescribes?

Describe any allergic reactions to medications:

Are you currently having any of these physical symptoms?

<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Poor memory
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Inability to control your bowel or bladder	<input type="checkbox"/> Ringing in your ears
<input type="checkbox"/> Loss weight by 5 pounds or more in past month.	<input type="checkbox"/> Inability to obtain orgasm	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Weight gain by 5 pounds or more in past month.	<input type="checkbox"/> Irregular or rapid heartbeat	<input type="checkbox"/> Sleep disturbance

Chronic cough	Joint aches and pains	Slowed Thinking
Chronic sore throat	Lack of energy	Swollen glands
Delayed ejaculation	Lack of sex drive	Vaginal dryness
Dizziness	Muscle aches and pains	Black-out spells
Fatigue	Nausea/vomiting	Fatigue
Feeling of fullness or bloating	Tremors	Low energy or fatigue
Shortness or breath	Accelerated heart rate	Increased need for sleep
Muscle tension	Feeling of choking	Premenstrual symptoms
Poor appetite	Insomnia	Overeating or bingeing
Headaches	Pain in your legs when you walk	Chest Pain

Reproductive History (Women only)

When was your last menstrual period? _____

Do you currently use birth control? If yes, what kind? Any problems?

Are you currently pregnant? Yes No

If not pregnant, are you trying to become pregnant? Yes No

Have you experienced any of the following:

Pregnancies Yes No

Elective Abortion Yes No

Miscarriages Yes No

Infertility Yes No

Weight and Eating Habits

Current Weight _____ Highest _____ Lowest _____ Height _____

	Yes	No
Are you unhappy with your current weight?		
Do you have intense fear of becoming fat?		
Have you ever missed 3 menstrual cycles in a row?		
Have you ever restricted your eating below 1000 calories/day?		
Do you ever binge or lose control of how much you eat?		
Do you ever intentionally vomit after eating?		
Do you ever use laxatives, diuretics, or other drugs to lose weight?		
Have you had a significant weight <u>gain</u> in the past 6 months?		
Have you had a significant weight <u>loss</u> in the past 6 months?		

Family Medical and Psychiatric History

Please list the blood relatives who have suffered from the following illnesses or problems:

Alcoholism: _____
 Abuse of illegal drugs: _____
 Depression: _____
 Manic depression/bipolar: _____
 Postpartum depression: _____
 Schizophrenia: _____
 Suicide: _____
 Cancer: _____
 Heart disease: _____
 Diabetes: _____
 Osteoporosis: _____
 Strokes: _____
 Thyroid disease: _____

Social Supports

Indicate who currently provides social and emotional support to you:
Family Friends Co-workers Others _____
Church Neighbors No support
 Who lives with you? _____
 Are you currently having any problems with the persons that you live with?
 Yes No *If yes, please explain:* _____

Developmental History

Please indicate which of the following you experienced while you were growing up:

Experience	Age	Comments
Death of a parent		
Death of other loved one		
Separation from parent or family		
Parent's separation/divorce		
Loss of home		
Financial problems		
Physical abuse		
Sexual abuse/in childhood		
Sexual assault or rape		
Parents with substance abuse		
Conflicts with parents/family		
Foster care		
Adoption		

Unwanted pregnancy		
School problems		
Medical illness in self		
Medical illness in family member		

Social History

What is the highest level of education you have achieved? _____

What jobs/occupations have you had? _____

Are you currently employed? Yes No

Where do you work, and what is your occupation? _____

How long have you been at current employment? _____

Are you experiencing any problems at your job? _____

If not employed, how do you support yourself? _____

Are finances a cause of stress for you? How? _____

How many times have you been: Married? _____ Divorced? _____ Widowed? _____

What is your present marital status? _____

Do you have any problems or concerns about your current intimate relationship? _____

How many children do you have? _____

Do any of children live with you? Yes No

Spiritual/Religious Background

Please summarize your spiritual or religious beliefs: _____

Do you belong to a congregation or formal religion? Which? _____

How important are your spiritual/religious beliefs/affiliation? _____

Safety

Do you feel unsafe in your current environment? Yes No

If no, please describe your concerns _____

Do you have access to any firearms in your home? Yes No
 Do you currently have thoughts/plans of hurting anyone else? Yes No
 Do you currently have thoughts/plans of hurting yourself? Yes No

Grief and Loss

Have you experienced any significant losses or changes (such as deaths, divorce, relocations, unemployment) that may be contributing to your current problems?
 Please explain. _____

History of Emotional Trauma

Have you ever been the victim of a violent crime? _____

 Have you ever witnessed a severe act of violence? _____

 Have you been the victim of physical abuse? _____

 Have you ever been a victim of rape or sexual assault? _____

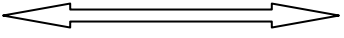
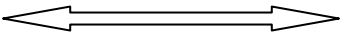
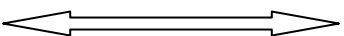
 Have you ever been a victim of childhood sexual abuse? _____

Recreation and Relaxation

Please list your favorite activities/hobbies: _____

Current Stress Level

Please rate the current level of stress in your life by placing an "x" on the lines below.

Job/Employment	None		Overwhelming
Family	None		Overwhelming
Life in General	None		Overwhelming

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

<p>CONSTITUTIONAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Weight Loss <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p>EYES: Yes No <input type="checkbox"/> <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> <input type="checkbox"/> Eye Pain <input type="checkbox"/> <input type="checkbox"/> Double Vision <input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p>EAR, NOSE, THROAT: Yes No <input type="checkbox"/> <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> <input type="checkbox"/> Vertigo <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> <input type="checkbox"/> Nasal Stuffiness <input type="checkbox"/> <input type="checkbox"/> Frequent Sore Throat</p> <p>CARDIOVASCULAR: Yes No <input type="checkbox"/> <input type="checkbox"/> Murmur <input type="checkbox"/> <input type="checkbox"/> Chest Pain <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Fainting Spells <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> <input type="checkbox"/> Difficulty lying Flat <input type="checkbox"/> <input type="checkbox"/> Swelling Ankles</p> <p>ENDOCRINE: Yes No <input type="checkbox"/> <input type="checkbox"/> Loss of Hair <input type="checkbox"/> <input type="checkbox"/> Heat/Cold Intolerance</p>	<p>RESPIRATORY: Yes No <input type="checkbox"/> <input type="checkbox"/> Cough Easy <input type="checkbox"/> <input type="checkbox"/> Coughing Blood <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p>GASTROINTESTINAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Change in BMs <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> <input type="checkbox"/> Black or Bloody BM</p> <p>GENITOURINARY: Yes No <input type="checkbox"/> <input type="checkbox"/> Burning/Frequency <input type="checkbox"/> <input type="checkbox"/> Nighttime <input type="checkbox"/> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> <input type="checkbox"/> Abnormal Discharge <input type="checkbox"/> <input type="checkbox"/> Bladder Leakage</p> <p>ALLERGIC/IMMUNOLOGIC: Yes No <input type="checkbox"/> <input type="checkbox"/> Hives/Eczema <input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p>PSYCHIATRIC: Yes No <input type="checkbox"/> <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> <input type="checkbox"/> Mood Swings <input type="checkbox"/> <input type="checkbox"/> Difficult Sleeping</p>	<p>HEMATOLOGY/LYMPH: Yes No <input type="checkbox"/> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> <input type="checkbox"/> Gums Bleed Easily <input type="checkbox"/> <input type="checkbox"/> Enlarged Glands</p> <p>MUSCULOSKELETAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Joint Pain/Swelling <input type="checkbox"/> <input type="checkbox"/> Stiffness <input type="checkbox"/> <input type="checkbox"/> Muscle Pain <input type="checkbox"/> <input type="checkbox"/> Back Pain</p> <p>SKIN: Yes No <input type="checkbox"/> <input type="checkbox"/> Rash/Sores <input type="checkbox"/> <input type="checkbox"/> Lesions <input type="checkbox"/> <input type="checkbox"/> Itching/Burning</p> <p>NEUROLOGICAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Loss of Strength <input type="checkbox"/> <input type="checkbox"/> Numbness <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Tremors <input type="checkbox"/> <input type="checkbox"/> Memory Loss</p> <p>FEMALES ONLY: Date Last Mammogram _____ Normal _____ Abnormal _____ Date last PAP _____ Normal _____ Abnormal _____ Age Onset Periods _____ Age Onset Menopause _____ Periods Regular? Yes _____ No _____ Number _____ Pregnancies _____</p>
--	--	---