ANC

Patient Intake

Date _____

Name_____ DOB_____

Address_____

_____

Phone number_____

Email address_____

Insurance payer _____ Self Pay_____

Insurance ID _____

Name of primary card holder _____

DOB_____ SS#_____

New Patient Intake

Medical and Counseling

Patient Name _____DOB_____

BH AND MAT

1. What do you need to be seen for? _____
2. Have you or are you being seen at another facility? _____
3. Is the facility in patient or outpatient? _____ where? _____
4. 9. Have you ever been diagnosed with mental health condition? _____
   if yes what was the diagnoses? _____

5. Are you currently taking any medications? Yes_____ No_____
6. List of medications currently prescribed.

Med _____Dosage_____ How often_____
Med _____ Dosage _____How often_____
Med _____Dosage _____How often_____
(If additional space needed, please list on back)

MAT

7. Are you taking any medications not prescribed to you Yes_____ No____
   List _____
8. Are you using street drugs? Yes ____No _____ What? _____
9. Have you ever used Medication for Addiction?
   Suboxone, Subclade Subutex, Methadone, Vivitrol
   Other? _____ Dosage_____
10. Is this treatment Self_____ Court Mandated_____ Other_____
11. Do you prefer a male or female counselor _____ Does not matter _____

General Questions

Do you currently work? _____ where? _____

Do you have reliable transportation? _____

Notes:

Appointment Date _____ time_____ set by_____