GAMMONS MEDICAL
1223 South Washington Ave
Royal Oak, MI 48067

PRETREATMENT SCREENING

Name _____

Phone # _____ Best time to contact _____

Address _____

_____

DOB _____ Age _____ Sex ( ) M ( ) F

Reason for seeking treatment

Substance _____ How long using? _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? ( ) N _____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? ( )N

(please describe setting, length) _____

Have you ever tried to quit on your own? ( ) N (Please describe) _____

_____

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of substance abuse? ( ) N _____

Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? ( )N _____

Are you currently taking any medications to test these conditions? ( ) N (List medications and dosage)

_____

Are you pregnant? ( )N/A ( )N ( )Y ( )Not Sure

Are there any current legal issues we should be aware of (probation, parole)? ( ) N _____

Are you currently employed? ( )N ( )Y How many hours/week (avg)? _____

I have read and agree to the terms of my patient treatment contract. I am alert, oriented, and understand the terms of my patient treatment contract. I certify that the above information is true to the best of my knowledge.

_____ _____

Patient Signature Date