PHOENIX RECOVERY CLINIC
7105-B BAILEY CREEK CIRCLE 35802
HUNTSVILLE, AL 35802
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ADDICTION THERAPY UPDATE

IT IS IMPORTANT FOR US TO KNOW IF YOUR CURRENT MEDICATIONS ARE EFFECTIVE IN IMPROVING YOUR QUALITY OF LIFE. PLEASE ANSWER HONESTLY AS THIS INFORMATION IS USED TO HELP US DETERMINE YOUR TREATMENT PLAN.

(FOR OFFICE USE ONLY)

VITALSIGNS:HT_____WT_____TEMP_____O2%_____HR_____RR_____B/P_____BMI_____

ALLERGY TESTING INFORMATION PROVIDED: YES_____ TOBACCO COUNSELING PROVIDED: YES_____

NAME_____ DOB_____AGE_____ DATE_____

MEDICATION ALLERGIES: _____

1. ARE YOU HAVING ANY SIDE EFFECTS FROM YOUR MEDICATION? YES ◯ NO ◯
   IF YES, PLEASE EXPLAIN:_____
   _____
2. IS THE CURRENT DOSE OF YOUR MEDICATION MANAGING YOUR WITHDRAWALS AND CRAVINGS? YES ◯ NO◯
   IF NO, EXPLAIN:_____
3. HAVE YOU ATTENDED ANY NA MEETINGS? YES◯ NO◯
4. HAVE YOU ATTENDED COUNSELING? YES◯ NO◯
5. HAVE YOU TAKEN ANY OPIOIDS SINCE YOUR LAST VISIT? YES◯ NO ◯
6. HAVE YOU TAKEN ANY ILLICIT DRUGS SINCE YOUR LAST VISIT? YES ◯ NO◯
7. HAVE YOU TAKEN ANY BENZODIAZEPINES SINCE YOUR LAST VISIT? YES◯ NO◯
8. DO YOU HAVE A SUPPORT SYSTEM ESTABLISHED? YES ◯ NO◯
9. HOW IS YOUR WORK/EMPLOYMENT SITUATION? _____
10. HOW IS YOUR SOCIAL/FAMILY SITUATION?_____
11. DO YOU HAVE ANY OTHER COMPLAINTS THAT NEED TO BE ADDRESSED THIS VISIT? YES◯ NO◯
    IF YES, DESCRIBE:_____
    _____
12. ADDITIONAL COMMENTS:_____

SOCIAL HISTORY

CAFFEINE USE: YES ◯ NO ◯ IF YES, HOW MANY CUPS?_____
TOBACCO USE: YES ◯ NO ◯ IF NO, WHEN DID YOU QUIT?_____
IF YES, HOW MANY YEARS?_____ HOW OFTEN? EVERY DAY ◯ OCCASIONALLY ◯
HOW MANY? 1-9 ◯ 10-19 ◯ 20-39 ◯ 40 OR MORE ◯
ALCOHOL USE: YES ◯ NO ◯ IF YES, HOW MANY DRINKS? _____
HOW OFTEN? DAILY ◯ WEEKLY ◯ MONTHLY ◯ OCCASIONALLY ◯
RECREATIONAL DRUG USE? YES◯ NO◯
IF YES, DESCRIBE: _____

SIGNATURE: _____