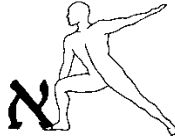


THE ALEPH CENTER, P.L.L.C.



6408 East Tanque Verde Road
 TUCSON, AZ 85715-3809
 PHONE: (520) 885-5558 FAX: (520) 885-5559

Welcome, please complete as much of this form as you can. The answers you provide will help us to plan your care. You will only have to fill this form out one time. If you would like a copy let us know and we will be happy to provide one. You may give this form to any other doctors so they can get a better understanding of who you are and how you are affected by your illness. We will fax this form to any provider you designate in the future. Hopefully, you will not have to fill out a form like this again. We will be happy to assist you as needed, Thank you.

Patients Name (Last, First, Middle)	Name you prefer to be called	Date
Family Physician (Name and Phone Number):	Date of Birth	

Why are you coming into the office now?

Emergency Contact	Relationship of Contact	Home Phone #	Work Phone #
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Have you been hospitalized in the last 30 days? Yes No

General History and Habits (Check all items that apply - past and present)

	No	Past	Current	How Long	Amount
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Caffeine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Habit forming drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

Nutritional History No Problem

<input type="radio"/> Weight Gain	Amount	Time Span	<input type="radio"/> Weight Loss	Amount	Time Span
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Allergies No Known Allergies

Allergic to:			
Drugs/Food	Describe your reaction	Drugs/Food	Describe your reaction

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Health History (Check All items that apply - past and present)

Head/Eyes/Ears/Nose/Throat	
o Hearing Loss o Right o Left	o Glaucoma o Cataracts o Hay Fever/Allergies
o Vision Loss o Right o Left	o Nosebleeds o No Problems o Other _____
Cardiovascular	
o High Blood Pressure o Heart Attack o Chest Pain/Angina o Pacemaker, Internal Defibrillator	
o Irregular Heart Rhythm/Murmur o Swelling of Ankles o Cardiac Catheterization /Angioplasty	
o Circulation Problems o Congestive Heart Failure o No Problems o Other _____	
Endocrine/Other	
o Diabetes o Home Glucose Monitoring o Thyroid Disease o Adrenal Disease o Immune Disorder	
o Cancer: Type _____ Treatment _____ o Blood Disorders-Bleeding, Anemia	
o No Problems o Other _____	
Neurological	
o Headaches o Seizures o Faintness/Dizziness o Weakness/Tingling/Numbness Where _____	
Stroke: Any Deficit? _____ o Back Pain o No Problems o Other _____	

Gastrointestinal

o Nausea and Vomiting o Heartburn/Indigestion o Ulcers o Loss of Appetite o Colostomy o Diarrhea
o Constipation o Change in Stool o Liver Disease o Hiatal Hernia o Hepatitis o No Problems
o Other _____

Genitourinary

o Difficult or Painful Urination o Kidney Stones o Frequent Urination o Prostate Problems
o Kidney Disease o Urinary Infection o Last Menstrual Period _____ Pregnant? o Yes o No
o Venereal Disease o No Problems o Other _____

Respiratory

o Shortness of Breath: Is shortness of breath worse at night? o Yes o No o Chronic Cough
o Cold/Sore Throat: greater than 4 a year o Asthma/Bronchitis o Oxygen at home- Flow Rate _____
o Tuberculosis o Phlegm, Color _____ o Chronic Lung Disease o Sinus Infection
o No Problems o Other _____

Musculoskeletal

o Rashes/Bruises/Sores Where _____ o Arthritis o Limited Mobility
Have you fallen in the last year? o Yes o No o No Problems o Other _____

Prosthesis/Assistive Devices

o Valves o Joints o Eyes o Artificial o Hearing Aides o Dentures/Teeth o Upper o Lower
o Contact Lens o Glasses o Walker, Cane, Wheelchair o No Problems o Other _____

Continuum of Care

Do you live alone? o Yes o No Are others dependent on you for their care? o Yes o No
Do you live in a nursing home, adult care home, or use home health services? o Yes o No
Facility Name: _____ Phone: _____ Do you have assistance available for your daily care(Examples: meals, bathing, transportation) o Yes o No
Do you feel safe at home? o Yes o No

Psychosocial History

Do you have an Advanced Directive/Living Will o Yes o No Where is it located? _____
Do you have a Durable Power of Attorney? o Yes o No If you have either of these documents please bring a copy with you next time.
Are you an Organ Donor? o Yes o No Are there any situations that are causing you stress? o Yes o No Explain: _____
How do you relax?: _____
Do you exercise? o Yes o No What and How often? _____
Where do you gain your greatest support? _____

Sexual Orientation: <input type="radio"/> Heterosexual <input type="radio"/> Homosexual <input type="radio"/> Bisexual <input type="radio"/> Transgender					
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Other				Number of Marriages	
	Age	Length	Termination	Children	Spouse's Name
1st Marriage					
2nd Marriage					
3rd Marriage					
4th Marriage					

Describe the relationship of current and/or past marriages.

Pain History
Do you have pain? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> New <input type="radio"/> Chronic
How do you manage your pain at home?

Children

Name	Age	Alive/Deceased	Amount of Contact	Quality of Relationship Past/Present

Miscarriages, abortions, stillbirths

Environment
Do you live in a: <input type="radio"/> House <input type="radio"/> Apartment <input type="radio"/> Nursing Home <input type="radio"/> Other
Do you: <input type="radio"/> Rent <input type="radio"/> Own <input type="radio"/> Live with relatives
Who are the members of your household?

Financial Summary: (Include resources, stability of resource and ability to live on current income)

Peer Relationships/Social Life.

Describe peer relationships, past and present

Has anyone important to you died or moved away recently? Yes No

Who? _____

Describe your social life, past and present

Club and/or Organization Affiliation, past and present

Cultural Influences/Spiritual History

Are there any particular cultural influences you feel need to be taken in consideration while you are in treatment?

Religious Affiliation _____

Present/Past participation in church _____

Vocational/Avocational History

Education: Grade completed _____ Trade School/College Attended _____

Current Employment status: Retired Date _____ Semi-Retired Date _____ Disabled Date _____
 Employed Full-Time Employed Part-Time

Are you satisfied with your current employment status?

Work History

Hobbies and interests (past and present)

Military History Not Applicable

Branch of Service _____ Rank _____ Date: From _____ To _____

Assignments

Wounded in Action? _____

Type of discharge _____

Medical History

To your knowledge, was your mother's pregnancy with you abnormal? If abnormal or problems with delivery or soon after your birth, Explain:

Childhood: Major Illnesses/Injuries/Handicaps/Surgeries

Psychiatric History
Have you ever participated in individual or group therapy and/or seen a Psychiatrist? <input type="radio"/> yes <input type="radio"/> no
Have you ever been treated for any of the following? <input type="radio"/> Yes <input type="radio"/> No (If Yes, check all that apply)
<input type="radio"/> Depression <input type="radio"/> Anxiety/Panic <input type="radio"/> Adjustment Problems(s) <input type="radio"/> Eating Disorder <input type="radio"/> Chemical Dependency
<input type="radio"/> Other

If you answered "Yes" to either of the above questions please give the date(s) and indicate treatment effectiveness

Family history of emotional problems

Drug and Alcohol History

Current Status of alcohol intake (include frequency, amount and date of last use)

Past history of alcohol intake (include frequency, amount and longest period of abstinence)

Have you ever cut down your intake of alcohol? Yes No
Were people around you ever angered at your drinking? Yes No
Have you ever felt guilty about things you've done while drinking? Yes No
Have you ever had a drink before noon? Yes No
Have you ever sought treatment for alcohol abuse (AA, private counseling, etc.)?

Have you ever used sleeping pills, pain killers, or tranquilizers? Yes No Explain: (include frequency, amount, longest period of abstinence, date of last use)

Have you ever used illegal drugs? Yes No
Marijuana Yes No LSD or other hallucinogens, mushrooms, peyote Yes No
Cocaine Yes No Speed Yes No Huffing gas, paint, etc. Yes No Heroin Yes No
I.V. Drugs Yes No Explain:

Have you ever-sought treatment for drug abuse? Yes No
Has or is anyone in your family attended/ing any other support group Yes No
If yes, specify who and what group

Are you concerned about drinking/drug abuse? o Yes o No If yes, why?

What changes about your personality when you drink or use?

When did you first become concerned and why?

After Completing this, is there anything else we have not addressed that is important to you?

Patient/Family Signature

Date

Time

THANK YOU FOR CHOOSING US TO HELP YOU.

THE *ALEPH* CENTER, P.L.L.C.