New Patient Questionnaire

Name: _____

What brought you to seek care at the Jamestown Healing Clinic today?

_____

_____

_____

Are you currently receiving methadone or suboxone from another Opiate Treatment Program? Yes ☐ No ☐

Do you currently have a primary care provider? Yes ☐ No ☐ If yes, who? _____

Do you plan to receive primary care at Jamestown Healing Clinic? Yes ☐ *No ☐

** If you do not want to transfer your primary care to the Jamestown Healing Clinic, please speak with your counselor about what information you would like to be shared with your primary care provider.*

Do you plan to receive dental care at Jamestown Healing Clinic? Yes ☐ No ☐

If yes, do you have any current urgent dental needs such as an active infection?

_____

_____

Do you have any long-term health conditions (physical or mental health)? Yes ☐ No ☐

If yes, please list: _____

_____

Do you see any specialists? Yes ☐ No ☐

If yes, please list: _____

_____

Do you take any medications, supplements, or other over the counter products? Please list all that you are currently taking (you will need to complete a medication registration form for each of your medications with the dispensing nurse which will be provided to you during the first week of your treatment). _____

_____

_____

Do you plan to utilize our van transportation service? Yes ☐ No ☐

Do you plan to use our child watch service? Yes ☐ No ☐

Do you have a case manager such as through a specialist's office, Peninsula Behavioral Health, First Step, or Rediscovery? Yes ☐ No ☐

If so, please provide their name and request a release of information form from the counselor if you would like your case manager involved in your care. Case Manager Name: _____

PATIENT INFORMATION

NAME: FIRST MIDDLE LAST

PREVIOUS NAME(S) | **PREFERRED NAME**

DATE OF BIRTH | **LEGAL GENDER:** FEMALE MALE | **IDENTIFIED GENDER:** FEMALE MALE | **SOCIAL SECURITY #**

STREET ADDRESS | **CITY** | **STATE** | **ZIP**

MAILING ADDRESS (IF DIFFERENT THAN ABOVE) | **CITY** | **STATE** | **ZIP**

HOME # | **CELL #** | **WORK #**

OK TO LEAVE DETAILED MESSAGES ON VOICEMAIL? YES NO | **EMAIL**

ETHNICITY (CIRCLE ONE) HISPANIC OR LATINO NON-HISPANIC OR LATINO DECLINE

RACE (CIRCLE ONE) AFRICAN AMERICAN ASIAN ALASKAN NATIVE/NATIVE AMERICAN CAUCASIAN PACIFIC ISLE OTHER/MULTI DECLINE

PREFERRED LANGUAGE: | **INTERPRETER NEEDED** YES NO

MARITAL STATUS (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

EMERGENCY CONTACT: NAME | RELATIONSHIP TO PATIENT | PHONE #

Address | City | State | Zip

EMPLOYMENT STATUS (CIRCLE ONE) FULL TIME PART TIME UNEMPLOYED RETIRED OTHER

EMPLOYERS NAME | **ADDRESS** | **PHONE #**

PARTY FINANCIALLY RESPONSIBLE FOR PATIENT ACCOUNT (CIRCLE ONE) SELF OTHER

IF OTHER, COMPLETE THIS SECTION: FIRST MIDDLE LAST | **RELATIONSHIP TO PATIENT**

MAILING ADDRESS | **CITY** | **STATE** | **ZIP**

PHONE # | **SOCIAL SECURITY NUMBER** | **DATE OF BIRTH** | **EMPLOYER**

WERE YOU REFERRED TO THE JAMESTOWN HEALING CLINIC? (Circle one) YES NO

If YES, by whom?