

# New Patient Questionnaire

Name: \_\_\_\_\_

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

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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?

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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). \_\_\_\_\_

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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**

<b>NAME:</b> 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	
<b>EMPLOYMENT STATUS (CIRCLE ONE)</b> FULL TIME PART TIME UNEMPLOYED RETIRED OTHER										
EMPLOYERS NAME			ADDRESS				PHONE #			
<b>PARTY FINANCIALLY RESPONSIBLE FOR PATIENT ACCOUNT (CIRCLE ONE)</b> 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?										