



ellie FAMILY SERVICES

www.elliefamilyservices.com
phone: 651.313.8080 fax: 651.925.0610

Medication Management Intake

Client's legal name: _____ Date of Birth: _____

Phone: _____ OK to leave voicemail? Yes No

Name of person completing this form (if not client): _____

Primary Physician and/or Clinic: _____

Phone: _____ Fax: _____ Date last seen: _____

Pharmacy Name & Address: _____

Phone: _____ Fax: _____

Mental Health Therapist Name: _____

Agency (if other than Ellie Family Services): _____

Phone: _____ Fax: _____

What concern(s) are you seeking to treat with medications, and how do you think they can help?

List all previous diagnoses you have received (medical and/or mental health):

Medical/Physical Health

Current prescribed medication	Dose	Dates	Purpose	Side Effects

Current over-the-counter medication	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? Yes No

If Yes, describe: _____

Most recent examinations	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			
Last hearing exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Please check conditions you have experienced or are currently experiencing:

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/cough | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | |

List any health concerns: _____

List any recent health or physical changes: _____

Have any of the following illnesses occurred among your blood relatives?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Perceptual motor disorder | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Spinal Bifida | |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Other (specify): _____ | | |

Comments regarding family health: _____

Nutrition						
Meal	How often	Typical foods eaten	Typical amount eaten			
			No	Low	Med	High
Breakfast	/week					
Lunch	/week					
Dinner	/week					
Snack	/week					

Chemical Use History						
	Method of use & amount	Frequency of use	Age of first use	Age of last use	Used in last:	
					48 hrs (Y/N)	30 days (Y/N)
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						

Reason(s) for use:

- Addicted Build confidence Escape Self-medication
 Socialization Taste Other (specify): _____

Counseling/Prior Treatment History

Information about **client** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Information about **family/significant others** (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Do you feel suicidal at this time? Yes No

If Yes, explain: _____

Personal History

Current school or work: _____

Feelings about school/work: _____

Approach to school/work: _____

Performance at school/work: _____

Are you affiliated with a spiritual or religious group? Please describe: _____

Describe any recreational activities or hobbies: _____
