SC Professional Services, LLC
d/b/a Hope Integrative Medicine
775 Saint James Avenue, Suite B
Goose Creek, SC 29445
Phone: 843.779.7718

New Patient Information

Record # _____

Name: _____ **Date of Birth:** _____

Gender (Circle One): Male Female Transgender Male Transgender Female **Other:** _____

Social Security Number: _____ **Drivers Lic. #:** _____

Address: _____
Street City State Zip Code

Home #: _____ **Cell #:** _____

Email: _____ **Ethnicity/Race:** _____

Marital Status (select one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sexual Orientation (optional): ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Other

Emergency Contact: _____ **Relationship:** _____

Email: _____ **Ethnicity/Race:** _____

Address: _____
Street City State Zip Code

Insurance Information

Primary Insurance	
Insurance Name	
Subscriber's Name	
Policy # / ID #	
Group #	
Insured's DOB	

Secondary Insurance	
Insurance Name	
Subscriber's Name	
Policy # / ID #	
Group #	
Insured's DOB	

How did you hear about our office? _____ **Relationship:** _____

Address: _____
Street City State Zip Code

Home #: _____ **Cell #:** _____

Referring Physician: _____

Address: _____
Street City State Zip Code

Phone #: _____ **Fax #:** _____

Pharmacy Information

Name: _____

Pharmacy Phone #: _____ **Fax #:** _____

Address: _____
Street City State Zip Code

I certify I have filled this above form with current and correct information to the best of my abilities.

_____ _____
Patient Signature, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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Patient's Medical History

Name: _____ **Date of Birth:** _____

Current or Past Medical Conditions

(check all that apply)

- ☐ Asthma/Respiratory
- ☐ Hypertension
- ☐ Head Trauma
- ☐ Liver Problems
- ☐ STDs
- ☐ Cardiovascular (heart attack, high cholesterol, angina)
- ☐ Addiction / Dependence
- ☐ Epilepsy or Seizure Disorder
- ☐ HIV/AIDS
- ☐ Pancreatic Problems
- ☐ Abnormal Pap Smear
- ☐ Cancer
- ☐ GI Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Nutritional Deficiency
- ☐ Other (Please Describe)

MD Notes: _____

Family History

(check all that apply)

- ☐ Asthma/Respiratory
- ☐ Hypertension
- ☐ Head Trauma
- ☐ Liver Problems
- ☐ STDs
- ☐ Cardiovascular (heart attack, high cholesterol, angina)
- ☐ Addiction / Dependence
- ☐ Epilepsy or Seizure Disorder
- ☐ HIV/AIDS
- ☐ Pancreatic Problems
- ☐ Abnormal Pap Smear
- ☐ Cancer
- ☐ GI Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Nutritional Deficiency
- ☐ Other (Please Describe)

MD Notes: _____

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No Please Explain: _____

MD Notes: _____

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Patient's Medical History (continued)

Name: _____ **Date of Birth:** _____

Childhood Illnesses

Measles ☐ Yes ☐ No Mumps ☐ Yes ☐ No Chicken Pox ☐ Yes ☐ No

Have you or a family member ever been diagnosed with a psychiatric or mental illness? ☐ Yes ☐ No

Describe: _____

Medication History

Have you ever been prescribed antidepressants? ☐ Yes ☐ No For what reason: _____

Medication(s) and dates of use: _____ Why stopped? _____

_____ Why stopped? _____

_____ Why stopped? _____

Please list **ALL** current prescription medications and how often you take it. DO NOT include medication you are misusing.

Medication	Dosage	Frequency	Start Date	End Date	Prescribing Physician

Please list ALL current herbal medicines, vitamin supplements, etc., and how often you take them.

Medication	Dosage	Frequency	Start Date	End Date

MD Notes: _____

Please list ALL allergies (e.g., Penicillin, bees, or peanuts): _____

MD Notes: _____

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Patient's Medical History (continued)

Name: _____ **Date of Birth:** _____

Tobacco History

Cigarettes: Now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How many per day, on average? _____ For how many years? _____

Pipe: Now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How many per day, on average? _____ For how many years? _____

Have you ever been treated for substance misuse? ☐ Yes ☐ No Please describe: _____

When: _____ (MM/YY) Where: _____ (Facility/State) How Long: _____ (Length of Time)

How long have you been misusing substances: _____

Substance Use History

Substance	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time Last Used	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Simulants (pills)							
Tranquilizers/Sleeping Pills							
Ecstasy							
Other:							

Did you ever stop using any of the above because of dependence? ☐ Yes ☐ No Please list: _____

_____

_____

What was the longest period of abstinence: _____ Why? _____

Are you receiving or have you ever received counselling support? ☐ Yes ☐ No Please describe where and for how long:

_____

_____

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Patient's Medical History (continued)

Name: _____ **Date of Birth:** _____

Patient Social History & Family History

Circle One: Married Single Long-term Relationship Divorced Separated Widowed

Years Married/in Long-term Relationship: _____ Times Married: _____ Times Divorced: _____

Children? ☐ Yes ☐ No Current Ages (please list) _____

Residing with you? ☐ Yes ☐ No If no, where? _____

Where are you currently living? _____

_____

Do you have family nearby? ☐ Yes ☐ No Please describe: _____

Education (check most recent degree):

☐ Graduate School ☐ Professional School ☐ College
☐ Vocational School ☐ Certificate Program ☐ High School, Grade _____

Are you currently employed? ☐ Yes ☐ No Where (if no, when were you last employed)? _____

What type of work do/did you do: _____ For how long? _____

Have you ever been arrested or convicted? ☐ Yes ☐ No (check all that apply)

☐ DWI ☐ Drug Related ☐ Domestic Violence ☐ Other: _____

Have you ever been abused? ☐ Yes ☐ No

☐ Physically ☐ Sexually (including rape or attempted rape) ☐ Verbally ☐ Emotionally

Have you ever attended:

AA: ☐ Current ☐ Past **NA:** ☐ Current ☐ Past **CA:** ☐ Current ☐ Past
ACOA: ☐ Current ☐ Past **OA:** ☐ Current ☐ Past

If you are not currently attending meetings, what factors led you to stop? _____

_____

_____

Have you ever been to counseling or therapy? ☐ Yes ☐ No Please Describe: _____

_____

MD Notes: _____

_____

_____

_____

_____

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Assessment of Withdrawal from Opioids

Name: _____ **Date:** _____ **Time:** _____

The Subjective Opiate Withdrawal Scale (SOWS)

Please score each of the 5 items below according to how you feel NOW (circle one number)

	Symptom	Not At All	A Little	Moderately	Quite A Bit	Extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goose bumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flashes	0	1	2	3	4
9	I have cold flashes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel like nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

Range 0-64, Handeisman, L, Cochranee, K.J., Anderson, M.J. et al. (1987)
Two New Rating Scales for Opiate Withdrawal, *American Journal of Alcohol Abuse*, 13, 293-308