



SC Professional Services, LLC
d/b/a Hope Integrative Medicine
 1064 Gardner Road, Suite 215, Charleston, SC 29407
 Phone: (843) 737-0312 Fax: (843) 279-3161

New Patient Information

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: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

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:

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

Medical, Psychiatric and Family History

Childhood Illnesses Measles ☐ Yes ☐ No Mumps ☐ Yes ☐ No Chicken Pox ☐ Yes ☐ No

Current or Past Medical Conditions (Please list all) _____

Family History (Please list family medical history) _____

Psychiatric History Have you or a family member ever been diagnosed with a psychiatric or mental illness? ☐ Yes ☐ No
Describe: _____

Surgical History/Prior Hospitalizations

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

Medication History

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

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

Please list **ALL** current prescription medications, herbal medicines, vitamins, supplements, etc., and how often you take it.
DO NOT include medication you are misusing.

Medication	Dosage	Frequency	Start Date	End Date	Prescribing Physician

MD Notes: _____

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

Tobacco and Substance Use 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: _____ Where: _____ How Long: _____
MM/YY Facility/State Length of Time

How long have you been misusing substances: _____

Please list any substances you use or previously used:

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? _____

Patient Social History

Marital Status (circle which one applies): Married Divorced Separated Widowed Other: _____

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? _____

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: _____
