Medical Intake

Date: _____ **Time:** _____

CLIENT INFORMATION	
Name	
DOB	
Sex assigned at birth	
Age	
Health card number	
Chart number	

Family practitioner name and contact info: _____

_____

Other care providers (e.g., psychiatrist, community social supports, etc.): _____

_____

Allergies: _____

EpiPen needed? ☐ Yes ☐ No

EpiPen available? ☐ Yes ☐ No

MEDICATIONS (prescriptions, over-the-counter, vitamins, supplements, inhalers, topicals, and samples)					
Medication	Dose, route, frequency	Reason	Prescriber	Pharmacy	Adherent?
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

MEDICAL HISTORY

Medical issues and surgical history:

- ☐ Diabetes
- ☐ Sleep apnea
- ☐ Renal problems
- ☐ Liver problems
- ☐ Respiratory concerns
- ☐ Chronic pain

Other: _____

Pregnant or chance of pregnancy? ☐ No ☐ Yes

If yes: Care provider: _____

LMP & EDD: _____

High-risk behaviours (e.g., IVDU, sharing supplies):

HIV: ☐ Unknown ☐ Negative ☐ Positive

If positive: Care provider: _____

Viral load: _____

Therapy: _____

Hepatitis A: ☐ Unknown ☐ Never had ☐ Has had ☐ Immunized

Date last tested: _____

Hepatitis B: ☐ Unknown ☐ Never had ☐ Has had ☐ Chronic infection ☐ Immunized

Date last tested: _____

Hepatitis C: ☐ Unknown ☐ Never had ☐ Positive ☐ Treated

Date last tested: _____

If positive/treated: Care provider: _____

Viral load: _____

Therapy (if/when completed): _____

TB: ☐ Unknown ☐ Negative ☐ Positive

If positive: Symptoms (e.g., hemoptysis, weight loss): _____

COVID-19 vaccination status: ☐ Unvaccinated ☐ One dose ☐ Two doses ☐ Booster

PHYSICAL EXAM

General appearance (e.g., intoxicated, physical withdrawal, calm and well): _____

_____

Height: _____ ☐ Reported ☐ Measured

Weight: _____ ☐ Reported ☐ Measured

Resp: _____

Pulse: _____

BP: _____

SpO2: _____

Temp: _____

Skin (e.g., track marks, wounds, infection): _____

Other: _____

SUBSTANCE USE

Completed Psychoactive Drug History Questionnaire[1]: ☐ No ☐ Yes

Past overdose: ☐ No ☐ Yes

If yes: Details: _____

DSM-5 substance use disorder diagnosis: ☐ No ☐ Yes

Withdrawal scale completed: ☐ COWS[2] ☐ CIWA-Ar[3] ☐ CIWA-B[4]

Previous addiction treatment: ☐ No ☐ Yes

If yes: Details: _____

MENTAL HEALTH

Received treatment for mental health: ☐ Currently ☐ Within past 12 months ☐ Within lifetime

Received medication for mental health: ☐ Currently ☐ Within past 12 months ☐ Within lifetime

Psychiatric admissions (inpatient/admitted to hospital): ☐ Within past 12 months ☐ Within lifetime

Previous suicide or self-harm attempts: ☐ No ☐ Yes

Current suicidal ideation or self-harm intent: ☐ No ☐ Yes

Homicidal ideation: ☐ No ☐ Yes

Details: _____

[1] https://www.porticonetwork.ca/documents/21686/199786/DHQ.pdf/370c51f7-1e99-49eb-90b7-1de0622dac35

[2] http://www.metaphi.ca/wp-content/uploads/ED_OUD_COWS.pdf

[3] http://www.metaphi.ca/wp-content/uploads/WMS_6.1_CIWA-Ar.pdf

[4] https://insight.qld.edu.au/file/410/download

PTSD screen: In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you…

	YES	NO
Had nightmares about it or thought about it when you did not want to?	☐	☐
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐	☐
Were constantly on guard, watchful, or easily startled?	☐	☐
Felt numb or detached from others, activities, or your surroundings?	☐	☐

**Yes to 3 or more should prompt further investigation.*

PHQ-2: Over the past 2 weeks, how often have you been bothered by the following problems?

	NOT AT ALL (0)	SEVERAL DAYS (1)	MORE THAN HALF THE DAYS (2)	NEARLY EVERY DAY (3)
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, or hopeless?	☐	☐	☐	☐

**A score of 3 or greater indicates depression is likely and further assessment is warranted.*

GAD-2: Over the past 2 weeks, how often have you been bothered by the following problems?

	NOT AT ALL (0)	SEVERAL DAYS (1)	MORE THAN HALF THE DAYS (2)	NEARLY EVERY DAY (3)
Feeling nervous, anxious, or on edge?	☐	☐	☐	☐
Not being able to stop or control worrying?	☐	☐	☐	☐

**A score of 3 or greater indicates anxiety is likely and further assessment is warranted.*

DISCUSSION/PLAN

☐ Referrals: ☐ Family practitioner ☐ Psychiatry ☐ Outpatient program/support groups
☐ Residential treatment ☐ HCV/HIV treatment

☐ Opioid agonist therapy: ☐ Naloxone kit ☐ National overdose response services
☐ Discuss risks of overdose after detox

☐ Anti-craving medication

☐ NRT

☐ Harm reduction practices reviewed and recommended

☐ Ministry of transportation reporting responsibilities reviewed (if client is non-compliant with treatment and/or returns to uncontrolled substance use and continues driving)

Details: _____

_____