

Any food or other allergies? Yes No Details: _____
 Special diet recommended Yes No Diet Information _____

Please list all type(s) of medication currently prescribed:

Name:	<input type="checkbox"/> SEDATIVE /TRANQUILLIZER	LENGTH OF USE:
Name:	<input type="checkbox"/> ANTI-PSYCHOTIC	LENGTH OF USE:
Name:	<input type="checkbox"/> ANTI-DEPRESSANT	LENGTH OF USE:
Name:	<input type="checkbox"/> ANTIBIOTIC	LENGTH OF USE:

What is the reason for this medication?

Is this person prepared to be drug/alcohol free during treatment?

In your opinion is this individual physically, mentally and emotionally suited to take treatment for drugs/alcohol at this time?

If you are aware of any difficulties that we should consider while this client is in treatment, please provide details. If this patient is on any PAIN medications please state why and length they will be on it. No mind altering drugs while in treatment. _____

CLINIC NAME: _____ **PHONE:** _____

PHYSICIAN'S NAME: _____

AUTHORIZED SIGNATURE: _____