Gulf Coast Recovery Clinic
14231 Seaway Road Suite 2003, Gulfport MS 39503
Phone: (228) 594-3377 Fax: (228) 594-6688 gulfcoastrecoveryclinic@gmail.com

Date _____

Dear _____

To help us prepare for your upcoming appointment we ask that you complete the Patient Consent to Disclose Protective Healthcare Data form and bring it to your previous/current health care provider. This will allow your health care provider to release your medical record, labs; x-rays and any other pertinent information, to us for review prior to your visit. We ask that your health care provider fax or mail your medical record to us. If you are unable to relay the release form to your health care provider, you may mail the completed form to our office, and we will request the records. The address and fax number is listed on the top of the release form. We are unable to receive your records without the completed authorization with your signature.

You must confirm your appointment within 24 hrs of appointment date. If you should need to cancel or reschedule this appointment please call 228-594-3377, or if after hours please leave message with our answering service or send an email to GULFCOASTRECOVERYCLINIC@GMAIL.COM. Enclosed is the necessary paperwork for you to complete before you arrive for your appointment. Please note you will be given a physical examination therefore, should you need to bring minor children with you, we ask that someone accompany you to assist with them. Please call our office at 228-594-3377 if you have any questions.

The fees associated with seeing the provider are for the associated cost to review the patient's records and completed a through history and physical. **The provider reserves the right to prescribe appropriate medication/s, and the patient will NOT be able to get a return of associated fees after seeing the provider.** The associated fees are for the provider’s evaluation and there is no guarantee that medication will be proscribed.

Thank you for choosing Gulf Coast Recovery Clinic

PLEASE KEEP THIS FORM FOR YOUR RECORD

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Patient Consent to Disclosure Protective Healthcare Data

Patient name: _____

Address: _____

Date of Birth: _____

Gulf Coast Recovery Clinic is authorized to furnish/receive from:

Recipient/Discloser: _____

For the Purpose of: _____

_____

I Authorize Release of the Following Medical Records:

☐ **I give permission to release all my medical records** including information and records or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permissions to release potentially sensitive information which may include information concerning my treatment of mental illness, human immunodeficiency virus (HIV), alcoholism, drug use/dependency, venereal diseases, sexual assaults, abortion, illegitimacy of birth, communications to social workers, and/or psychotherapies, psychologist, if any.

☐ **I give permission to release only Records specifically described below:**

_____

_____

I release Gulf Coast Recovery Clinic, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notifications to Gulf Coast Recovery Clinic, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization

This authorization expires on ___/ ___/ ___ (optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____ _____

Patient signature Date

_____ _____

Witness signature Date

Patient Registration for Gulf Coast Recovery Clinic

Date: _____ S.S. # _____

Patient Name:_____ Phone:_____

Address:_____ Cell:_____

City/State:_____ ZIP code:_____ Patient's email:_____

Date of Birth:_____ Age:_____

Emergency Contact:_____ Relationship to you:_____ Phone #:_____

Referred By:_____

Marital Status; Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

If married, Spouse Name:_____ Spouse Date of Birth:_____

Spouse SS#:_____ Any Children (list and ages) _____

_____

Patient's Employer:_____ Job Description:_____

Spouse's Employer:_____ Job Description:_____

Insurance: Primary

Insurance Plan:_____ Insurance ID:_____ Group #:_____

Insurance Address:_____

Insurance Phone #:_____Name of Insured:_____ DOB:_____

What age were you when you started using Opioids regularly, and what type of opioid(s) did you take?

_____

At what age did you realize that you would have withdrawal symptoms if you stopped taking Opioids?

At what age did your opioid use get out of control? _____

What is the maximum dosage of Opioids that you have taken daily? (total number, type, and dose)

_____

What Opioids (including Suboxone) have you used in the last few months? (dose, types, date last used)

_____

What other medications or illicit substances have you every used in the past? (include age range and if use was rarely/occasionally/daily)

Alcohol _____ Stimulants _____ Benzodiazepines _____

Cocaine _____ Marijuana _____ Inhalants _____

Hallucinogens _____ PCP _____ Sedatives _____

Why are you seeking help currently? Are you doing so voluntarily or are you being coerced by others?

_____

What consequences do you see for yourself if you do not enter treatment? _____

_____

Have you tried to quit in the past or have you been in any treatment programs? How long did you stay clean? _____

_____

DAST-10 SCREEN	YES	NO
1) Have you use drugs other than those required for medical reasons?	☐	☐
2) Do you use more than 1 drug at a time?	☐	☐
3) Do you have trouble stopping to use drugs when you want to?	☐	☐
4) Have you ever had blackouts or flashbacks as a result of drug use?	☐	☐
5) Do you ever feel bad or guilty about your drug use?	☐	☐
6) Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
7) Have you ever neglected your family because of use of drugs?	☐	☐
8) Have you engaged in any illegal activities in order to obtain drugs?	☐	☐
9) Have you ever experienced withdrawal symptoms (felt sick) when you stopped using drugs?	☐	☐
10) Have you had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding)?	☐	☐
Totals:		

CAGE-AID QUESTIONS	YES	NO
Have you felt you ought to CUT down on your drinking or drug use?	☐	☐
Have people ANNOYED you by criticizing your drinking or drug use?	☐	☐
Have you felt bad or GUILTY about your drinking or drug use?	☐	☐
Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover (EYE opener) ?	☐	☐

Opioid Risk Tool- Mark each that applies	
Family history of substance abuse:	
Alcohol	☐
Illegal drugs	☐
Rx Drugs	☐
Personal history of substance abuse:	
Alcohol	☐
Illegal drugs	☐
Rx Drugs	☐
Age between 16-45 years	☐
History of preadolescent sexual abuse	☐
Psychological disease	
ADD, OCD, Bipolar, Schizophrenia	☐
Depression	☐
Total:	

Gulf Coast Recovery Clinic

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:_____NAME:_____DATE OF BIRTH_____
____MARRIED ____SINGLE ____DIVORCED ____WIDOWED; OCCUPATION:_____
NO.OF CHILDREN:____TOBACCO USE: YES/NO HOW MUCH?_____/DAY HOW LONG? DATE QUIT_____
ALCOHOL USE: HOW MUCH PER DAY?_____CAFFEINE (COFFEE,TEA,COLAS) PER DAY_____

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY	YOU/YOUR FAMILY	YOU/YOUR FAMILY
☐☐ ALCOHOLISM	☐☐ HIGH BLOOD PRESSURE	☐☐ STROKE
☐☐ ANEMIA	☐☐ KIDNEY DISEASE	☐☐ SUICIDE ATTEMPT
☐☐ ASTHMA	☐☐ LIVER DISEASE	☐☐ THYROID DISEASE
☐☐ CANCER/TUMOR	☐☐ HEPATITIS	☐☐ TUBERCULOSIS, TB
☐☐ DIABETES	☐☐ LUNG DISEASE	☐☐ ULCER IN GI TRACT
☐☐ DRUG ABUSE	☐☐ MENTAL ILLNESS	☐☐ VENEREAL DISEASE
☐☐ DEPRESSION	☐☐ OSTEOARTHRITIS	☐☐ HIGH CHOLESTEROL
☐☐ EPILEPSY/SEIZURES	☐☐ OSTEOPOROSIS	☐☐ HIV/IMMUNE DX
☐☐ GLAUCOMA	☐☐ PHLEBITIS	☐☐ OTHER_____
☐☐ HEART DISEASE	☐☐ RHEUMATIC ARTHRITIS	

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____
_____
_____
_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EYES:	☐	☐
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty lying Flat	☐	☐
Swelling Ankles	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Hives/Eczema	☐	☐
Hay Fever	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficult Sleeping	☐	☐

HEMATOLOGY/LYMPH	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
MUSCULOSKELETAL:		
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

FEMALES ONLY:

Date Last Mammogram_____
Normal_____Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular? Yes_____No____
Number Pregnancies_____

NEW PATIENT- PLEASE COMPLETE THE FOLLOWING

Name:_____Date:_____

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS,VITAMINS, AND SUPPLIMENTS

MEDICINE NAME	HOW TAKEN?	WHO PRESCRIBES?	NEED RX
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO

PREFERRED PHARMACY:_____LOCATION:_____

PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:

NAME	CITY/STATE	PROBLEM CARED FOR:	STILL SEEING?	REFERRAL?
			YES/NO	**YES/NO**
			YES/NO	**YES/NO**
			YES/NO	**YES/NO**
			YES/NO	**YES/NO**

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION:	ADVERSE REACTION

ADDITIONAL INFORMATION:

LAST MAMMOGRAM?_____ WHERE?_____LAST PAP?_____GYN?_____

LAST COLONOSCOPY?_____NORMAL?_____DR?_____REPEAT DATE?_____

APPROXIMATE DATE OF LAST BLOODWORK?_____

VACCINE DATES:

TETANUS?_____PNEUMONIA?_____FLU?_____HEPATITIS B SERIES?_____

COVID 19? 1ST: 2ND: