THE TAUB GROUP
Treatment for Pain and Addiction

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illness, ect.)

_____ _____ _____

_____ _____ _____

Surgical History (unrelated to pain; such as appendectomy)

_____ _____ _____

_____ _____ _____

Surgical History (related to pain; such as laminectomy)

_____ _____ _____

_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____

_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, ect.)

_____ _____ _____

_____ _____ _____

Current Medications (include vitamins and birth control pills, if applicable)

_____ _____ _____

_____ _____ _____

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain	Chronic Fatigue
Vision Problems	Nausea	Shortness of Breath	
Hearing Problems	Vomiting	Urinary Problems	
Dizziness	Constipation	Rashes	
Difficulty Swallowing	Diarrhea	Swollen Joints	

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Domestic Situation

1. With whom do you live?_____
2. Are there any substance abuse issues in the household? Yes_____ No_____
   If yes, please explain_____
3. Are you able to take care of yourself? Yes_____ No_____
   If no, please provide your caregiver's name_____

Work History

Occupation | Years Worked | Reason for Leaving

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

_____

_____

Substance Abuse

Which of the following drugs or substances, if any, have you used in the **past**? (Circle all that apply)

*Next to each drug or substance that you have circled, indicate if you used it occasionally ("O"), frequently ("F") or continuously ("C").

Alcohol_____ Barbiturates_____ Cocaine_____
Heroin_____ Amphetamines_____ Marijuana_____
Other_____ (specify) Other_____ (specify) Other_____ (specify)

Are you **presently** using any of the drugs or substances below? (Circle all that apply)

*Next to each drug or substance that you have circled, indicate if you used it occasionally ("O"), frequently ("F") or continuously ("C").

Alcohol_____ Barbiturates_____ Cocaine_____
Heroin_____ Amphetamines_____ Marijuana_____
Other_____ (specify) Other_____ (specify) Other_____ (specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____
If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_____
How many packs do/did you smoke in one day? _____ For how many years? _____