Jeff Blixt D.O., Inc.
1715 N. Weber Street
Suite 260
Colorado Springs, CO 80907

New Patient Intake Form

Full Name: _____

Address: _____ Apt#:_____

City: _____ State: _____ Zip:_____

Date of Birth: _____

Email Address:_____
(For Appointment Reminders Only)

☐ Consent to voice/text messaging
(For Appointment Reminders Only)

☐ Do not consent to voice/text messaging

Our office cares about our client's privacy and will protect the confidentiality of your medical information. Due to current State and Federal Laws regarding our office's responsibility to protect your information, you may request a copy of our Notice of Privacy Practices. Just ask our front desk for a copy.

Signature: _____ Date:_____

By signing on the above line, you agree to have been notified that our office has a privacy policy in place and have been allowed a copy of these policies. If you have any questions regarding our policies, please ask our office staff.

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Dear Client, Date:_____

Our office has adopted a policy that requires my office staff to obtain an authorization from you so we may contact you regarding appointments, test results, and account information. In an effort to protect your privacy and follow federal guidelines, please complete the following information:

I, _____, give permission for Dr. Blixt or his office
(Print name)
staff to leave a phone message regarding my medical care/account information. I fully

understand that this consent will remain valid unless revoked in writing by me.

Where can we leave a message for you?

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Is there anyone else we can leave this information with on your behalf?

Spouse/Partner: if yes, Name:_____
Phone Number:_____

Child: if yes, Name:_____
Phone Number:_____

Other: if yes, Name:_____
Relationship:_____
Phone Number:_____

Any special
instructions?_____
_____

Signature: _____ Date:_____

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Due to a high rate of clients not showing up for their scheduled appointments, I have found it necessary to charge a fee of $20.00 for these missed appointments. If you are unable to make your appointment, we require a 24-hour notice of your cancellation. We understand that unforeseen circumstances arise. However, we still need you to call as soon as possible. Clients that have 3 or more no-shows in a 12-month period will be dismissed.

Another concern I have is clients being late for their appointments. I understand that some of you drive a long distance. Unfortunately, when you are late for your appointment, the clients that arrive on time are not able to be seen at their scheduled time. Therefore, if you will be arriving late for your appointment, please notify my office staff at 719-896-4794. You may be informed that you need to wait until we can get you in, or you may need to be rescheduled.

I understand Dr. Blixt's Policy:

Signature: _____ Date:_____

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I, _____ (print name) have agreed to take urinary analysis (UA's) in Dr. Blixt's office.

I acknowledge that these UA's may be randomly sent out to a 3rd party laboratory for further analysis.

I may get a bill for these costs if insurance does not cover them, or I have no insurance at all.

Signature: _____ Date:_____

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Pretreatment Screening for Substance Use Disorder

Name: _____
DOB: _____
Age: _____
Gender: _____
Reason and/or motivation for seeking treatment:

How long have you been using a substance? _____

How old were you when you first started using a substance? _____

How often do you use? _____

How much to use? _____

What route do you use (oral, intranasal, inhalation, IV)? _____

How much do you spend per week? _____

History of withdrawal symptoms? _____

History of frequent cravings? _____

What other mind altering substances do you currently use? (include prescription medication)

What consequences has your use of a substance caused you? Your own health? Physical problems? Mental problems? Relationship problems? Occupation problems? Legal Problems? Loss of self-esteem or self-worth? Other consequences?

Do you use alcohol, if so how much:

Do you use sedatives such as benzodiazepines? (Valium, Xanax, Klonopin?)

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Have you ever been treated for substance dependence or misuse (detox , in-patient substance abuse services, outpatient substance abuse services, Suboxone program, methadone program, and vivitrol):?

Have you ever tried to quit on your own? _____

Have you ever been treated by a psychiatrist? No
(If yes, please describe):

Current Psychiatric Symptoms include:

Current Physicians: _____

Current Therapists: _____

Current Support Groups: _____

Do you have any medical conditions?:

History of IV drug use? No
History of brain injuries? No
History of seizures? No
History of liver problems? No
History of cardiac problems? No
History of Hypertension? No
History of diabetes? No
History of chronic pain? No
History of Hepatitis C? No
History of Overdose? No Accidental? No Intentional? No
If you answered yes to any of the questions above, please explain:

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Current medications with dosage (please include over-the-counter medication such as ibuprofen, Tylenol, supplements, etc.):

Any ALLERGIES to medications: _____

Past surgical history:

Last time had a complete physical exam: _____

History of psychiatric disorder before use of substance? No

History of psychiatric disorder during use of substance? No

History of psychiatric disorder after use of substance? No

Any thoughts of self-harm or suicidal thoughts? No

Any history of suicidal attempts?
No
Any history of violence?
No

(Females only)

Are you pregnant?: No
How many pregnancies?

Are you using birth control?: No
Result of pregnancies?:
Live births
Miscarriages
Elective abortions.

Are there any current legal issues we should be aware (e.g., probation and parole)?:

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Do you use tobacco or nicotine in any form? No
How much?
Are you a former tobacco user? No
When did you quit?

Employment status:
Occupation:
How many hours per week do you work?:

Please describe your current living arrangements, who do you live with and what is their relationship to you:

Do you have reliable transportation (If so, describe)?

Degree of Family support from family and significant others?

Do you have substance free friends?

Dependent children?

Highest level of education completed:

Marital status?
History of domestic violence? No
History of sexual abuse? No
Do you feel safe at home? No

Do you have meaningful interpersonal relationships?

History of trauma?

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Are there people with substance abuse in the household? No
When did they start?

What do they use?

Family History of substance abuse or mental health problems?

Father: _____
Mother: _____
Siblings: _____
Grandparents: _____
Extended Family: _____

Do you exercise? If so, what type?

Nutritional status:
Caffeine intake; how much?

Sugar intake; how much?

Sleeping problems?

Hours of sleep per night?

Do you feel rested after sleep? No

Do you have spiritual beliefs that help you cope? Are you part of a religious or spiritual community? Does your current situation affect your ability to do things that usually help you spiritually?

AUDIT

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

Note: Alcohol is inclusive of beer, wine, liquor or any other alcoholic beverage. One drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were unable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you felt guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total:	

Saunders JB; Aasland OG, Babor TF, De La Fuente JR, Grant M. 1993. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-11.