Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, #10
Sarasota, Fl 34239
(941) 375-2812

PRETREATMENT SCREENING

Name

____

Phone no. _________________________ Best time to contact ____________________________

Address

____

____

DOB _______________________ Age _______ Sex ( ) M ( ) F

Insurance co.___________________________________ Insurance member #
____

Do you plan to submit a claim? ( ) Yes ( ) No

Reason for seeking treatment
Substance _______________________ How long using? _______________________

How much? _______________________ How often? _______________________

Has your drug use ever resulted in medical or legal problems? ( ) N ______________________________

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? ( ) N
(Please describe setting, length) ____
____
____
____

Have you ever tried to quit on your own? ( ) N (Please describe) ____________________________
____

Have you ever been treated by a psychiatrist? ( ) N(Please describe treatment reason, setting, and length)

____

____

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Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of substance abuse? ( ) N ____

____

____

Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? ( ) N ____________________

____

____

Are you currently taking any medications to treat these conditions? ( ) N (List medication and dosage)

____

____

Are you pregnant? ( ) N/A ( ) N ( ) Y ( ) Not Sure

Are there any current legal issues we should be aware of (probation, parole)? ( ) N ________________

____

Are you currently employed? ( ) N ( ) Y How many hours/week (avg.)? __________________

Please describe your current living arrangements ____

____

____

Other ____

____

____ Date: _______________

Patient Interviewer Signature