

STAPLEFORD CENTRE PERSONAL HISTORY FORM
STRICTLY CONFIDENTIAL

Please print a copy (3 pages), then fill in the form and tick the check boxes on the hard copy.

Please send to the completed form to:

The Stapleford Centre, 25a Eccleston Street, Belgravia, London, SW1W 9NP.

Title: Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> First Name:	D.O.B.
Family Name:	Nationality
Address:	NHS No.
	Contact Tel. Numbers: List those we may use
	Home:
Postcode:	Mobile:
Place of Birth:	Work:
Living with: Alone <input type="checkbox"/> Parent(s) <input type="checkbox"/> Partner <input type="checkbox"/> Other <input type="checkbox"/>	
Employment Current:	
Previous:	
Please list your highest educational qualifications:	

Person to notify in emergency:		
Relationship to you:		
Address:		
Tel Nos (Home):	Mobile:	Work:

Please give full details of your GP & Chemist:	
GP:	Chemist:
Address:	Address:
Postcode:	Postcode:
Tel no:	Tel no:
Fax no:	Fax no:

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Type of Treatment Required. Please check box(es) & add details as necessary.

	Daily Amount (if known)
<input type="checkbox"/> Maintenance on Oral Methadone	
<input type="checkbox"/> Maintenance on I/V Methadone	
<input type="checkbox"/> Maintenance on Subutex	
<input type="checkbox"/> Maintenance on morphine	
<input type="checkbox"/> Maintenance on other opiate	
<input type="checkbox"/> Benzodiazapine maintenance/reduction	
<input type="checkbox"/> Rapid opiate Detox as In-patient	
<input type="checkbox"/> Subutex Out-patient Detox	
<input type="checkbox"/> Naltrexone Implant (Please specify type)	3/12 <input type="checkbox"/> 6/12 <input type="checkbox"/>
<input type="checkbox"/> Alcohol treatment (Please give details of your alcohol consumption)	
<input type="checkbox"/> Other treatment (Please specify)	

List All Medication (Prescribed or otherwise) that you are currently taking			
	Medication	Daily Amount	Reason for Use
1			
2			
3			
4			
5			
6			
7			
8			

Drug History

Drug	Age first tried	Give details of any heavy use e.g. 18 – 20 years 1.5 gm daily
Tobacco		
Alcohol		
Solvents		
Hallucinogens		
Ketamine		
Ecstasy		
Amphetamines		
Cocaine		
Heroin		
Other Opiates		
Crack		
Benzodiazepines		
Barbiturates		

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Your Social History

Describe anything unusual about your early life

Give details of any drug, alcohol or mental health problems that close family members have had.

(For women only) Are you pregnant? Yes No

List past/present medical problems

List past/present mental/health problems

List past/present life problems

Previous Addiction Treatments

Type of Treatment	Clinic/Service	Approximate Dates

How did you first hear about The Stapleford Centre?

Did you find our contact details by:

Visiting our website Google or other search engine Other _____

All information that you provide will be kept strictly confidential. We do not release any information without your knowledge and consent. You may withhold consent, of course.