PERSONAL HISTORY

PERSONAL INFORMATION:

NAME_____ TODAY'S DATE_____
LAST FIRST MI

LIST ANY ADDITIONAL NAMES USED: _____

ADDRESS_____ PHONE _____
(MAILING ADDRESS) (CITY) (STATE) (ZIP) (COUNTY)

AGE:_____ DATE OF BIRTH:_____ SOCIAL SECURITY #: _____

RACE: Check all that apply: Caucasian (white)____ African American____ Native American____ Hispanic_____

Asian_____ Other (identify)_____ GENDER: M or F Religious/Spiritual Affiliation_____

Emergency Contact Name/Relationship_____ Phone #:_____

EDUCATION LEVEL: Circle number of last grade completed:
6 7 8 9 10 11 12 GED HS Diploma HS Name_____

College--undergraduate--Fresh Soph Junior Senior Degree_____Date Awarded_____

College-graduate Degree_____ Date Awarded _____

Special or Vocational Training: Yes_____ No_____ Type: _____

WHAT SPECIAL SKILLS OR TRADES DO YOU POSSESS? _____

EMPLOYMENT RECORD:
Currently Employed: YES____ NO____ FT____ PT____ Other_____ HOW MANY HOURS/WEEK?_____

FIVE (5) YEAR EMPLOYMENT HISTORY

EMPLOYER	**TYPE OF WORK**	**DATES OF EMPLOYMENT**	**REASON FOR LEAVING**

DESCRIBE YOUR RELATIONSHIP WITH YOUR CURRENT EMPLOYER? GOOD__ AVERAGE__ POOR__

MILITARY SERVICE: YES_____ NO_____ TYPE: (CIRCLE ONE) ARMY NAVY AIR FORCE MARINES

DATE OF SERVICE: FROM_____TO_____ TYPE OF DISCHARGE:_____

ARE YOU RECEIVING VETERAN'S BENEFITS? YES_____ NO_____ TYPE_____

ECONOMIC INFORMATION: ANNUAL INCOME: $_____

LIST ANY OTHER SOURCES OF INCOME: TYPE_____ AMOUNT _____

IF CURRENTLY UNEMPLOYED, GIVE PRIOR YEARS INCOME REPORTED TO IRS: $_____

DO YOU HAVE HEALTH INSURANCE? YES_____ NO_____

LEGAL HISTORY: ARREST RECORD--**INCLUDE ANY JUVENILE CHARGES**

ALCOHOL/DRUG RELATED

CHARGE	DATE ARRESTED	CITY/STATE OF ARREST	CURRENT STATUS	COMMENTS

OTHER ARRESTS

CHARGE	DATE ARRESTED	CITY/STATE OF ARREST	CURRENT STATUS	COMMENTS

NAME OF ANY FEDERAL OR STATE PENAL INSTITUTION(S) IN WHICH YOU HAVE BEEN CONFINED

_____ FROM_____TO_____

_____ FROM_____TO_____

HAVE YOU EVER BEEN ON PROBATION BEFORE? YES_____ NO_____ WHERE_____

ANY CRIMINAL BEHAVIOR IN FAMILY? YES_____ NO_____ IF YES, WHO AND WHAT TYPE_____

_____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? YES_____ NO_____

NAME:_____PHONE NUMBER:_____

SOCIAL/FAMILY BACKGROUND:

FAMILY BACKGROUND: Parents: Natural_____Adoptive_____Other_____

Name: _____ Name: _____

Age:_____ Health:_____ Age:_____ Health:_____

Address: _____ Address: _____

_____ _____

Phone: (___)_____ Phone: (___)_____

Married_____Separated_____Divorced_____Remarried_____Widowed_____

SIBLINGS:

Name: Age: Name: Age

1)_____ 3)_____

2)_____ 4)_____

LIST SUPPORTIVE FAMILY AND FRIENDS:

Name: Name:

_____ _____

WERE YOU RAISED BY BOTH PARENTS? YES_____ NO_____ IF NO, BY WHOM:_____

_____

MARITAL HISTORY: Present Status: Single_____Never Married_____Divorced_____Widowed_____

Separated_____Married # of times_____

SPOUSE INFORMATION:

Name:_____ Age:_____ DOB:_____

(last) (first) (mi)

Address:_____ Phone:_____

(street) (city) (state) (county) (zip)

RACE: Check all that apply: Caucasian___ African American___ Native American___ Hispanic___ Asian___ Other_____

EDUCATION LEVEL: Circle number of last grade completed:

6 7 8 9 10 11 12 GED HS Diploma College

Employed: Yes No Employer_____ Type of Work_____

Any previous marriages?_____

Prior A/D Treatment:_____ Health Status_____

CHILDREN INFORMATION: #_____ His Hers Ours_____

Name: Sex Age

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ALL CITIES AND STATES IN WHICH YOU HAVE RESIDED IN THE PAST FIVE YEARS

_____

MEDICAL HISTORY: Have you or any of your immediate family ever been diagnosed or treated for any of the following:

	YES	NO	WHO		YES	NO	WHO
Diabetes	____	____	_____	High Blood Pressure	____	____	_____
Low Blood Sugar	____	____	_____	Low Blood Pressure	____	____	_____
Heart Problems	____	____	_____	Epilepsy	____	____	_____
Hepatitis	____	____	_____	Ulcers	____	____	_____
Gastritis	____	____	_____	Cancer	____	____	_____
Pancreatitis	____	____	_____	Depression/Anxiety	____	____	_____

In the past three months, have you had:

Trouble sleeping_____ Trouble breathing _____

Trouble staying awake _____ Loss of appetite_____

Fatigue_____ Unusual pains _____

Other_____ Date of Last Physical _____

Name of Current Medical Professional/Provider:_____Phone #:_____

CURRENT MEDICATIONS: Prescribed by what doctor:_____

Name of medication: Dosage Frequency Still taking? Allergic reactions

_____

_____

Do you have any handicaps? Yes_____ No_____ If yes, please list:_____

_____

Have you ever been hospitalized overnight? Yes_____ No_____ If yes, please list:
Type When Where Current Status

_____

Do you have any allergies? Yes_____ No_____ If yes, please list:_____

_____

Have you had any major injuries? Yes_____ No_____ If yes, please list:_____

_____

List any risk factors for infectious diseases (IV drug use, unsafe sexual practices, hospital worker, etc.)

_____

Risk of Suicidal or Homicidal Behavior

History of suicidal or homicidal behavior	Yes	No	Who	Details
Suicidal thoughts?				
Suicidal plan?				
Attempts (last 10 yrs)?				

History of Abuse

History or pattern of abuse	Yes	No	Victim?	Perpetrator?	Alleged/Documented
Physical abuse?					
Sexual abuse?					
Emotional abuse					

PSYCHIATRIC/MENTAL HEALTH TREATMENT: (Mental Health Center, Hospital, Private, Minister)

Name of Program Where When How long:

_____ _____ _____ _____

_____ _____ _____ _____

TREATMENT HISTORY:

CHEMICAL DEPENDENCY TREATMENT (in patient, out patient, half way house, etc.)

Name of Program Where When How long:

_____ _____ _____ _____

_____ _____ _____ _____

Has any family member (parents, grandparents, siblings, spouse, children) ever had, at any time, an alcohol or other chemical dependency problem? YES_____ NO_____ If yes, please specify who and what type of abuse, alcohol or other drugs.

_____

What is the longest period of time, since your first use, that you have ***NOT*** used alcohol or drugs:

_____

How long ago has that been?_____

Date and time of your last drink or use of any other drug?_____

Please write a description of your presenting issue, including the reason you are here and how you feel about it:

_____

_____

_____

Indicate age at first use and age at last use for each drug in the columns below. Also indicate frequency of use by using the following code:

E= Experimented
X= Daily
N= No Use
O= Occasionally, less than once a week
R= Regularly, at least once a week
RX= By doctor's prescription

IF YOU HAVE USED DRUGS WHICH ARE NOT LISTED, PLEASE ADD THEM.

Age@ 1st use	Age@ last use	Amt used	Frequency of use		Age@ 1st use	Age@ last use	Amt used	Frequency of use	
____	____	_____	_____	**Adderall**	____	____	_____	_____	**Morphine**
____	____	_____	_____	**Vyvanse**	____	____	_____	_____	**Vicodin**
____	____	_____	_____	**Ritalin**	____	____	_____	_____	**Bath Salts**
____	____	_____	_____	**Meth**	____	____	_____	_____	**Cough Syrup**
____	____	_____	_____	**Cocaine**	____	____	_____	_____	**GHB**
____	____	_____	_____	**Shrooms**	____	____	_____	_____	**Steroids**
____	____	_____	_____	**PCP**	____	____	_____	_____	**Ketamine**
____	____	_____	_____	**LSD**	____	____	_____	_____	**Valium**
____	____	_____	_____	**Ecstasy**	____	____	_____	_____	**Xanax**
____	____	_____	_____	**Marijuana**	____	____	_____	_____	**Beer**
____	____	_____	_____	**K2**	____	____	_____	_____	**Wine**
____	____	_____	_____	**Heroin**	____	____	_____	_____	**Hard Alcohol**
____	____	_____	_____	**Opium**	____	____	_____	_____	**Inhalants**
____	____	_____	_____	**Methadone**	____	____	_____	_____	**Anti-depressants**
____	____	_____	_____	**Codeine**	____	____	_____	_____	**Tobacco**
____	____	_____	_____	**Oxy/Hydro**	____	____	_____	_____	**Other**

Please describe your behavior under the influence of alcohol and/or drugs:

_____

_____

Please describe the effect your substance use has on your relationship with others:

_____

_____