

## PERSONAL HISTORY

**PERSONAL INFORMATION:**

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
                     LAST                      FIRST                      MI

LIST ANY ADDITIONAL NAMES USED: \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
   (STREET)                      (CITY)                      (STATE)                      (COUNTY)                      (ZIP)

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

RACE: Circle one: Caucasian (white) \_\_\_\_\_ African American \_\_\_\_\_ Native American \_\_\_\_\_ Hispanic \_\_\_\_\_

Asian \_\_\_\_\_ Other \_\_\_\_\_ 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

DOES YOUR EMPLOYER KNOW OF THIS ARREST? YES \_\_\_\_\_ NO \_\_\_\_\_

**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:** GROSS ANNUAL INCOME: \$ \_\_\_\_\_

LIST ANY OTHER SOURCES OF INCOME: TYPE \_\_\_\_\_ AMOUNT \_\_\_\_\_

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

HEALTH INSURANCE COMPANY: \_\_\_\_\_ POLICY #: \_\_\_\_\_

TYPE OF COVERAGE: \_\_\_\_\_

**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:**

**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 one: Caucasian\_\_\_\_ Black\_\_\_\_ Indian\_\_\_\_ Hispanic\_\_\_\_ 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? \_\_\_\_\_ Current marriage # \_\_\_\_\_

Prior A/D Treatment: \_\_\_\_\_ Health Status \_\_\_\_\_

**CHILDREN INFORMATION: #** His Hers Ours

Name:	Sex	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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:
_____	_____	_____	_____
_____	_____	_____	_____

**LIST SUPPORTIVE FAMILY AND FRIENDS:**

Name:	Age:	Name:	Age:
_____	_____	_____	_____

WERE YOU RAISED BY BOTH PARENTS? YES\_\_\_\_ NO\_\_\_\_ IF NO, BY WHOM: \_\_\_\_\_

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

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**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	_____	_____	_____

In the past three months, have you had:

Trouble sleeping \_\_\_\_\_ Trouble breathing \_\_\_\_\_

Trouble staying awake \_\_\_\_\_ Loss of appetite \_\_\_\_\_

Fatigue \_\_\_\_\_ Unusual pains \_\_\_\_\_

Other \_\_\_\_\_

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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: \_\_\_\_\_

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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: \_\_\_\_\_

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Have you had any major injuries: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_

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

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**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 can remember **NOT** using 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 full description of your presenting issues, including your feelings about your involvement (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 under frequency of use by using the following code:

E = Experimented  
 X = Daily  
 RX = By doctor's prescription

O = Occasionally, less than once a week  
 R = Regularly, at least once a week

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

Age @ first use	Age @ last use	Amt used per occasion	Frequency of use	Age @ first use	Age @ last use	Amt used per occasion	Frequency of use
_____	_____	_____	_____ BARBITURATES	_____	_____	_____	_____ HALDOL
_____	_____	_____	_____ RITALIN	_____	_____	_____	_____ THORAZINE
_____	_____	_____	_____ LITHIUM	_____	_____	_____	_____ VALIUM
_____	_____	_____	_____ HEROIN	_____	_____	_____	_____ OPIUM
_____	_____	_____	_____ OXYCOTIN	_____	_____	_____	_____ ECSTASY
_____	_____	_____	_____ GLUE	_____	_____	_____	_____ PCP
_____	_____	_____	_____ DILANTIN	_____	_____	_____	_____ AMPHETAMINES
_____	_____	_____	_____ QUAALUDES	_____	_____	_____	_____ METH
_____	_____	_____	_____ PHENOBARBITAL	_____	_____	_____	_____ SPEED
_____	_____	_____	_____ SERAX	_____	_____	_____	_____ COCAINE
_____	_____	_____	_____ LIBRIUM	_____	_____	_____	_____ POT/MARIJUANA
_____	_____	_____	_____ PRELUDIN	_____	_____	_____	_____ HARD LIQUORS
_____	_____	_____	_____ ANTI DEPRESSANT	_____	_____	_____	_____ BEER/ALE
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Please describe your behavior under the influence of drugs which you use: \_\_\_\_\_

\_\_\_\_\_

Please describe the effect your substance use has on your relationships with others: \_\_\_\_\_

\_\_\_\_\_