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

____

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 ____

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 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

<u>IF YOU HAVE USED DRUGS WHICH ARE NOT LISTED, PLEASE ADD THEM.</u>

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: ___________________________

____

____