Overmountain Recovery
Medical Intake/Annual Follow-Up

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: ❑None

How did your opioid use start? Energy? High? Escape? Prescribed?

**New Patients** please complete this section (**Annual Follow-Ups Skip to Page 2**).

Which medication do you want to start: Methadone or Suboxone?
When was your last use of an opioid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
When do you expect your withdrawal symptoms to start? To peak? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you been using any alprazolam/Xanax in the past 7 days? ☐ Yes ☐ No
Have you been using any alcohol in the past 7 days? ☐ Yes ☐ No
Have you had any severe complications in the past from withdrawing? ☐ Yes ☐ No
Any hospitalizations for withdrawal? ☐ Yes ☐ No

## Criteria for Opioid use Disorder

Which of the following applies to your **use of opioids** before entering treatment?

|  |  |
| --- | --- |
| 1. Taken in larger quantities or longer time than intended
 | ☐ Yes ☐ No |
| 1. Persistent desire or unsuccessful efforts to cut down or control use
 | ☐ Yes ☐ No |
| 1. A great deal of time spent in activities related to or recovering from effects
 | ☐ Yes ☐ No |
| 1. Craving or a strong desire to use
 | ☐ Yes ☐ No |
| 1. Recurrent use resulting in failure to fulfill major role obligations at work, school, home
 | ☐ Yes ☐ No |
| 1. Continued use despite recurrent problems at work, relationships
 | ☐ Yes ☐ No |
| 1. Important social, family, or job related activities given up or reduced as a result of use
 | ☐ Yes ☐ No |
| 1. Recurrent use in situations potentially physically hazardous (driving, heavy machinery)
 | ☐ Yes ☐ No |
| 1. Continued use despite knowledge of having psychological problems due to use
 | ☐ Yes ☐ No |
| 1. Tolerance (need increased amount, diminished effect with same amount)
 | ☐ Yes ☐ No |
| 1. Withdrawal (withdrawal symptoms or taking opioids to prevent withdrawal)
 | ☐ Yes ☐ No |

## Your Addiction/Drug Use History

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug** | **First Use****(Age or Year)** | **Last Use(Age or Year)** | **Past 30 days?****Y or N** | **Max amount in 24 hour period** | **IV, snort, smoke, swallow** |
| *Example* | *Age 12* | *Age 34 (2014)* | *No* | *150 mg* | *Swallow* |
| Lortab |  |  |  |  |  |
| Percocet |  |  |  |  |  |
| Oxy/Roxy |  |  |  |  |  |
| Heroin |  |  |  |  |  |
| Tramadol |  |  |  |  |  |
| Fentanyl |  |  |  |  |  |
| Oxymorphone (Opana) |  |  |  |  |  |
| Hydromorphone |  |  |  |  |  |
| Morphine |  |  |  |  |  |
| Other |  |  |  |  |  |
| Methadone |  |  |  |  |  |
| Buprenorphine |  |  |  |  |  |
| *Have you ever taken buprenorphine for at least 7 days continuously? Did it work for you?* |
| Alcohol |  |  |  |  |  |
|  *Any history of blackouts, seizures, hallucinations, or confusion? Admission to hospital for detox?* ☐ Yes ☐ No |
|  |  |
| Marijuana |  |  |  |  |  |
|  *Any hashish, oils, dabbing?* ☐ Yes ☐ No |
| CBD |  |  |  |  |  |
|  |  |  |  |  |  |
| Lorazepam/Ativan |  |  |  |  |  |
| Alprazolam/Xanax |  |  |  |  |  |
|  ***Xanax -* *Any history of blackouts, seizures, hallucinations, or confusion? Shoplifting on Xanax?*** ☐ Yes ☐ No |
| Clonazepam/Klonopin |  |  |  |  |  |
| Diazepam/Valium |  |  |  |  |  |
| GHB, Rohypnol |  |  |  |  |  |
| Zolpidem/Ambien |  |  |  |  |  |
|  ***Any of above currently prescribed? Any hospitalizations for detox?*** ☐ Yes ☐ No |
|  |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Crack |  |  |  |  |  |
|  |  |  |  |  |  |
| Methamphetamine |  |  |  |  |  |
| Amphetamine/Adderall |  |  |  |  |  |
| Phentermine |  |  |  |  |  |
| Diet Pills |  |  |  |  |  |
| Other ADHD med (Ritalin, Vyvanse, etc) |  |  |  |  |  |
|  *Any of above currently prescribed?* ☐ Yes ☐ No |
|  *Any history of paranoia, hallucinations, or psychosis on any stimulants?* ☐ Yes ☐ No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug** | **First Use****(Age or Year)** | **Last Use(Age or Year)** | **Past 30 days?****Y or N** | **Max amount in 24 hour period** | **IV, snort, smoke, swallow** |
| LSD |  |  |  |  |  |
| Ketamine |  |  |  |  |  |
| Mushrooms |  |  |  |  |  |
| Ecstasy |  |  |  |  |  |
| PCP |  |  |  |  |  |
|  |  |  |  |  |  |
| Inhalants (whippits, poppers, glue, paint) |  |  |  |  |  |
|  |  |  |  |  |  |
| Kratom |  |  |  |  |  |
| Bath salts |  |  |  |  |  |
| Khat |  |  |  |  |  |
| Krokodil |  |  |  |  |  |
| Gravel |  |  |  |  |  |
| CCC/DXM dextromethorphan |  |  |  |  |  |
| Carisopradol (Soma) |  |  |  |  |  |
|  |  |
| Tobacco |  |  |  |  |  |
|  *Are you interested in medications or counseling to facilitate quitting?* ☐ Yes ☐ No |

|  |  |
| --- | --- |
| **Behavior Addictions** | **Describe** |
| Gambling |  |
| Sex or Pornography |  |
| Stealing |  |
| Computer gaming |  |
| Shopping |  |

## Prior Treatments

|  |  |  |
| --- | --- | --- |
| Addiction Treatment Facility | Location | Year |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Readiness to Change

What do you hope to gain from treatment at Overmountain Recovery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your motivation for services:

1 2 3 4 5

|  |  |
| --- | --- |
| I want medication only |  I want medication and counseling |

How willing are you to engage with a counselor?

1 2 3 4 5

|  |  |
| --- | --- |
| I’ll engage minimally |  I want to engage to learn  skills and have support  |

How willing are you to “work on” emotional triggers or past traumas?

1 2 3 4 5

|  |  |
| --- | --- |
| Not willing |  Willing |

How difficult is it for you to follow-through with medical appointments?

1 2 3 4 5

|  |  |
| --- | --- |
| I hardly make my appointments |  I never miss an appointment |

Drug Use Consequences (while intoxicated or related to your drug use)
How many times have you overdosed on opioids? ………………………………………….. 0 1 2 3 4 5+

Have you ever had a cardiac arrest? ☐ Yes ☐ No
Have you had injuries while using?......................................................................... ☐ Yes ☐ No
Medical problems for drug-related issues? (heart, infections, injury) ☐ Yes ☐ No
Have you given custody of your children to someone else? ☐ Yes ☐ No

Traded or sold sex for drugs?.................................................................................. ☐ Yes ☐ No

Have you ever used a needle to inject drugs (IV drug use)? ☐ Yes ☐ No
Last IV use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have track marks?....................................................................................... ☐ Yes ☐ No
Have you ever **injected** Suboxone/Subutex? ☐ Yes ☐ No
Have you ever **snorted** Suboxone/Subutex? .......................................................... ☐ Yes ☐ No
Have you ever sold drugs? ☐ Yes ☐ No
Other consequences not listed above? Please describe:

## Recovery Skills

What is your longest period of sobriety (except tobacco) since age 18 after you started using? When?

Have you tried naltrexone/Vivitrol? ☐ Yes ☐ No

How strong is the link between your emotions or stress and your drug use? (Circle)

1 2 3 4 5

|  |  |
| --- | --- |
| I don’t see a link between emotions and my drugs use |  I self-medicate my emotions |

How aware are you of ways to prevent relapses, i.e. relapse prevention skills?

1 2 3 4 5

|  |  |
| --- | --- |
| I have never learned relapse prevention skills | I am highly familiarwith relapseprevent skills |

Have you thought about the people, places, and things that lead to your relapses?

1 2 3 4 5

|  |  |
| --- | --- |
| I have not thought about this much | I have thought aboutthe people, places, and thingsI need to avoid to maintainsobriety |

## Recovery/Living Environment

Living Situation? own/rent/family/friend/couch surf/car
Who do you live with? alone/friend/family/coworker
Have you been homeless in the past six months? ................................................. ☐ Yes ☐ No
Living in a controlled environment in the past 30 days (jail/prison, group home, hospital) ☐ Yes ☐ No
Do other people in your life current use drugs? ……………………………………………… ☐ Yes ☐ No
Who uses? (Friend, spouse? No names)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How many sober supports do you have in your life? 0 1 2 3 4 5+
Do you have a sponsor? ……………………………………………………………………………………… ☐ Yes ☐ No
Have you ever had one? ☐ Yes ☐ No
Are you open to the idea of one?......................................................................... ☐ Yes ☐ No
Are you open to community support groups (AA, NA, Celebrate Recovery, Smart Recovery) ☐ Yes ☐ No
Do you have reliable transportation to make appointments? ……………………………. ☐ Yes ☐ No

How long have you had your current phone number?

Psychiatric History:
Have you ever felt you have emotional problems and need help? ☐ Yes ☐ No
Have you had a psychiatric diagnosis in the past? ☐ Yes ☐ No

|  |  |  |
| --- | --- | --- |
| ❑ Major Depression | ❑ Obsessive Compulsive Disorder | ❑ ADHD |
| ❑ Post-Partum Depression | ❑ Trichotillomania | ❑ Learning Disorder |
| ❑ Bipolar/Manic-Depressive | ❑ Body Dysmorphic Disorder | ❑ Schizophrenia |
| ❑ Panic Attacks | ❑ Anorexia | ❑ Schizoaffective Disorder |
| ❑ Social Anxiety | ❑ Bulimia | ❑ Psychosis |
| ❑ Phobias | ❑ Insomnia | ❑ Antisocial Personality |
| ❑ Generalized Anxiety | ❑ Oppositional Defiant  | ❑ Borderline Personality |
| ❑ PTSD |  /Conduct Disorder | ❑ Narcissistic Personality |

Have you ever attempted suicide? ☐ Yes ☐ No
Do you have a current psychiatrist? ………………………………………………………………… ☐ Yes ☐ No
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Former psychiatrist? ☐ Yes ☐ No
Have you had any psychiatric hospitalizations? ................................................... 0 1 2 3 4 5+
Have you ever had a severe head injury/traumatic brain injury? ☐ Yes ☐ No
Any coma or concussions? ..................................................................................... ☐ Yes ☐ No
Have you had any seizures? ☐ Yes ☐ No
Have you ever had a counselor or a therapist? ………………………………………………… ☐ Yes ☐ No
Did you find your counselor helpful? If no, please describe: ☐ Yes ☐ No

What psychiatric medications have you tried?
**SSRIs/SNRIs:**

|  |  |  |
| --- | --- | --- |
| ❑Prozac (fluoxetine) | ❑Zoloft (sertraline) | ❑Paxil (paroxetine) |
| ❑Celexa (citalopram) | ❑Lexapro (escitalopram) | ❑Trintellix (vortioxetine) |
| ❑Luvox (fluvoxamine) | ❑Viibryd (vilazodone) |  |
| ❑Effexor (venlafaxine) | ❑Pristiq (desvenlafaxine) | ❑Cymbalta (duloxetine) |
| ❑Fetzima (levomilnacipran) | ❑Savella (milnacipran) |  |

**Tricyclic Antidepressants:**

|  |  |  |
| --- | --- | --- |
| ❑Silenor (doxepin) | ❑Norpramin (desipramine) | ❑Pamelor (nortriptyline) |
| ❑Elavil (amitriptyline) | ❑Tofranil (imipramine) |  |

**Other:**

|  |  |  |
| --- | --- | --- |
| ❑Wellbutrin (bupropion) | ❑Buspar (buspirone) | ❑trazodone |
| ❑Vistaril/Atarax (hydroxyzine) | ❑Remeron (mirtazapine) |  |

 **Mood stabilizers/Seizure Medications:**

|  |  |  |
| --- | --- | --- |
| ❑Neurontin (gabapentin) | ❑Depakote (valproic acid) | ❑lithium |
| ❑Topamax (topiramate) | ❑Tegretol (carbamazepine) | ❑Trileptal (oxcarbazepine) |
| ❑Lamictal (Lamotrigine) |  |  |

**Antipsychotics:**

|  |  |  |
| --- | --- | --- |
| ❑Seroquel (quetiapine) | ❑Risperdal (risperidone) | ❑Zyprexa (olanzapine) |
| ❑Abilify (aripiprazole) | ❑Haldol (haloperidol) | ❑Vraylar (cariprazine) |
| ❑Rexulti (brexpiprazole) | ❑Invega (paliperidone) | ❑Latuda (lurasidone) |

**Sedatives/Hypnotics:**

|  |  |  |
| --- | --- | --- |
| ❑Xanax (alprazolam) | ❑Ativan (lorazepam) | ❑Valium (diazepam) |
| ❑Klonopin (clonazepam) | ❑Ambien (zolpidem) | ❑Sonata (zaleplon) |
| ❑Lunesta (eszopiclone) | ❑Librium (chlordiazepoxide) | ❑Serax (oxazepam) |
| ❑Restoril (temazepam) |  |  |

**Stimulants:**

|  |  |  |
| --- | --- | --- |
| ❑Ritalin, Concerta, others (methylphenidate) | ❑Adderall (amphetamine salts) | ❑Vyvanse (lisdexamfetamine) |
| ❑Provigil (modafinil) | ❑Nuvigil (armodafinil) | ❑Diet pills (phentermine) |

**ADHD (non-stimulant):**

|  |  |  |
| --- | --- | --- |
| ❑Strattera (atomoxetine) | ❑Intuniv (guanfacine) |  |
|  |  |  |

**PTSD:**

|  |  |  |
| --- | --- | --- |
| ❑Minipress (prazosin) | ❑Catapres (clonidine) | ❑Intuniv (guanfacine) |
| ❑Inderal (propranolol) |  |  |

Other psychiatric medication: please list

CURRENT MOOD SYMPTOMS: **Over the last 2 weeks…**

…h**ow many days** would you say you have felt sad, down or depressed?

…h**ow many days** have you felt unable to enjoy things you normally enjoy?

…how often have you been bothered by any of these problems:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at All | Several Days | More than half the days | Nearly Every Day |
| 1. Little interest or pleasure in doing things  | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless  | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much  | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy  | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating  | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

Adverse Childhood Events.
This applies only to the time of your life while you were growing up, **during your first 18 years of life**:

|  |  |
| --- | --- |
| 1. Did a parent or other adult in the household often… swear at you, insult you, put you down or humiliate you, OR, act in a way that you may be physically hurt?
 | ☐ Yes ☐ No |
| 1. Did a parent or other adult in the household often…push, grab, slap, or throw something at you, OR, ever hit you so hard you had marks or were injured?
 | ☐ Yes ☐ No |
| 1. Did an adult or person at least 5 years older than you ever… touch or fondle you or have you touch their body in a sexual way, OR, try to or actually have oral, anal, or vaginal sex with you?
 | ☐ Yes ☐ No |
| 1. Did you often feel that no one in your family loved you or thought you were important or special, OR, your family didn’t look out for each other, feel close to each other, or support each other?
 | ☐ Yes ☐ No |
| 1. Did you often feel that…you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? OR, your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
 | ☐ Yes ☐ No |
| 1. Were you parents ever separated or divorced?
 | ☐ Yes ☐ No |
| 1. Was your mother/father or stepmother/stepfather… often pushed, grabbed, slapped, or had something thrown at her/him, OR, sometimes or often kicked, bitten, hit with a fist, or hit with something hard, OR, ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
 | ☐ Yes ☐ No |
| 1. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
 | ☐ Yes ☐ No |
| 1. Was a household member depressed or mentally ill, or attempt suicide?
 | ☐ Yes ☐ No |
| 1. Did a household member go to jail or prison?
 | ☐ Yes ☐ No |

## Past Medical History:

**Have you ever been DIAGNOSED with any of the following:** (Circle) ❑None
**Head:** perforated nasal septum

**Lungs:** COPD, tuberculosis, obstructive sleep apnea or central sleep apnea, have CPAP, have BiPAP, have home oxygen, asthma, or other breathing problem,

**Heart issues:** high blood pressure, chest pain, congestive heart failure, heart murmur, endocarditis, heart valve problems, irregular heartbeat such as atrial fibrillation, Wolf-Parkinson-White, long QT syndrome, have an implanted pacemaker defibrillator

**Liver issues:** Hepatitis A B C D E, cirrhosis of the liver, other liver condition. Treated for Hep C?

**Stomach/Intestines:** Irritable bowel syndrome, irritable bowel disease, Crohn’s disease,
severe constipation or diarrhea, regular vomiting, vomiting blood, blood in stool, dark stool, GERD

**Kidney issues:** kidney disease, kidney stones

**Neuromuscular:** neuropathy, neuropathic pain, seizure, brain injury, back injury, herniated disks

**Skin:** infections, rashes, abscesses, ulcers

**Genitals/Urinary:** frequent urinary tract infections, blood in urine, sexually transmitted infection

**Endocrine:** diabetes (using insulin?), thyroid problems (specify)

**Cancer** of any kind

**Bleeding** or **clotting** problems

**Chronic pain condition**: (specify)

Have you ever been hospitalized? List year and reason ☐ Yes ☐ No

Any surgeries? List year and reason ☐ Yes ☐ No

Have you received education on HIV? ☐ Yes ☐ No
Have you received education on Hepatitis? ☐ Yes ☐ No
Have you received education on Sexually Transmitted Infections? ☐ Yes ☐ No

What side effects do you experience from the methadone/buprenorphine?

Current Primary Care Physician: ☐ Yes ☐ No
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENTLY/recently experienced any of the following: (Circle)** ❑None

GENERAL: fevers, chills, unexplained weight loss or gain, feeling ill

HEAD/EYES/EARS: headaches, vision changes, hearing changes, dizziness

NOSE/MOUTH/THROAT: nosebleeds, sinus infection, bleeding gums, pain or soreness.

LUNGS: wheezing, cough, asthma

HEART: chest pain, palpitations, high blood pressure

STOMACH/INTESTINES: nausea, vomiting, blood in stool, diarrhea, constipation, stomach cramps

GENITALS: blood in urine, discharge, itching, sores, foul smell

NEUROLOGIC: fainting, blackouts, seizures, sensory loss

MUSCLES/JOINTS: weakness, joint pain, back pain

ENDOCRINE: elevated blood sugars (diabetes), thyroid problems

HEMATOLOGIC: easy bruising, unusual bleeding

SKIN: rashes, sores

**For Women**Do you use birth control? ☐ Yes ☐ NoHow many pregnancies have you had? 0 1 2 3 4 5+How many live births? 0 1 2 3 4 5+First day of your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

Please list current medications you take, the dosage, frequency, and reason for each ❑None
Please list over the counter medications or complementary or alternative medicine (yoga, supplements)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Reason |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family Medical History**Please list any medical problems in your first degree relatives (parents, children, brothers or sisters):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Social History
Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Where were you raised? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Were your parents married or divorced, or never together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
If divorced, how old were you then? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Who took care of you as a kid (mom? grandma?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How many brothers and sisters? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Mother’s occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Father’s occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What’s the highest grade you completed in school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Who do you live with currently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What types of work have you done?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you current employed? What type of work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Primary source of money:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
If you are disabled, list the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How many people other than you do you financially support?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How many minors (17 and younger) are dependent on your income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Does your family know you are seeking/in treatment at this time? ☐ Yes ☐ No
What is your sexual orientation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What is your gender expression?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Relationships/Support Network, and Family History

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Age | Deceased? | AddictionHistory | Mental Health | Relationship |
| Mother |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |
| Step-mother |  |  |  |  |  |  |
| Step-father |  |  |  |  |  |  |
| Brother/Sister |  |  |  |  |  |  |
| Brother/Sister |  |  |  |  |  |  |
| Brother/Sister |  |  |  |  |  |  |
| Brother/Sister |  |  |  |  |  |  |
| Brother/Sister |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Age | Relationship Length | AddictionHistory | Mental Health | Relationship |
| Spouse |  |  |  |  |  |  |
| Ex-Spouse |  |  |  |  |  |  |
| Other/current partner |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Children Names❑None | Age | SupportFinancially? | AddictionHistory | Mental Health | DCF/CPS Involved? |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Military Experience:** ☐ Yes ☐ No

**Legal History:**

Do you have any history of arrests? ☐ Yes ☐ No (If no, skip)
Do you currently have any legal charges/cases pending? ☐ Yes ☐ No
Do you currently have any probation/parole? ☐ Yes ☐ No
Do you have any history of legal charges for distribution? ☐ Yes ☐ No
Do you have any outstanding warrants? ☐ Yes ☐ No
Have you ever been arrested for DWI/BWI? ☐ Yes ☐ No
Have you ever been arrested for arson? ☐ Yes ☐ No
Have you ever been arrested for assault? ☐ Yes ☐ No
Have you ever been charged with sexual assault? ☐ Yes ☐ No

**Religion:**Are you religious? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk-Taking Behaviors:**
Do you harm yourself via cutting or other means? ☐ Yes ☐ No
Share needles? ☐ Yes ☐ No
Have unprotected sex? ☐ Yes ☐ No
Engage in extreme sports? ☐ Yes ☐ No
Drive at excessive speeds? ☐ Yes ☐ No
Drive under the influence? ☐ Yes ☐ No