

2. FAMILY HISTORY:	<u>Mother</u>	<u>Father</u>
Health	Deceased, poor, good, fair, excellent	Deceased, poor, good, fair, excellent
Personality	_____	_____
Special Problems	_____	_____
If dead, cause of death (age and date of death)	_____	_____
Current marital status of parents	Married, separated, divorced, widowed.	Married, separated, divorced, widowed.
Your past relationship	Poor, fair, good, excellent, other____	Poor, fair, good excellent, other____
Parents' relationship	Poor, fair, good, excellent, other _____	

Give similar information regarding stepparents or other persons who were responsible for your upbringing. _____

A. How would you describe your mother? (List five adjectives)

B. How would you describe your father? (List five adjectives)

3. SIBLINGS (Brothers and Sisters) Include full siblings, half-siblings, stepsiblings and adopted siblings.

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Residence</u>	<u>Health</u>	<u>Social Problems</u>
-------------	------------	------------	------------------	---------------	------------------------

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

4. MILITARY HISTORY (if applicable)

Branch _____

Dates 19____ to 19____

Nature of Discharge_____

Special Problems_____

5. MARRIAGES

Number of marriages 0 1 2 3 4 5

<u>Spouses Names</u>	<u>Dates</u>	<u>Reason for Termination of Relationship</u>
_____	19____ to 19____	_____
_____	19____ to 19____	_____
_____	19____ to 19____	_____
_____	19____ to 19____	_____
_____	19____ to 19____	_____

6. CHILDREN (By all marriages)

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Legal Status:</u> <u>Own, adopted,</u> <u>stepchild, other</u>	<u>Residence</u>	<u>Marital Status</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

7A.

LIST ALL DOCTORS YOU ARE SEEING:

<u>Name</u>	<u>Specialty</u>	<u>Address & phone #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7B. List any present medical problems _____

8. If you are taking medication for any of these problems please list all the medications and dosage

9. Please list with dates any serious illnesses, hospitalizations, operations, or injuries you have had.

<u>Operation, Hospitalization, Illness, or Injury</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____

10. What is your height: _____

11. What is your weight: _____

12. Do you smoke? _____ No _____ Yes

If yes, how much? _____

13. Do you drink tea and/or coffee? _____ No _____ Yes

If yes, how many cups per day? _____

14. What are your hobbies and interests? _____

a. How many times a week do you engage in an athletic event or game (tennis, jogging, baseball, etc)?

_____3-4 days a week

About how much did you drink in a typical day?

(Note: 1 pint- 16 oz. or sixteen 1 oz. shots. There are 2 pints in 1 quart and a little over 1 1/2 pints in a fifth).

_____4 pints or more _____2 pints

_____11-14 shots _____1 pint

_____7-10 shots _____4-6 shots

_____3 pints _____1-3 shots

20a. ARE YOU CURRENTLY EXPERIENCING WITHDRAWAL SYMPTOMS? NO YES

Substance: _____

Symptoms: _____

For how long?

b. HAVE YOU EVER BEEN GIVEN MEDICATIONS TO WITHDRAW FROM A
SUBSTANCE? NO YES

Substance(s): _____

c. HAVE YOU EVER HAD MEDICAL HELP TO SOBER UP?

NO YES

21. How old were you the first time any of the following problems occurred because of alcohol or drug use?

a. Were fired because of drinking.

_____Never or I was _____years old

How many times did this happen?_____

b. Were picked up for drunk driving.

_____Never or I was _____years old

How many times did this happen?_____

c. Were separated or divorced from spouse because of your drinking problem.

_____Never or I was _____years old

How many times did this happen?_____

d. Had to go to the hospital because of drinking.

_____Never or _____I was_____years old

How many times did this happen?

e. A doctor told you alcohol had harmed your health.

_____Never or _____I was_____years old.

How many times did this happen?_____

f. The first time you seriously tried to stop drinking.

_____Never or _____I was_____years old.

How many times did this happen?_____

g. The first time you had shakes "the morning after".

_____Never or _____I was_____years old.

How many times did this happen?_____

h. The first time you had a blackout.

_____Never or _____I was_____years old.

How many times did this happen?_____

i. Have you ever attended a social support group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?

_____Never or _____Times _____Last Attended

j. Have you ever gotten physically sick (vomit, stomach cramps, Etc.) as a result of drinking?

_____Never or _____Times

k. Do you ever drink or use drugs to relieve a hangover?

No Yes

l. Do you sometimes find that you've had more to drink than you planned?

No Yes

m. Have you ever set rules for your drinking or drug use that you couldn't follow?

- No Yes
- n. Have you ever exceeded the limit you set for your drinking and continued to drink until drunk?
- No Yes
- o. Have you ever hidden your alcohol or drugs from others (i.e. hid beer from your roommates or in several places to ensure you never ran out)?
- No Yes
- p. Have you ever felt you should cut down on your use of alcohol or drugs?
- No Yes
- q. Have you gone "on the wagon" (not drink at all) after a period of drinking or using drugs?
- _____ Never or _____ Times
- r. Do you worry about your drinking or drug use?
- No Yes
- s. Have you ever found yourself scheduling your activities so you could get something to drink?
- No Yes
- t. As a result of your drinking or drug use, have family members or close friends commented that you don't spend as much time with them as you used to?
- No Yes
- u. How often do you have six or more drinks on one occasion?
- _____ Never _____ Less than monthly _____ Monthly _____ Weekly
- or _____ Daily or almost daily
- v. Thinking about the past year, what is the greatest number of drinks you've had on any one occasion?
- _____ 1-2 _____ 3-4 _____ 5-6 _____ 7-8 _____ 9 or more
- w. How often during the last year have you found that you were not able to stop drinking once you had started?

Never Less than monthly Monthly Weekly

or Daily or almost daily

- x. How often during the last year have you failed to do what was normally expected from you because of drinking or drug use?

Never Less than monthly Monthly Weekly

or Daily or almost daily

- y. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never Less than monthly Monthly Weekly

or Daily or almost daily

- z. How often during the last year have you had a feeling of guilt or remorse after drinking or drug use?

Never Less than monthly Monthly Weekly

or Daily or almost daily

- aa. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly

or Daily or almost daily

- bb. Have you or someone else been injured as a result of your drinking or drug use?

No Yes, but not in the last year Yes, during the last year.

- cc. Has a relative or friend or a doctor or other health worker been concerned about your drinking or drug use or suggested you cut down?

No Yes, but not in the last year Yes, during the last year.

- dd. Did you ever pass a field sobriety test even though you had been drinking heavily?

No Yes

ee. Have you ever had a convulsion (fit) following a period of drinking?

___No ___Yes

ff. When drinking or using drugs, are you often very sad (cry a lot, feel very depressed, etc.)?

___No ___Yes

gg. When drinking or using drugs, do you sometimes physically or verbally abuse family members/others?

___No ___Yes

hh. When drinking or using drugs, do you lose control over what you do?

___No ___Yes

ii. Do you feel bad or guilty after drinking or drug use?

___No ___Yes

jj. Does your drinking or drug use cause hardships for your family and/or friends?

___No ___Yes

kk. Have you ever had medical help or been seen by the emergency room for alcohol or drug related symptoms (i.e., had a drunk watch, dehydration, vomiting, intoxication, alcohol poisoning, etc.)?

___No ___Yes

21a. How many times in your life do you estimate that you have taken the following substances?

Marijuana (including Hashish and THC)?

___Never or ___Times ___Last Used?

Hallucinogens (LSD, Mescaline, Peyote, PCP, STP, Psilocybin, etc.)?

___Never or ___Times ___Last Used?

Barbiturates and downers that weren't prescribed for your use?

___Never or ___Times ___Last Used?

Oral Amphetamines, Ritalin, Methamphetamine, ("Speed, Meth, Crystal'), Diet Pills, and Other Amphetamines that weren't prescribed for your use?

_____Never or _____Times _____Last Used?

Opiates (Heroin, Vicoden, Etc. that weren't prescribed for your use?)

_____Never or _____Times _____Last Used?

Solvents (Glue, Aerosols, Toluene, Gasoline, Paint, Etc.)?

_____Never or _____Times _____Last Used?

Cocaine? (Crack, Freebase, Coke, Rock Cocaine Etc.)?

_____Never or _____Times _____Last Used?

Club Drugs (Ecstasy, MDMA, GHB, Rohypnol, Ketamine, Etc.)

_____Never or _____Times _____Last Used?

Are there any others? If Yes, which ones?

b. Have you ever had any of the following problems because of drug use?

___No ___Yes Marital separation or divorce because of your drug use?

___No ___Yes Laid off from work or fired because of your drug use?

___No ___Yes One or more arrests because of your drug use?

___No ___Yes A doctor has said that drugs have harmed your health?

___No ___Yes Used drugs intravenously?

22. Were you ever treated by a mental health worker such as a psychiatrist, psychologist, marriage family counselor, social worker (Check all that apply)

___No, Never Treated ___Yes, Marriage Family Counselor
___Yes, Social Worker
___Yes, Psychiatrist ___Yes, Other
 Please specify_____

____ Yes, Psychologist
 If Yes, why did you see them? _____

b. Did you ever attempt suicide?
 ____ No or ____ If Yes: ____ Actual number of times

If yes, how old were you the first time?

c. Did you ever feel as if your mind was being manipulated or actually controlled by some unusual or mysterious force?

____ No ____ Yes

Please describe: _____

d. Have you ever felt influenced in unusual ways, such as by machines, hypnosis, radar waves, radio, television or newspapers?

____ No ____ Yes

Please describe: _____

e. Have any of your close relatives ever seen a psychiatrist, psychologist, chemical dependency counselor or other behavioral health worker for treatment of an emotional problem or drug/alcohol problem?

____ No ____ Yes

If Yes, fill out the answers for each of your relatives who have seen a psychiatrist, psychologist, or other mental health worker for treatment of an emotional problem or a drug/alcohol problem.

	<u>No</u>	<u>Yes</u>	<u>How Old</u> <u>First Time</u>	<u>How Old</u> <u>Now</u>	<u>What Were Their</u> <u>Symptoms/Problem</u>
Father	____	____	_____	_____	_____
Mother	____	____	_____	_____	_____
Any Brother	____	____	_____	_____	_____
Any Sister	____	____	_____	_____	_____
Any Son	____	____	_____	_____	_____
Any Daughter	____	____	_____	_____	_____

NOTE: If more than one brother, sister or child saw a behavioral health worker, please give information on each.

23. Have you ever spent the night in jail?

___ No ___ Yes If Yes, Why? _____

24. Have you ever hurt anyone in a fight badly enough so that they needed to see a doctor?

___ No ___ Yes

25. Please list your major concerns these days (for example, physical pain, arguing with spouse, money problems)

1.

2.

3.

PLEASE CHECK ALL THAT APPLY

	YES	NO		YES	NO
Sleep problems	___	___	Thinking problems	___	___
Poor appetite	___	___	Anxiety	___	___
Body weakness	___	___	Depression	___	___
Fatigue	___	___	Crying spells	___	___
Headaches	___	___	Nervousness	___	___
Stomach problems	___	___	Thoughts of suicide	___	___
Back pain	___	___	Thoughts of homicide	___	___
Nausea	___	___	Feeling of helplessness	___	___
Dizziness	___	___	Feeling of hopelessness	___	___
Chest pain	___	___	Fears	___	___
Shortness of breath	___	___	Anger Problems	___	___
Weight changes	___	___	Irritability	___	___
Diabetes	___	___	Insecurity	___	___
High blood pressure	___	___	Problems with friends	___	___
Numbness	___	___	Money problems	___	___
Tingling	___	___	Problems at work	___	___
General body pain	___	___	Poor self-esteem	___	___
Skin rash	___	___	Drinking problems	___	___
Sexual problems	___	___	Drug problems	___	___

Nightmares	___	___	Loss of interest in life	___	___
Memory changes	___	___	Suspiciousness	___	___
Poor concentration	___	___	Feelings of discrimination	___	___
Marital problems	___	___	Problems with supervisors	___	___
Mood changes	___	___	Strange happenings	___	___
Hearing voices	___	___	Visual problems	___	___
Fainting spells	___	___	Vomiting	___	___
Hearing loss	___	___	Swelling of joints	___	___
Heart pounding	___	___	Problems with family	___	___
Paralysis	___	___	Assertiveness Problems	___	___

26. How do you spend your day? Please list all the activities you pursue. (Be *Specific and detailed*) Use the times of day listed as a guide.

What time do you generally wake up?

early morning...

mid morning...

late morning...

noon hour...

early afternoon...

mid afternoon...

late afternoon...

early evening...

middle evening...

late evening...

What time do you usually go to bed?

How do you spend the weekends? (Be Specific)

27. Which of the following have ever applied during your years in school?

	<u>Grade</u>		<u>Grade</u>
Afraid to attend	_____	Picked on	_____
Problems with teachers	_____	Fights	_____
Frequent or prolonged absence	_____	Enjoyed school	_____
Disciplined by school personnel	_____	Failing Grades	_____

Expulsions/suspensions _____

Honor role _____

Medical problems _____

Family problems _____

Your grades in school were generally (Circle): A B C D F

Were you ever held back a grade? Y / N Which grade(s)

Why? _____

Where you ever told you had a learning disability or ADHD? Y / N (Explain)

Were you ever placed in a special class? Y / N Which grade(s) _____

28. Are you a highschool graduate? Y / N What school? _____

Location? Year graduated _____

GED? Y / N

29. Did you work outside the home before you left highschool? Y / N What types of jobs did you have?

30. Please tell us about your income at this time...

Source

Amount

Since when?

31. College or specialized training:

Where

Degrees/Credentials

When

32a. Please account for the last five jobs (even if the same employer) or the jobs you've held for the past ten years.

List your most recent job first.

Employer

Job Title

City

Dates of employment

b. Has your drinking or drug use ever caused you to miss work or be late to work?

_____Never or _____Times

c. Has your drinking ever resulted in your supervisor reprimanding or criticizing you?

No Yes

33. Were you ever terminated from a job? (Please explain)

34. Have you ever attended an AA or NA meeting? Y / N

If yes, how many? _____AA _____NA

35. What do you want to do about your drinking/drug use?

_____Cut down _____Stay the same
_____Stop altogether _____Other:_____

36. Are you currently experiencing any (civil) legal difficulties (custody, restraining order, divorce)? Y / N

Describe: _____

37. Are you represented by an attorney? ____No ____Yes If yes, please provide the name, address, and phone number of your attorney. _____

38. Where were you born? _____

39. Where were you raised? _____

40. Who would you say really cares about you? _____

41. Have you recently withdrawn from friends or family? ____No ____Yes

42. Do you belong to any groups or organizations that are supportive and helpful to you?

_____No ____Yes If yes, please explain: _____

43. What do you like about yourself? _____

44. What do you dislike about yourself?_____

45. What would you change about yourself?)_____

46. Do you believe in a concept of a God/a supreme being/a higher power of some kind?

____No ____Yes, please explain_____

47. Has your belief about God/supreme being/higher power changed during your lifetime?

____No ____Yes, please explain_____

48. What are your future plans?