

Please complete this questionnaire and give it to your counselor on your first visit. This information will help your clinician gain an understanding of the problems for which you are seeking help and of other important events in your life.

YOUR NAME IN FULL	AGE	DATE OF BIRTH	MEDICAL RECORD NUMBER
WHO REFERRED YOU TO LAUREATE?			TODAY'S DATE

MOTIVATION FOR CHANGE

WHAT FACTOR(S) LED YOU TO SEEK CHEMICAL DEPENDENCY TREATMENT AT THIS TIME? *EXPLAIN*

Legal problems
 Health problems
 Financial problems
 Other -
 Relationship problems
 School problems
 Work problems

PREVIOUS TREATMENT

TELL US ABOUT YOUR PREVIOUS MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT

DATE OF TREATMENT	SUBSTANCE ABUSE	MENTAL HEALTH	NAME OF TREATMENT PROVIDER OR CENTER	TYPE OF TREATMENT (Residential, Detox, Outpatient, etc.)	RESPONSE TO TREATMENT (How long did you stay sober?)

WHILE USING ALCOHOL OR DRUGS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING MENTAL HEALTH OR BEHAVIORAL PROBLEMS?

Depression
 Anxiety
 Compulsive gambling
 Compulsive sex or pornography
 Drug dealing
 Eating disorder

SUBSTANCE USE HISTORY

SUBSTANCES	AGE FIRST USED	DATE LAST USED	CURRENT CRAVING INTENSITY (None, moderate or strong)	PATTERN OF USE (How much, how often)	
				PREVIOUS PATTERN	CURRENT PATTERN
				FREQUENCY AND QUANTITY	FREQUENCY AND QUANTITY
ALCOHOL (including beer and wine)					
DEPRESSANTS (Valium, Xanax, etc.)					
STIMULANTS (Speed, Meth, etc.)					
COCAINE (Powder, Crack, etc.)					
MARIJUANA (Any form)					
HALLUCINOGENS (Acid, Mushrooms, Ecstasy)					
INHALANTS (Poppers, paint, glue, etc.)					
OPIATES (Pain meds, heroin, etc.)					
NICOTINE (Smoked, smokeless, etc.)					
OTHER (Over-the-counter, etc.)					
OTHER (Over-the-counter, etc.)					
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CONSEQUENCES OF SUBSTANCE USE

Have you ever had work or school problems related to alcohol or drug use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has alcohol or drug use ever had a negative impact on any of your relationships?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had legal charges related to your alcohol or drug use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has alcohol or drug use ever led to any medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has alcohol or drug use ever caused you any financial problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OBSTACLES TO RECOVERY

DO YOU BELIEVE ANY OF THE FOLLOWING WILL MAKE IT MORE DIFFICULT FOR YOU TO STOP USING ALCOHOL OR DRUGS?

<input type="checkbox"/> Living with someone who uses alcohol or drugs	<input type="checkbox"/> Having friends who use alcohol or drugs
<input type="checkbox"/> Experiencing a great deal of job stress	<input type="checkbox"/> Being depressed or anxious
<input type="checkbox"/> Having strong cravings for alcohol or drugs	<input type="checkbox"/> Having few or no hobbies or interests

DO YOU HAVE ANY COMMUNICATION DIFFICULTIES WHICH COULD AFFECT YOUR RECOVERY EFFORT (IE SPEECH, VISUAL, OR HEARING IMPAIRMENTS)? IF SO - WHAT?

DURING TREATMENT, WHAT SUPPORT SYSTEMS (FAMILY, FRIENDS, NEIGHBORS, CHURCH, ETC.) WILL BE AVAILABLE TO HELP YOU WITH YOUR SUBSTANCE ABUSE PROBLEM?

CHILDHOOD DEVELOPMENTAL HISTORY

PROBLEMS EXPERIENCED DURING CHILDHOOD OR ADOLESCENCE	CHECK ONE		IF YES - DESCRIBE
	YES	NO	
Delayed speech			
Delayed motor development			
Excessive shyness			
Excessive aggression			
Hyperactivity			
Learning problems			
Poor peer relationships			
Alcohol or drug abuse			
Depression			
School failure / dropout			
Runaway behavior			
Illegal activities			
Sexual abuse			
Physical abuse			
Abusing someone sexually			
Abusing someone physically			

FAMILY HISTORY

LIST ANY FAMILY MEMBERS BELOW WHO HAVE BEEN TREATED FOR MENTAL HEALTH OR SUBSTANCE ABUSE PROBLEMS

FAMILY MEMBER (Parents, grandparents, siblings)	TYPE OF PROBLEM OR DISORDER	TYPE OF TREATMENT (Hospitalization, medication, etc.)

DESCRIBE ANY SIGNIFICANT CHILDHOOD EVENTS THAT YOU THINK MIGHT BE IMPORTANT TO UNDERSTAND YOUR CURRENT PROBLEM



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ENVIRONMENT AND HOME

MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living as married <input type="checkbox"/> Divorced	SEXUAL ORIENTATION	WHO LIVES IN YOUR HOME WITH YOU?
LIST NAMES OF YOUR CHILDREN		WHO HAS CUSTODY?
WHAT CHILDCARE ARRANGEMENTS DO YOU HAVE?	HOW MANY CLOSE FRIENDS DO YOU HAVE?	ARE YOU SATISFIED WITH THIS NUMBER?
HAS THERE BEEN VIOLENCE / PHYSICAL / SEXUAL ABUSE IN YOUR CURRENT RELATIONSHIPS? <input type="checkbox"/> Yes <input type="checkbox"/> No	YOUR PAST RELATIONSHIPS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF THERE IS SIGNIFICANT INFORMATION REGARDING YOUR SEXUAL HISTORY - LIST HERE		

VOCATIONAL, EDUCATIONAL AND MILITARY HISTORY

WHERE ARE YOU EMPLOYED?	JOB TITLE	DO YOU LIKE YOUR JOB? <input type="checkbox"/> Yes <input type="checkbox"/> No
HAVE YOU BEEN IN THE MILITARY? <input type="checkbox"/> No <input type="checkbox"/> Yes -	IF YES - BRANCH	HIGHEST RANK
HIGHEST LEVEL OF EDUCATION		TYPE OF DISCHARGE
<input type="checkbox"/> Did not complete high school	<input type="checkbox"/> Completed college	<input type="checkbox"/> Technical training
<input type="checkbox"/> Obtained GED	<input type="checkbox"/> Completed high school	<input type="checkbox"/> Completed graduate school

RELIGION AND SPIRITUAL ORIENTATION

IS SPIRITUALITY A SIGNIFICANT PART OF YOUR LIFE? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHAT DENOMINATION ARE YOU AFFILIATED WITH - IF ANY	DO YOU ATTEND REGULARLY? <input type="checkbox"/> Yes <input type="checkbox"/> No
WHAT GIVES YOUR LIFE MEANING?		

FINANCIAL AND LEGAL STATUS

CURRENT LEGAL PROBLEMS - DESCRIBE

PAST LEGAL CHARGES - DESCRIBE

CURRENT FINANCIAL PROBLEMS - DESCRIBE

LEISURE AND RECREATION

LIST ANY INTERESTS OR HOBBIES

WHAT SOCIAL ACTIVITIES DO YOU PARTICIPATE IN?

ETHNIC AND CULTURAL INFORMATION

WHAT IS YOUR ETHNIC GROUP?

African American Asian Hispanic
 Native American Caucasian Other -

WHAT, IF ANY, CULTURAL BELIEFS DO YOU HAVE THAT COULD BE RELEVANT TO YOUR TREATMENT?

WHAT ARE YOUR STRENGTHS, SUCH AS TALENTS, SKILLS OR PERSONAL CHARACTERISTICS?



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BIOMEDICAL SCREENING

WHO IS YOUR PRIMARY CARE PHYSICIAN?	LIST YOUR PSYCHIATRIST - IF ANY
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DESCRIBE ANY CHRONIC PAIN YOU MAY EXPERIENCE

CHECK ANY OF THE MEDICAL CONDITIONS BELOW WHICH YOU HAVE HAD

<input type="checkbox"/> Chronic headaches	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> GYN problems	<input type="checkbox"/> Blood disorder
<input type="checkbox"/> Chronic stomach pains	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Numbness	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Eye disease	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Weight loss

HOW LIKELY IS IT THAT ANY OF THE ABOVE ARE RELATED TO YOUR ALCOHOL OR DRUG USE?

WHICH OF THE FOLLOWING OCCUR WHEN YOU DISCONTINUE USING ALCOHOL OR DRUGS - CHECK ALL THAT APPLY

<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Racing pulse	<input type="checkbox"/> Extreme anxiety	<input type="checkbox"/> Dilated pupils
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Sweating	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Fever	<input type="checkbox"/> Hand tremors

GOALS FOR TREATMENT

PLEASE INDICATE WHICH ONE OF THE FOLLOWING MOST APPLIES TO YOU AT THIS TIME

I think that total abstinence from alcohol and drugs is the only answer for me, and I want to stop drinking and using completely.

I think that total abstinence from alcohol and drugs may be necessary for me, but I am not sure. If I knew that controlled drinking and using were impossible for me, then I would want to stop drinking and using completely.

I think that total abstinence is not necessary for me, but I would like to reduce my drinking and using to a "light social" non-problem level.

I think that total abstinence is not necessary for me, but I would like to reduce my drinking and using to a "moderate social" non-problem level.

I think that total abstinence is not necessary for me, but I would like to reduce my drinking and using to a "heavy social" non-problem level.

I think that total abstinence is not necessary for me, and I see no need to reduce my drinking and using.

IS THERE ANY OTHER INFORMATION THAT YOU WANT STAFF MEMBERS TO KNOW ABOUT YOU?

HAVE YOU EVER ATTEMPTED SUICIDE?	DO YOU CONSIDER YOURSELF A HIGH RISK TO ATTEMPT SUICIDE IN THE FUTURE?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

DO YOU CONSIDER YOURSELF OR ANY FAMILY MEMBER A SERIOUS THREAT TO DO HARM OR BE HARMED BY SOMEONE?



