Date:_____ Preferred Phone Number:_____

Name:_____ DOB:_____ Age:_____

Referral Source:_____

Would you like them to be updated on progress: Y N

Primary Care Provider:_____

Would you like them to be updated on progress: Y N

Other Current Treating Providers:

_____
_____
_____
_____

Reason (Motivation) for Visit (Referral):

_____
_____
_____

AODA History:

Current Concerns: Alcohol Use Drug Use Both

Because of use do you have any of the following concerns?

Emotional	Interpersonal	Behavioral
Sadness	Relationship Issues	Restlessness
Irritability	Marital Difficulties	Can't Sit Still
Death/ Grief	Parent/ Child Issues	Temper Outburst
Anger/ Rage	Physical Abuse	Aggression
Nervousness	Sexual Abuse	Impulse Control Issues
Panic	Domestic Violence	Gambling
Mood Instability	Family Problems	Compulsive Behaviors
Low Self Esteem	Coworker Problems	Sleep Difficulties
Hypersensitivity	Social Skills	Fatigue
Perfectionism	Money Issues	Chronic Pain
		Legal Problems
		Academic Problems
		Disability
		Irresponsible Spending

Other:
_____
_____

Do you feel you have a Substance use issue? Yes No

Substance	1st age of Use	Pattern of Use/ How Used	Avg. Amt. /Frequency	Max. Amt.	Last
Alcohol					
Marijuana **K2**					
Amphetamines (Speed, Ephedrine, Adderall, meth)					
Cocaine (Crack, crystal meth)					

Hallucinogens (LSD, Mushrooms, Ecstasy, PCP, Acid, Bath Salts)					
Heroin/Opiates (Oxy, codeine, methadone, Suboxone, vicadin)					
Sedatives (Benzos, sleeping aids, valium, Ativan, Xanax)					
Rx Drugs (Abuse any Prescribed meds)					
OTC (Cough Syrup, Aerosol, Cold Meds, Etc.)					
Other (Nicotine Caffeine)					

Have you had prior AODA treatment: Yes No

Out Patient Treatments (Dates/ Reasons):

_____
_____
_____
_____
_____

Inpatient Treatments (Dates/ Reason):

_____
_____
_____
_____
_____

Halfway Houses: (Dates/ Reasons):

_____
_____
_____

Detox (Dates/ Reasons):

_____
_____
_____

OWI Classes (Dates/ Reasons):

_____
_____

Do or have you attended AA/NA: Yes No

_____
_____

Have You Ever injected Drugs For IV Drug Use: Yes No

Have You Ever Shared Needles: Yes No

Withdrawal Symptoms (Explain): Yes No

_____
_____
_____

Medical Information:

Do you currently have any medical issues: Yes No

_____

_____

_____

Any past medical issues, including surgeries: Yes No

_____

_____

_____

Current Mental Health Diagnoses:

_____

_____

Current Medications:

_____

_____

Medication Allergiies: _____

Medication Side Effects: _____

Have you had any of the following Health Problems?

	Past	Current	Due to Use			Past	Current	Due to Use
Head Injury					High Blood Pressure			
Blackouts					Diabetes			
Migraines					Asthma			
Hepatitis					Allergies			
Seizures					Liver Problems			
MS					Kidney Problems			
STD's					Skin Problems			
Fibromyalgia					Vision Problems			
Heart Attack					Hearing Problems			
Coronary Problems					Olfactory Problems			
Stroke					Low Back/ Neck Pain			
TIA's					Insomnia			
Dizziness					Early Awaking			
Paralysis					Frequent Awakening			
Thyroid Problems					Sleep Apnea			
IBS					Cancer			
GI Difficulties					Tics			
Communication Issues					Eye Hand Functioning			
Self Care					Suicide Attempt			

Other Health Problems (Past/ Current) not listed above:

_____

_____

Are you Currently Sexually Active: Yes No

Family History	Mother	Father	Siblings	Children	Self	Other Relatives
Suicide Attempts						
Completed Suicide						
Depression						
Bi- Polar						
Anxiety						
Panic Disorder						
OCD						
Schizophrenia						
ADHD						
Learning Problems						
Alcoholism						
Other Drug Abuse						

Any Concerns:_____

Other Information that you feel may be relevant:

_____
_____
_____
_____

Family History

Marital Status: Single Married Divorced Remarried Widowed Other

Present Household Members:

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

Do you have Children: Yes No

Names & Ages:

_____
_____
_____

Have relationships been strained due to your usage? Yes No

_____
_____
_____

Has there been a history of abuse in your relationships: Yes No

History	Been	Accused	Information
Physical Abuse			
Sexual Molestation			
Domestic Abuse			
Rape			
Elder Neglect/ Abuse			
Child Neglect / Abuse			

Where were you Born: _____

Relationship With:
Mother- Living Deceased
_____
_____
Father- Living Deceased
_____
_____
Step Parent- Living Deceased
_____
_____

Do you have siblings (Ages/ Names & Relationship):_____
_____

Spirituality/ Religion/ Culture

Do you believe in god or higher power: Yes No

Do you have any Issues you want to address about your belief system: Yes No
_____
_____
_____

Are you open to NA/ AA: Yes No
_____
_____
_____

Personal History

Do you have people who support you in your choices (I.E. stopping usage): Yes No

_____
_____
_____

Do you Have someone you are able to talk to about your problems (Who): Yes No

_____
_____
_____

Do you feel there is anyone in your circle of support that may make it hard for your recovery (whom/ why): Yes NO

_____
_____
_____

Interest & Activities

What are your hobbies/ Interests (Do you do these with anyone else):

_____
_____
_____
_____

Do you feel your usage has affected these activities: Yes No

_____
_____
_____

Education

Years of school completed:____ Degree(s):_____
Difficulties with reading:_____ Written Language:_____
How do you learn best: Verbal or Observation
Have you ever been diagnosed with a learning disability:
Any Current/Future Schooling Plans: _____

Employment

Current Status: Full Time Part Time Unemployed Retired Disabled
Current Employer:_____
Job Responsablities:_____
_____
If Unemployed/Disabled/ Retired, where previously employed:
_____

Military History

Ever served in Military: Yes No
Branch:_____
Years:_____
Rank:_____
Type of Discharge:_____
Was usage an issue in service: Yes No
_____
_____
_____

Legal

Current Legal problems or lawsuits:_____
_____
_____

Past legal difficulties (was it due to alcohol/ drug use):
_____
_____
_____
_____

Have you been incarcerated (Dates): Yes No
_____
_____

Are you on probation (why & who is PO): Yes No
_____
_____

Strengths/ Weaknesses

Strengths: _____
Weakness: _____