1. Personal Data Intake Information Form

Today's Date: _____

Demographics

Client's First Name: _____ MI: _____ Last Name: _____

Client prefers to be called: _____

DOB: _____ Age: _____ Gender: ☐Male ☐Female

Social Security Number: _____-_____-_____

Name of person completing this form: _____ Relationship to Client: _____

Client's Primary Address: _____ How long have you lived at this address? _____

_____

_____

Client's Phone Numbers: (Check YES or NO if I can call and identify myself or leave messages on each phone)

Home: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

Cell: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

Text Reminders: ☐YES ☐NO

Work: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

How would you prefer appointment reminders? ☐ Phone call ☐ Text Message ☐ Email ☐ None

Current Marital Status:

☐ Single – Never Married
☐ Married
☐ Separated
☐ Living together, but not legally married
☐ Divorced
☐ Widowed
☐ Minor Child

Number of Marriages: _____

Race

☐ White
☐ Black
☐ Native American
☐ Hispanic
☐ Asian
☐ Pacific Islander
☐ Other _____
☐ More than one race

Highest Education Completed

☐ Grade _____
☐ Associate Degree
☐ Certificate Program
☐ Bachelors Degree
☐ Masters Degree
☐ Professional Degree (JD, MD)
☐ PhD

Military History

Are you a military veteran? ☐ Yes ☐ No Are you currently on active duty in the military? ☐ Yes ☐ No

If you have military history, what branch? _____ Have you ever been deployed? ☐ Yes ☐ No

Legal

Have you ever been arrested? ☐Yes ☐No If yes, what charges? _____

Have you ever been convicted? ☐Yes ☐No If yes, what charges? _____

Do you have any current legal concerns? _____

Educational Experience:

Tell me about your school experiences. How were your grades; were you bullied; did you participate in extracurricular activities or have any major disruptions in your school experiences, such as moves?

_____

_____

_____

_____

Current level of employment:

☐ Unemployed ☐ Part-time: Paid work less than 30 hrs/wk ☐ Full-time: Paid work more than 30 hrs/wk
☐ Homemaker ☐ Day laborer: No consistent work ☐ Retired from active employment
☐ Child under 15 ☐ Full-time student ☐ Disabled and unable to work
☐ Other (please indicate): _____

How long have you been at your current job? _____

Do you have any employment concerns? _____

Do you have financial concerns? _____

Who lives with you?

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

How would you describe your relationships with the people you live with? Who do you get along with the best and who do you have the most conflict with? _____

_____

_____

Do you have any other immediate family who does not live with you? (If yes, list below)

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Are you adopted? ☐ Yes ☐ No

Where were you raised? _____

Do any of your family members have any diagnosed mental health concerns? (Relationship and diagnosis)

_____

_____

_____

Who referred you to Addiction Recovery Counseling, LLC?

☐ Self	☐ Police/Law Enforcement	☐ Another counselor
☐ Family/Friend	☐ Court/Judge	☐ Hospital
☐ School	☐ Probation Officer	☐ Clergy
☐ Employer	☐ Inpatient SA/MA Facility	☐ Attorney
☐ EAP	☐ Doctor/Medical Professional	☐ Other _____

Medical

Current Medical Conditions:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Seizures ☐ Tuberculosis ☐ Activity Restrictions

☐ Dietary Restrictions ☐ Allergies_____ ☐ Infections Disease _____

☐ Other _____

Past Health Problems: _____

Date of Last Physician Visit: _____

Name of Current Physician: _____

Current Medications	Dose	Prescribed For?	Side Effects?	Helpful?

SUBSTANCE ABUSE SCREENING SELF-REPORT

Have you used or are you currently using:		**Please check if current**
Alcohol	Frequency/Amount: _____	☐
Marijuana	Frequency/Amount: _____	☐
Cocaine	Frequency/Amount: _____	☐
Meth	Frequency/Amount: _____	☐
Pain Pills	Frequency/Amount: _____	☐
Heroin	Frequency/Amount: _____	☐
Sleeping Pills	Frequency/Amount: _____	☐
Tranquilizers	Frequency/Amount: _____	☐
Nicotine	Frequency/Amount: _____	☐
Caffeine	Frequency/Amount: _____	☐
Diet Pills	Frequency/Amount: _____	☐
Spice	Frequency/Amount: _____	☐
Bath Salts	Frequency/Amount: _____	☐
LSD/PCP	Frequency/Amount: _____	☐
Ecstasy/Molly	Frequency/Amount: _____	☐
_____ (other)	Frequency/Amount: _____	☐

If you checked yes to any of the above answer the following:	**Please check if yes**
Have other people said you have a problem with drugs and/or alcohol?	☐
Has your use of drugs and/or alcohol interfered with school, work or social functioning?	☐
Have you ever been arrested for behavior that occurred under the influence of drugs and/or alcohol? (e.g. disorderly conduct, DUI, MIP, other crimes?)	☐
Have you ever tried to cut back on your use of drugs and/or alcohol and been unsuccessful?	☐
Have you noticed that it takes more of your drug or alcohol to have the same effect?	☐
When you stop using your drug and/or alcohol do you have any side effects?	☐
Do you focus a lot on getting drugs and/or alcohol?	☐
Are you preoccupied with your next use or obtaining the drug?	☐
Have you stopped doing activities because you were using drugs and/or alcohol?	☐

Previous Treatment (when, where, outcomes): _____

_____

_____