Application for Admission

How To Apply to Stepping Stones of Atlanta

1. Please download the Application and Orientation Guide and review it carefully.
2. If you would like to apply for admission to Stepping Stones, please call **:**

Chris Zollman-678-668-3426

Program Requirements

At Stepping Stones, the goal is **permanent recovery** from drugs & alcohol. In order to achieve that goal, we ensure a safe, structured environment where all residents have the opportunity to succeed.

Minimum Requirements for Admission to Stepping Stones of Atlanta:

1. Commitment to stay at least 6 months. You may stay longer.

2. Complete abstinence from all mind & mood altering substances. This includes illegal drugs, alcohol, prescription drugs (certain medical exceptions can be made), or any other substance used to alter your mind or mood. We do drug & alcohol screening several times a month, and all screens are lab verified for accuracy and tampering. ***We do not accept residents that are taking Vyvanse, Suboxone or Subutex, and we screen for those as well.*** We ensure that you will have a safe and sober place to recover, and we discharge immediately with zero tolerance for a failed drug or alcohol screen.

3. You must be willing to get a "sponsor", which is a person who will guide you through the 12 Steps of recovery. We expect everyone to have a sponsor within 1 week. One-on-one work with a sponsor is the most important part of your recovery and you must meet with your sponsor once a week.

4. Willingness to learn how to stay clean & sober through the 12 Steps of Recovery. Active participation in all groups, step-work with your sponsor, and attendance of outside 12 Step meetings is mandatory.

5. Complete willingness to follow all rules and directions. Stepping Stones is a structured living environment that provides all residents with the opportunity to live life to the fullest, but learn to live with structure and accountability.

6. You must either have a job, be actively seeking employment (this will be verified), be attending an outpatient program, or be attending school full time during the day (you may also have to work part time). Part of the structure of recovery is learning to fill our day with worthwhile and productive activities.

7. Willingness to focus on yourself. We have a strict “No Fraternization” policy for a minimum of 60 days.

This means no dating, hanging out, or spending time with members of the opposite sex. If you are already in a relationship, you must be willing to put it on hold and focus on your recovery for a minimum of 60 days.

8.. Willingness to attend mandatory meetings. There are three mandatory meetings that are at specific times and days of the week. Additionally, you are required to attend a minimum of two additional 12 Step meetings of your choice. There may also be other mandatory meeting, retreats, and functions throughout the year.

<u>CLIENT INFORMATION</u> (Please print CLEARLY and complete as much as possible)

Name: ____
Last First Middle

Age: ____ Date of Birth: ___/___/____ City/State of Birth: ____________ Race: ____________

Marital Status: S M W D Social Security Number: ______________

Home Address: ____

City: ______________________ State: ______ Zip Code: ______________

Cell Phone #: ________________

Will you be participating in an Outpatient Program? If so, where: ________________

Emergency Contact: ____________________ Relationship: ______________

Address: ______________________ City/State/Zip: ______________

Cell Phone #: ________________ Other Phone#: ______________

Are you currently in a relationship, or have you been in one within the last 3 months? ______________

If yes, are you willing to put that relationship on hold (no visitation whatsoever) for at least 60 days? __________

Have you been mandated to treatment? ________ If yes, Explain: ______________

____

Do you have legal charges pending? ________ If yes, Explain: ______________

____

Are you on probation or parole? ______________ What county: ______________

Probation/Parole Officer Name: ________________ Phone ______________

P.O. Fax # and/or email address ______________________________

Attorney/Legal Representative Name: ______________________________

Phone #: ______________ Fax #: ______________

Where are you employed: ____

How long have you worked there:_____________________________Is your job in jeopardy: ___________________

Employer Contact/Supervisor: _______________________________

Company Address: __________________________________ Phone Number: _________________________

_

AUTHORIZATION FOR SERVICES/LIABILITY AGREEMENT

I _______________________________, do hereby voluntarily consent to services provided by Stepping Stones of Atlanta, including residential services, consultation, and therapeutic services. Failure to participate in recommendations may result in termination or referral to other setting of care. No information will be released outside the team without express written consent. I give consent for the team to share information about me and my substance abuse or mental health records in order to provide me treatment services. I understand that I must provide truthful information regarding my medical and legal status. I understand the Stepping Stones of Atlanta will not harbor fugitives from the legal system. I also agree that Stepping Stones of Atlanta is not liable for any injuries, and/or death(overdoses, suicide)

I hereby certify that I have read and fully understand the above agreement

____ ________________________________

Signature of Resident Date

AUTHORIZATION FOR RELEASE OF INFORMATION – (Fill this out for the last place you had a TB test)

NAME OF CLIENT ________________________ Social Security # ________________________ Date of Birth ___/___/___

I hereby request and authorize: Stepping Stones of Atlanta
2916 Porter Glade Ct
Atlanta, GA 30360
Phone (678)668-3426

To disclose to or obtain from:

____
Name of Person or Agency

____
Address (if known)

The following information from my records (if available):

___X___ **History and Physical exam**

___X___ **Alcohol and Drug Abuse Treatment records**

___X___ **TB (tuberculosis) Results**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients records, 41 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV related information about me, STD related information about me, and TB related information about me is protected by State law and cannot be disclosed unless the disclosure is authorized by State law. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as follows. If you wish to discuss revoking this authorization or refuse to sign this form, you can ask for assistance from your Therapist or Program Director who can go over this information in more detail:

__X__ **The period necessary to complete all transactions on accounts related to services provided to me.**

Signature of Client ____________________ Date ____________ Witness Signature ____________________

Use this Space Only If Client Withdraws Consent

Witness/Title Date Signature of Client

FEE FOR SERVICE AGREEMENT

Stepping Stones is based on community living and the 12-step program for individuals seeking recovery from alcohol and drug addiction. The undersigned acknowledges, accepts and understands that they are living in an alcohol and drug free shared recovery residence. The undersigned also acknowledges that residency is in the capacity of a lodger sharing a housing unit and not as a tenant with rights or possession of space exclusively.
This is a contract between ________________________________ _

Date: ________________________________

This does not bind the resident or Stepping ~~Sto~~nes, and services may be terminated by either party at any time. However, all program fees must be paid in advance, and ***no refunds will be given for any reason***.

Please check one of the boxes below:

□ **Paying Monthly:** The client agrees to pay a $200 NON REFUNDABLE ADMISSION FEE,and a monthly fee of **$900 per month**, for residential recovery services. Client agrees to pay fees for service on a monthly basis due the 1st day of each month. ALL PAID FEES ARE NON REFUNDABLE. There is a late fee of $20 if fees are not received by 8:00pm on the 1st day of the month.

□ **Paying Weekly:** The client agrees to pay a $200 NON REFUNDABLE ADMISSION FEE, and a weekly fee of **$225 per week**, for residential recovery services provided by Stepping Stones of Atlanta. Client agrees to pay fees for service on a weekly basis due each Friday, for the FOLLOWING week. ALL PAID FEES ARE NON REFUNDABLE. There is a late fee of $20 if fees are not received by 8:00pm on Friday for the following week.

FEE FOR SERVICE AGREEMENT (continued)

The undersigned acknowledges that management reserves the right to terminate this agreement and residents are required to provide a thirty-day written notice of intent to leave the recovery residence. The undersigned also acknowledges that in the event of discharge from Stepping Stones of Atlanta, the resident shall immediately vacate the premises, turn over possession of any and all keys, security cards, parking passes, etc. and shall remove all personal property. The removal of personal property shall be arranged and supervised by assigned staff, and any property not removed within 72 hours will be disposed of in any manner that staff deems necessary.

Resident's printed name: ______________________________

Resident's signature: ______________________________ Date: ______________

RESPONSIBLE PARTY

***** IMPORTANT: If someone else will be responsible for paying your program fees (parents, a church, etc.) they MUST sign below in order for you to complete intake. If you are not *personally*, fully capable of paying your program fees and supporting your other expenses while at Stepping Stones (food, transportation, etc), then you must have a responsible party sign below or we will have to refer you to another program that is a better fit for you.*****

______________________________ is the responsible party for the payment of program fees for
(Responsible Party's Name)

______________________________. I understand the amount due and the date that it is due, and accept responsibility
(Resident's Name)

for the payment of their program fees while they are in the Stepping Stones of Atlanta program. In the event they are discharged for any reason with a balance due, I will pay the balance within 48 hours. I also understand that all fees are non-refundable.

______________________________ Date: ______________
Signature of Responsible Party

CLIENT CONFIDENTIALITY AGREEMENT

The confidentiality of recovering persons living in a Supportive Living Environment is protected under **Federal Law 42 CFR,** which protects them from anyone outside of the program having knowledge of their participation in the program without the client's specific permission. No information regarding a client of Stepping Stones may be release to anyone outside of the program unless:

1. The client has signed a consent form to that person/agency;
2. A court order is issued to Stepping Stones regarding information on the client;
3. Medical personnel require the information in a medical emergency, or;
4. The client threatens to harm him/herself or someone else.

Federal Law does not protect a client if they commit a crime against anyone at Stepping Stones of Atlanta**.** Also, Federal Law does not restrict sharing information regarding reported child abuse/neglect to appropriate State and local authorities.

I agree to inform staff if any of my peers reveal any information about themselves or another client that may be a cause for concern.

Resident's printed name: ___________________________________

Resident's signature: ______________________________________ Date: ____________________

AUTHORIZATION FOR RELEASE TO COMMUNICATE

IF YOU WANT US TO SEND YOUR ATTORNEY OR P.O. ANYTHING, YOU MUST FILL THEIR INFORMATION OUT COMPLETELY! ALSO, IT MUST BE CURRENT, WE WILL NOT ACCEPT ANY VERBAL OR EMAILED UPDATES. ALSO MUST PUT EMERGENCY CONTACT BELOW.

NAME OF RESIDENT ____

I hereby request and authorize STEPPING STONES OF ATLANTA., and its representatives to disclose information to, and discuss my participation in STEPPING STONES OF ATLANTA with the following people:

Name: ______________________________ Phone: ______________________________

Relationship: ______________________________ Email: ______________________________

Name: ______________________________ Phone: ______________________________

Relationship: ______________________________ Email: ______________________________

Name: ______________________________ Phone: ______________________________

Relationship: ______________________________ Email: ______________________________

Name: ______________________________ Phone: ______________________________

Relationship: ______________________________ Email: ______________________________

By signing below, I understand that in the event of an emergency or a relapse (which is a life-threatening emergency, I give Stepping Stones permission to notify ANYONE associated with me, whose contact information they can obtain.

______________________________ ______________ ______________________________

Signature of Resident Date Witness Signature

PRESCRIBED MEDICATIONS RECORD

List ALL medications that you are taking. If your medication or dosage changes in ANY way, please notify Staff and they will update this list immediately. Failed drug screens due to missing or false information on this page are grounds for immediate discharge.

NAME: ______________________________ Date ______________________

Date	Medication	Doctor	Dosage	DC (date you discontinue the med)

Resident's printed name: ______________________________

Resident's signature: ______________________________ Date: ______________

URINE ALCOHOL TESTING AND INCIDENTAL ALCOHOL EXPOSURE CONTRACT

Recent advances in the science of alcohol detection in urine have greatly increased the ability to detect even trace amounts of alcohol consumption. In addition, these tests are capable of detecting alcohol ingestion for significantly longer periods of time after a drinking episode. Because these tests are sensitive, in rare circumstances, exposure to non-beverage alcohol sources can result in detectible levels of alcohol.
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It is **YOUR** responsibility to limit your exposure to the products and substances detailed below that contain ethyl alcohol. It is **YOUR** responsibility to read product labels, to know what is contained in the products you use and consume and to stop and inspect these products BEFORE you use them. Use of the products detailed below in violation of this contract will NOT be allowed as an excuse for a positive test result. ***When in doubt, don't use, consume or apply.***

Cough syrups and other liquid medications: Stepping Stones prohibits the use of alcohol or Dextromethorphan (SDM) containing cough/cold syrups, such as Nyquil®. Other cough syrup brands and numerous other liquid medications, rely upon ethyl alcohol as a solvent). All prescription and over-the-counter medications should be reviewed with your house manager before use. Information on the composition of prescription medications should be available upon request from your pharmacist. Non-alcohol containing cough and cold remedies are readily available at most pharmacies and major retail stores.

Non-Alcoholic Beer and Wine: Although legally considered non-alcoholic, NA beers (e.g. O'Douls®, Sharps®) do contain a residual amount of alcohol that may result in a positive test result for alcohol, if consumed.

Food and Other Ingestible Products: There are numerous other consumable products that contain ethyl alcohol that could result in a positive test for alcohol. Flavoring extracts, such as vanilla or almond extract, and liquid herbal extracts (such as Ginko Biloba), could result in a positive screen for alcohol or its breakdown products. Communion wine, food cooked with wine, and flambé dishes (alcohol poured over a food and ignited such as cherries jubilee, baked Alaska) must be avoided. Read carefully the labels on any liquid herbal or homeopathic remedy and do not ingest without approval from your house manager.

Mouthwash and Breath Strips: Most mouthwashes (Listermint®, Cepacol®, etc.) and other breath cleansing products contain ethyl alcohol. The use of mouthwashes containing ethyl alcohol can produce a positive test result. Use of ethyl alcohol-containing mouthwashes and breath strips by Stepping Stones participants is not permitted. Non-alcohol mouthwashes are readily available and are an acceptable alternative. If you have questions about a particular product, bring it in to discuss with your house manager.

(Continued on next page)

URINE ALCOHOL TESTING AND INCIDENTAL ALCOHOL EXPOSURE CONTRACT (Continued)

Hand sanitizers: Hand sanitizers (e.g. Purell®, Germex®, etc.) and other antiseptic gels and foams used to disinfect hands contain up to 70% ethyl alcohol. Excessive, unnecessary or repeated use of these products could result in a positive urine test. Hand washing with soap and water are just as effective for killing germs.

Hygiene Products: Aftershaves and colognes, hair sprays and mousse, astringents, insecticides (bug sprays such as Off®) and some body washes contain ethyl alcohol. While it is unlikely that limited use of these products would result in a positive test for alcohol (or its breakdown products) excessive, unnecessary or repeated use of these products could affect test results. Participants must use such products sparingly to avoid reaching detection levels.

Remember! When in doubt, don't use, consume or apply.

I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES. I understand the terms of this contract and the reason I am being asked to sign it. I agree to abide by this contract. In the event I breach this contract, I will be choosing to leave the program and accept any legal consequences should I be mandated to complete the program.

____ _________________________________

Signature of Resident Date

____ _________________________________

Signature of Staff Date

ADMISSION NOTE

Client Name:_________________________________ Date:________________________

SUBSTANCE ABUSE HISTORY: Please briefly describe your history of drug & alcohol abuse, dating back to your first use. Be sure to list any other programs/treatments you may have had, and also describe the crisis that got you to Stepping Stones

ISSUES TO BE ADDRESSED: Please describe the issues you feel you need to address while at Stepping Stones

Driving Contract & Vehicle Information

****You must completely fill this out in order to bring a vehicle to Stepping Stones. All information must be valid****

Your Name: ______________________________

*Driver's License # ______________________________ State: _______

Make of Vehicle_ ______________________________ Model: ______________

Color: ______________________________ Tag# ___________

*Is your insurance current? ______________

Insurance company ____

Policy# ____

*******You must turn in a copy of your Driver's License & Insurance Card with this form.********

I understand that having a vehicle at Stepping Stones of Atlanta is a privilege, and I will adhere to the following conditions in order to maintain my ability to have a vehicle.

1. I will drive safely and obey all traffic laws, as I am responsible for the safety of all the passengers in my vehicle.
2. I will "use my words" and make sure to ask anyone I give a ride to, to contribute to my gas expenses.
3. I recognize that service to my community members is of utmost importance, and will offer to give rides and help others out when they are in need.
4. I understand that loss of driving privileges may be a consequence of my violating any rules, directions, or policies.
5. SPECIAL STIPULATIONS: ____

____

______________________________ ______________________________

Signature of Resident Date

BIOPSYCHOSOCIAL HISTORY

Client Name: ____ Date: ____

CURRENT SYMPTOMS CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) __________	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] **Prior outpatient psychotherapy?**
No Yes If yes, on _______occasions. Longest treatment by _____________ for ____ sessions from ____/_______ to _____/_______
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] **Has any family member had outpatient psychotherapy?** If yes, who/why (list all): ___________________________
No Yes ____

(Continued on next page)

[ ] [ ] **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
No Yes If yes, on ______occasions. Longest treatment at ____________________________ from ___/______ to _____/______
Name of facility Month/Year Month/Year

Facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?** If yes,

No Yes who/why (list all): ____

[ ] [ ] **Prior or current psychotropic medication usage?** If yes:

No Yes

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

[ ] [ ] **Has any family member used psychotropic medications?** If yes, who/what/why (list all): ______________________

No Yes ____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

____

Parents' current marital status:
[ ] married to each other
[ ] separated for ____years
[ ] divorced for ___years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name		
occupation		
education		
general health		

Describe childhood family experience:
[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: __________ **Circumstances:** ______________________________
____
____

Special circumstances in childhood:____
____
____

IMMEDIATE FAMILY

Marital status:
[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___years
[ ] separated for ____years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:
[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List children not living in same household as patient:

Name	Age	Sex	Relationship to patient

Frequency of visitation of above: ____________________

Describe any past or current significant issues in intimate relationships: ____________________

Describe any past or current significant issues in other immediate family relationships: ____________________

MEDICAL HISTORY (check all that apply)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

List name of primary care physician:
Name ____________________ Phone ______________

List name of psychiatrist: (if any):
Name ____________________ Phone ______________

List any medications currently being taken (give dosage & reason):

Is there a history of any of the following in the family:

[ ] tuberculosis
[ ] birth defects
[ ] emotional problems
[ ] behavior problems
[ ] thyroid problems
[ ] cancer
[ ] mental retardation
[ ] heart disease
[ ] high blood pressure
[ ] alcoholism
[ ] drug abuse
[ ] diabetes
[ ] Alzheimer's disease/dementia
[ ] stroke
[ ] other chronic or serious health problems ______________

List any known allergies: ____________________

Describe any serious hospitalization or accidents:

Date ______________ Age ___ Reason ______________
Date ______________ Age ___ Reason ______________
Date ______________ Age ___ Reason ______________
Date ______________ Age ___ Reason ______________

SUBSTANCE USE HISTORY (check all that apply)

Family alcohol/drug abuse history:

[ ] father
[ ] mother
[ ] grandparent(s)
[ ] sibling(s)
[ ] other ________
[ ] stepparent/live-in
[ ] uncle(s)/aunt(s)
[ ] spouse/significant other
[ ] children

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:
(complete all that apply)

Substance	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol	____	____	____	____	____
[ ] amphetamines/speed	____	____	____	____	____
[ ] barbiturates/owners	____	____	____	____	____
[ ] caffeine	____	____	____	____	____
[ ] cocaine	____	____	____	____	____
[ ] crack cocaine	____	____	____	____	____
[ ] hallucinogens (e.g., LSD)	____	____	____	____	____
[ ] inhalants (e.g., glue, gas)	____	____	____	____	____
[ ] marijuana or hashish	____	____	____	____	____
[ ] nicotine/cigarettes	____	____	____	____	____
[ ] PCP	____	____	____	____	____
[ ] prescription ________	____	____	____	____	____
[ ] other________	____	____	____	____	____

Treatment history:

[ ] outpatient (age[s] ________)
[ ] inpatient (age[s] ________)
[ ] 12-step program (age[s]________)
[ ] stopped on own (age[s]________)
[ ] other (age[s] ________
describe:________

Consequences of substance abuse (check all that apply):

[ ] hangovers
[ ] seizures
[ ] blackouts
[ ] overdose
[ ] withdrawal symptoms
[ ] medical conditions
[ ] tolerance changes
[ ] loss of control amount used
[ ] sleep disturbance
[ ] assaults
[ ] suicidal impulse
[ ] relationship conflicts
[ ] binges
[ ] job loss
[ ] arrests
[ ] other ________

DEVELOPMENTAL HISTORY (check all that apply)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications ____
____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age ________)
[ ] German measles (age _____)
[ ] red measles (age ________)
[ ] rheumatic fever (age _____)
[ ] whooping cough (age _____)
[ ] scarlet fever (age ________)
[ ] autism
[ ] ear infections
[ ] lead poising (age ______)
[ ] mumps (age ________)
[ ] diphtheria (age________)
[ ] poliomyelitis (age ______)
[ ] pneumonia (age ______)
[ ] tuberculosis (age ______)
[ ] mental retardation
[ ] asthma
[ ] allergies to ________
[ ] significant injuries ________
[ ] chronic, serious health problems ________
____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other ________
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other ________
____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other ____________________

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level ____________________________________

Describe any other developmental problems or issues: ____

SOCIO-ECONOMIC HISTORY (check all that apply)

Living situation:

[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Employment:

[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: ________________

Financial situation:

[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Social support system:

[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Military history:

[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident
____

Legal history:

[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _________ time(s)
total time served: ____________
describe last legal difficulty: _____
____

Sexual history:

[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _______
[ ] age first pregnancy/fatherhood ___
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ___

Additional information: ______________________________

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): ______________________
____
describe any cultural issues that contribute to current problem: ______
____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: ____________________
____
____

Staff Use ONLY

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ________________

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ________________

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________________