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.

MAILING ADDRESS:

5953 Krim Drive, Atlanta GA 30093

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CLIENT INFORMATION (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 #: _____

Stepping Stones of Atlanta Recovery Residences

www.SteppingStonesofAtl.com

Where are you employed: _____

How long have you worked there:_____Is your job in jeopardy: _____

Employer Contact/Supervisor: _____

Company Address: _____Phone Number: _____

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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

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

NAME OF CLIENT _____ Social Security # Dateof 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 Stones to any specific length of stay at Stepping ~~Stones,~~ 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 **$1100per 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 **$275 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 Yeswho/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
[ ] motherdeceased 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:

Frequency of visitation of above:_____

Describe any past or current significant issues in intimaterelationships: _____

Describe any past or current significant issues in other immediate familyrelationships: _____

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

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)

	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 [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationshipconflicts
[ ] 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
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems ___
[ ] lead poising (age_____)
[ ] mumps (age_____)
[ ] diphtheria (age_____)
[ ] poliomyelitis (age_____)
[ ] pneumonia (age_____)
[ ] tuberculosis (age_____)
[ ] mental retardation
[ ] asthma

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
[ ] extremeworrier
[ ] self-injuriousacts
[ ] impulsive
[ ] easilydistracted
[ ] poorconcentration
[ ] oftensad
[ ] breaksthings
[ ] 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

Social support system:

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

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: _____

Military history:

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

_____ describe any cultural issues that contribute to current problem: _____

Employment:

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

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: _____

_____

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): _____

_____

_____

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: _____

_____

_____

Financial situation:

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

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) _____