Treatment Evaluation Application

Assessor
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Treatment Court Application

Name:		Today's Date:	Date of Birth:
Address you will reside at:			
Social Security Number:		Phone Number:	
Height:	Weight:	Eye Color:	Hair Color:
Email Address:		Attorney's Name:	

Race: ☐ Asian/Pacific Islander ☐ Multi-racial ☐ Black ☐ White ☐ Hispanic ☐ Native American ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Sex: ☐ Male ☐ Female **Gender:** ☐ Male ☐ Female ☐ Non-binary

Do you have access to daily transportation for work/meetings/groups/court? ☐ Yes ☐ No ☐ Unsure

Do you have a valid driver's license? ☐ Yes ☐ No

If yes: Number: _____

If no: ☐ Expired ☐ Suspended ☐ Never had one

Are you able to gain or regain your driver's license at this time? ☐ Yes ☐ No ☐ Unsure

Do you have a safe place to live in which there is no drug use, no criminal activity and no residents on felony probation or parole? ☐ Yes ☐ No ☐ Unsure

Emergency Contact Information

Full Name:	Address:	
Phone Number:	Relationship:	May we contact? ☐ Yes ☐ No

Household Information

(All people who reside in your household. Use back of paper if needed)

Full Name:	Relationship:	
Phone Number:	Criminal Record? ☐ Yes ☐ No	May we contact? ☐ Yes ☐ No

Full Name:	Relationship:	
Phone Number:	Criminal Record? ☐ Yes ☐ No	May we contact? ☐ Yes ☐ No

Full Name:	Relationship:	
Phone Number:	Criminal Record? ☐ Yes ☐ No	May we contact? ☐ Yes ☐ No
Full Name:	Relationship:	
Phone Number:	Criminal Record? ☐ Yes ☐ No	May we contact? ☐ Yes ☐ No

Child Information

(Use back of paper if needed)

Name of child #1:		Name of Other Parent:	
Child's Age and Date of Birth		Child's Address:	
Do you have custody? ☐ Yes ☐ No	Do you have visitation? ☐ Yes ☐ No	Involved with DFCS? ☐ Yes ☐ No	Involved with Legal Battle? ☐ Yes ☐ No

Name of child #2:		Name of Other Parent:	
Child's Age and Date of Birth		Child's Address:	
Do you have custody? ☐ Yes ☐ No	Do you have visitation? ☐ Yes ☐ No	Involved with DFCS? ☐ Yes ☐ No	Involved with Legal Battle? ☐ Yes ☐ No

Parent Information

Mother's Full Name:	Mother's Address:	
Mother's Phone Number:	Criminal Record? ☐ Yes ☐ No	May we contact? ☐ Yes ☐ No

Father's Full Name:	Father's Address:	
Father's Phone Number:	Criminal Record? ☐ Yes ☐ No	May we contact? ☐ Yes ☐ No

Relationship Information

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Live-In Relationship
Are you currently in a relationship? ☐ Yes ☐ No **If yes, complete below:**

Partner's Full Name:		Partner's Address:	
Partner's Date of Birth:		Partner's Phone Number:	
Criminal Record? ☐ Yes ☐ No	Currently on Supervision? ☐ Yes ☐ No	In Recovery? ☐ Yes ☐ No	Addiction of any kind? ☐ Yes ☐ No

Companions/Friends/Social Network

Please list names of people you spend time with:

_____

_____

Education

Highest level of education completed: ☐ 11th Grade or below ☐ GED ☐ High School Graduate

☐ Some Trade School ☐ Trade School Graduate ☐ Some College ☐ College Graduate-2 Year Program

☐ College Graduate-4 Year Program ☐ Some Post Graduate ☐ Advance Degree

Employment

Current Employment Status: ☐ Unemployed ☐ Disabled ☐ Employed Part Time (Less than 35 Hours/Week)

☐ Employed Full Time (More than 35 Hours/Week) ☐ Not in Labor Force (includes if incarcerated) ☐ Retired

☐ Full Time Student ☐ Volunteer

Places of Employment (Use back of paper if needed)

Name Employer:	Phone Number:	Supervisor:	
Position/Duties:	Start Date:	End Date:	May we contact? ☐ Yes ☐ No

Name Employer:	Phone Number:	Supervisor:	
Position/Duties:	Start Date:	End Date:	May we contact? ☐ Yes ☐ No

Name Employer:	Phone Number:	Supervisor:	
Position/Duties:	Start Date:	End Date:	May we contact? ☐ Yes ☐ No

Primary source of support/income: ☐ Disability ☐ Family ☐ Retirement ☐ Salary/Wages (job) ☐ Retired

☐ SSI ☐ SSD ☐ Unemployment ☐ VA Benefits ☐ Welfare ☐ Other

Are you legally eligible for employment? ☐ Yes ☐ No

Have you ever served in a branch of the U.S. Military? ☐ Yes ☐ No

If yes, what branch? _____ **Type of discharge**: _____

Substance Use History:

(List all substances you have experienced with/used. Use back of paper if needed)

Substance/Drug:	Frequency of Use:	Date of Last Use:	Age Started Using:	Drug of Choice
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

1st Drug of Choice	2nd Drug of Choice	3rd Drug of Choice

Current IV Drug User: ☐ Yes ☐ No **History of IV Drug Use:** ☐ Yes ☐ No

Prior Substance Use Treatment

(List all prior Inpatient/Rehab, Halfway House & Outpatient Counseling. Use back of paper if needed)

Name and Location of Treatment Facility	Start Date:	End Date:	Completed:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Prior Substance Use Treatment: ☐ RSAT ☐ DRC ☐ Other: _____
Dates of Treatment: _____

Currently prescribed Medication Assisted Treatment (MAT)? ☐ Yes ☐ No **If yes, complete below:**
Type of MAT: ☐ Suboxone ☐ Subutex ☐ Vivitrol ☐ Methadone ☐ Other

Prescriber: _____ **Length of Time on MAT:** _____

Psychological/Mental Health Diagnosis

(Use back of paper if needed)

Diagnosis	Diagnosing Doctor/Group	Age Diagnosed:

Physical Condition/Medical Diagnosis

(Use back of paper if needed)

Diagnosis	Diagnosing Doctor/Group	Age Diagnosed:

All Current Medications & Over the Counter Supplements

(Use back of paper if needed)

Name of Medication	Purpose	Prescribing Doctor/Group	Dose

Type of Health Insurance: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ None

Health Insurance Provider: _____

Past Criminal Record

(List all Felony and Misdemeanor Offences in the past 10 years. Use the back of this paper if needed)

Offense	Grading	Date	Outcome
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
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	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER
	☐ Misdemeanor ☐ Felony		☐ Jail/Prison ☐ Probation ☐ DRC/Diversion Program ☐ OTHER

Did you use or possess a firearm during any of your offenses? ☐ Yes ☐ No

Did any of your offenses involve violence (physical, domestic violence, assault, etc.)? ☐ Yes ☐ No

Was a minor child present during your current offense? ☐ Yes ☐ No

Have you ever been charged with Drug Delivery or Possession with Intent to Delivery? ☐ Yes ☐ No

Confidential Informant Policy

Confidential Informant Policy: While participating in a Treatment Court Program and/or for the duration of supervision, you may not act as a confidential informant for any law enforcement agencies.

Please check one box only:

☐ I understand and agree to abide by the Confidential Informant Policy

☐ I do not agree to abide by the Confidential Informant Policy

Case Management Needs

Check any area which you will need assistance/help obtaining stability:

☐ Housing ☐ Employment ☐ Food ☐ Insurance ☐ Mental Health Services ☐ Significant Health Needs

☐ "Shut-Off" Notices ☐ Transportation ☐ Family/Children Social Services ☐ Medication

Do you have any trauma, abuse, distress, or loss history? ☐ Yes ☐ No **If yes, explain below:**

Have you ever physically assaulted anyone? ☐ Yes ☐ No **If yes, explain below:**

What do you need to work on in therapy? And do you believe you could benefit from medication for any emotional symptoms?

RELEASE OF INFORMATION ONLY FOR THIS EVALUATION/ASSESSMENT:
I understand I must sign below to allow the application, the results of the evaluation, the recommendations, and any high-risk information to be shared with my legal representation and the judicial team in consideration of this assessment. I understand that any medical or sensitive, private information will never be exploited, but will be shared if required for this process.

By signing, I also acknowledge that I will commit my time and effort to create true life changes if accepted and that I have been truthful, to the best of my knowledge, with regard to all my answers in this application. I understand that in the event I willingly falsify any information on this application, it may be grounds for denial and/or termination from any treatment program.

Signature: _____ Date: _____