

Name: _____ Relationship to patient: _____

Telephone: (Home) _____ (Cell) _____ (Work) _____

Please list all family members, their age and relationship to patient:

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I. Chemical Dependency History

A. Why do you think the patient is seeking treatment at this time? _____

B. Type of mood-altering chemicals used by patient:

Alcohol Amphetamines Opiates Cocaine Marijuana

Hallucinogenics Anti-anxiety Sleeping Pills

Other: _____

C. What is the patient's longest period of sobriety? _____ When? _____

D. Has the patient ever been in treatment before? Yes No

If yes, what kind of program? Inpatient Outpatient Residential

Please list facilities and dates of treatment: _____

E. Did the patient remain sober following treatment? Yes No

If yes, how long? _____

F. Does the patient see a Psychiatrist? Yes No

If yes, please give name: _____

G. Does the patient see a Psychologist/ Therapist? Yes No

If yes, please give name: _____

H. Has the patient been involved in 12- Step Groups? AA NA CA

Other: _____

II. Personal and Social Assessment

A. Do you believe the patient suffers/ has suffered from depression? Yes No

B. Has the patient had any psychiatric hospitalizations? Yes No

C. Do you know what medications are prescribed for the patient? Yes No

If yes, please list: _____

D. Has the patient exhibited any verbal or physical abuse? Yes No

If yes, please explain: _____

E. Has the patient demonstrated any unsafe/ dangerous behaviors? Yes No

If yes, please explain: _____

III. Patient's Family of Origin

- A. Does the patient's family have problems with alcohol or drugs? Yes No
If yes, please explain: _____

- B. How do you see the patient's relationship with:
Mother: _____
Father: _____
Siblings: _____
Spouse: _____
Friends: _____

IV. Sexual

- A. Has the patient ever sexually abused anyone, or been accused of it? Yes No
If yes, please explain: _____

- B. Has there ever been any Child Protective Services involvement? Yes No
If yes, please explain: _____

V. Strengths and Weaknesses

- A. What do you see as the patient's strengths? _____

- B. What do you see as the patient's weaknesses? _____

VI. Legal

- A. Does the patient have a history of legal problems? Yes No
If yes, please explain: _____

- B. Does the patient have any legal issues pending? Yes No
If yes, please explain: _____

VII. Family Psychosocial Addiction History

- A. Have you ever used drugs or alcohol with the patient? Yes No
- B. Do you believe you have a problem with drugs or alcohol? Yes No
- C. Have you ever been treated for an addiction? Yes No
 Alcohol Food Prescribed medications
 Street Drugs Gambling Shopping/spending
 Other: (explain) _____
- D. Have you ever attended: Al-anon Coc-anon Narc-anon CODA
- E. How would you describe your relationship with the patient? _____

- F. Who has the patient's addiction affected? _____

F. **Spouses only**

Have you ever sought Marriage Counseling? Yes No

If yes, please explain: _____

H. Do you have children? Yes No

NAMES	AGES
_____	_____
_____	_____
_____	_____
_____	_____

I. Are any of your children involved with the use of drugs or alcohol? Yes No

If yes, please explain: _____

J. What do you do for leisure as a family? _____

K. What would you like to do as a family in the future? _____

VIII. **Family Concept of Chemical Dependency**

A. How has addiction affected your relationship with the patient? _____

B. What are other concerns or issues in the family? _____

C. Are you willing to participate in the Family Program? Yes No

If not, please explain: _____

C. Which other family members would be willing to participate? _____

IX. **Career**

A. How has addiction affected the patient's job, career, finances? _____

X. **Other**

A. Is there anything else we should know? Yes No

If yes, please explain: _____

Family member/Significant Other Signature: _____ Date: _____ Time: _____

Staff Member Signature: _____ Date: _____ Time: _____