

Program Participant Information

1. Name: *
2. Who referred participant to this program?
3. Date of Birth: *
4. Marital Status: *
 - Single
 - Married
 - Separated
 - Divorced
 - Widowed
 - In a relationship
5. Spouse's name (If applicable):
6. Living arrangement: *
 - Independent (pay all or partial household bill)
 - Dependent (reside with family/friends who pay household bills)
 - Homeless (transitional housing)
7. Address: *
8. Phone number: *
9. Email: *
10. Who currently lives with you? *
11. Length of time at current address: *
12. How many times have you moved in the last 3 years? *
13. Preferred language: *
14. Race/Ethnicity: *
 - Asian
 - African American
 - Caucasian
 - Hispanic/Latino
 - Native American
 - Other
15. Driver's license status:
 - Valid
 - Revoked
 - Suspended
 - Cancelled
 - No driver's license/State ID only
16. Driver's license state and number:
17. Are you interested in receiving information about a hardship license?
18. Transportation status: *
 - Own vehicle
 - Reliable assistance
 - No reliable assistance
19. Emergency Contact Name:
20. Emergency Contact Number:
21. Have you ever served in the United States Military? *
22. If yes, What branch of service?

23. Military discharge date:
24. Reason for discharge:
25. Were you exposed to combat while in the military?
26. Did you witness or have involvement in any casualties while in the military?
27. Indicate any of the following that apply:
- PTSD (Diagnosis of Post Traumatic Stress Disorder)
 - TBI (Occurrence of Traumatic Brain Injury while in the service)
 - IED OR HME (Exposure or Proximity to blasts from an Improvised Explosive Device or Homemade Explosive)
 - MST (Victim of Military Sexual Trauma)
28. Names and DOB's of all children not involved in current case:
- *
-
-

Education and Employment Information:

29. Highest Level of Education:
30. Employment Status: *
- Employed
 - Not Employed
31. Employer Name: *
32. Employer Phone Number:
33. Employer Address:
34. Monthly Net Pay (after taxes):
35. Do you currently pay child support?
36. Is Support Enforcement (DOR) involved?

Medical History:

37. Are you currently pregnant? * Yes No
38. Expected due date: *
39. Doctor's name: *
40. Do you have health insurance? *
41. If yes, which type? *
42. Currently prescribed medications? *
43. If yes, the condition is: *
- Physical
 - Psychological
 - Both

44. Please list all current medications: _____

45. Mental Health Disorders or concerns:

46. Physical Health Disorders or concerns:

47. Do you have a Medical Marijuana card? *

48. Are you interested in Medically Assisted Treatment if deemed medically appropriate? *

49. Have you ever received any kind of mental health counseling/ therapy/treatment? *

50. What kind of traumas have you endured? _____

Substance Abuse History:

51. Substance Abuse History: *

	Primary Drug of Choice	Secondary Drug of Choice	Have use in my lifetime
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Cannabinoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids/Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine (Special K/PCP/DXM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salvia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Spice"-Synthetic Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Bath Salts"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Kratom"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MDPV "Mollys"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD/Mescaline/Psilocybin (Mushrooms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MDMA (Ecstasy/Rohypnol/GHB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RX Stimulants (Adderall/Ritalin/etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RX Depressants (Xanax/Qualude, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RX Opioids (Oxy, Roxy, Lortab etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. What is your drug of choice?

53. How old were you when you first tried alcohol? *

54. How old were you when you first tried drugs? *

55. When was your last use? *

56. Have you ever injected substances? *

57. Have you ever been treated for substance abuse through pharmacological interventions such as Methadone Treatment? *

58. Have you ever received substance misuse treatment? *

59. If so, list dates and where treatment took place:

60. Did you successfully complete treatment?

Legal History:

61. Have you ever been convicted of a crime? *

62. If yes, list the charges and approximate dates?

63. Are you currently on any kind of probation or contract with the court?

64. If yes, list the charges and your Probation officer's or Community Control officer's name.

65. Have you ever been involved with the Department of Children & Families prior to the current case?

66. If yes, list dates and reasons for involvement.

67. Have you ever participated in a Problem-Solving Court program before this current case?

68. Is there anything else you would like to share or think we should know about?

