Capstone Treatment Center
Profile Sheet

Name:_____ Case #:_____DOA:_____TOA:_____

DOB:_____ Age:_____Race:_____ SSN:_____ Therapist:_____

Address 1:_____

Address 2:_____

Email Address 1:_____

Email Address 2:_____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

Work Phone:_____ Work Phone:_____

Name and Relationship of Legal Guardian:_____

Billing Address if Different from above:_____

How were you referred to Capstone: _____

1. DOC:_____ Age at 1st use:_____ Route:_____ Frequency:_____ Last use:_____
2. DOC:_____ Age at 1st use:_____ Route:_____ Frequency:_____ Last use:_____
3. DOC:_____ Age at 1st use:_____ Route:_____ Frequency:_____ Last use:_____
4. DOC:_____ Age at 1st use:_____ Route:_____ Frequency:_____ Last use:_____
5. DOC:_____ Age at 1st use:_____ Route:_____ Frequency:_____ Last use:_____

DSM: Code Name of Disorder Specifier

Axis I: _____

_____

_____

_____

Axis II: _____

_____

Axis III:_____

_____

Axis IV:_____

_____

_____

_____

Axis V: Current GAF:_____ Highest GAF in the past 12 months:_____

Discharge

Type:_____ Days in Treatment:_____ Date:_____

Reason for Discharge:_____

Hours: Group_____ Individual_____ Family_____ Phone_____ Adventure_____ Aftercare_____

Discharge GAF: _____

ADMISSION AGREEMENT

_____ is being admitted to Capstone Treatment Center, Inc. on _____ for an evaluation period for the following reasons, but not limited to: (check appropriate spaces) _____Family Conflict; _____ Substance Abuse/Dependency; _____Parent/Child Relationship Problems; _____Adjustment Disorder; _____Anger Management; _____Depression; _____Oppositional Defiance; _____other.

I, _____, understand that he will be evaluated monthly for appropriateness of placement. If at any time it is determined that he has been inappropriately placed at Capstone Treatment Center, he is subject to discharge. In the event of discharge, Capstone shall comply with regulatory requirements on advance notice to parents.

Continued placement will be determined on the basis of, but limited to:

- Hospitalization beyond 10 calendar days
- The cost for care for the resident becomes prohibitive
- Family or legal guardian does not consent to the course of treatment recommended by Capstone Treatment Center
- Placement is no longer appropriate

I understand the above statements and agree to the terms outlined.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

_____ _____
Resident Date

_____ _____
Witness Date

NOTICE TO RESIDENT CONCERNING CONFIDENTIALTY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by Capstone Treatment Center, Inc. is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1) The patient consents in writing; OR
2) The disclosure is allowed by a court order; OR
3) The disclosure is made by medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
4) The patient commits or threatens to commit a crime either at the program against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(see 42 USC Sections 290dd-22 for Federal laws and
42 CFR Part 2 for Federal regulations)

I acknowledge receipt of the Notice.

_____ _____

Date Signature of Resident

_____

Signature of Parent

_____

Signature of Parent

Understanding of Mandated Reporters

I/we understand that all Capstone employees are mandated child abuse and neglect reporters. In the case of abuse or neglect disclosure they must contact appropriate authorities.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

_____ _____
Signature of Resident Date

CAPSTONE TREATMENT CENTER, INC.
RELEASE AND WAIVER OF LIABILITY

KNOW ALL MEN BY THESE PRESENTS:

All residents of Capstone Treatment Center, Inc. (collectively, with its owners, directors, officers, employees, representatives and/or agents, referred to herein as "Capstone") will be actively involved in activities at various locations that may be dangerous and that may involve an inherent risk of physical injury, illness or death. These activities include, but are not limited to, participating in a ropes course, weight lifting, canoeing, hiking, trekking, mountaineering, rappelling, rock climbing, solo time in the wilderness, backpacking, swimming, fishing, and various other activities.

This Release and Waiver of Liability is provided as a condition of enrollment as a resident at Capstone Treatment Center, Inc. Acceptance as a resident at Capstone is the sole compensation for this Release and Waiver of Liability.

Without limitation of the causes of physical injury, the undersigned acknowledges that the inherent danger of participation in activities at Capstone can include, but is not limited to: falls; cold weather related injuries such as frostbite and hypothermia; heart related injuries such as heat exhaustion and heat stroke; acts of nature which may include, among other things, cave-ins, rock slides, high winds, crevice falls, severe weather, hail and lightning; river crossings, fording, or travel including travel to and from activities; risks associated with crossing, climbing or down-climbing rocks and mountains; risks associated with canoeing and water sports; risks such as muscle strain, stress fracture, other fractures and tears, associated with weight lifting, ropes course participation, and other activities; and equipment failure.

The undersigned acknowledges that certain foreseeable and unforeseeable events may contribute to the unpredictability of any activity. The undersigned acknowledges that personal property may be lost, and that he may suffer an accident or illness in remote places where there is no medical facility immediately available, and acknowledges that wearing a helmet, wearing appropriate clothing, and following safety instructions provided by Capstone are basic safety precautions. The undersigned further acknowledges that he will comply with any safety precautions required by Capstone, but that such precautions may not adequately protect him against all risks of injury, illness or death.

By enrolling as a resident at Capstone and signing below, you acknowledge that (i) these risks have been adequately explained to you, (ii) you comprehend and appreciate the nature of these risks, (iii) you understand and have voluntarily consented to accept these risks, and (iv) you hereby forever release, waive, acquit, discharge, and covenant to indemnify, defend and hold harmless Capstone from and against all actions, rights, and causes of action, expenses, costs, claims and demands whatsoever that may exist or hereafter accrue against Capstone and any other person, corporation, association or partnership who or which may be charged with responsibility for injuries to the undersigned person, the treatment thereof, and all consequences flowing there from, as a result of participation in any activity at any property or location while a resident at Capstone Treatment Center, Inc. The foregoing waiver, release and indemnity shall also apply with respect to any injury, illness or death resulting from the undersigned's receipt of medical care with respect to any injury or illness occurring through participation in the activities that are the subject to this Release and Waiver of Liability.

As a potential participant in actives during the course of your treatment by Capstone Treatment Center, Inc., you have the right to ask to see the safety record and know of accidents and incidents of past residents at Capstone Treatment Center, Inc.

Initial_____

The undersigned warrants that no promise or inducement has been offered for this Release and Waiver of Liability except as set out herein; that the undersigned is of legal age (or signature of a responsible adult parent or guardian accompanies his signature) and is competent to sign this Release and Waiver of Liability, and he accepts full responsibility therefore.

Witness my hand this _____ day of _____, 20____.

_____
Signature of resident

_____
Signature of Witness

PARENT/GUARDIAN RELEASE AND WAIVER OF LIABILITY

I/We, the undersigned parent(s) or legal guardian(s) of _____, a minor, acknowledge that we have read the forgoing Release and Waiver of Liability, that we agree with the provisions set out therein in all respects, and that we acknowledge receipt of valuable consideration for this release, that being the acceptance of the identified minor as a resident at Capstone Treatment Center, Inc.

I/We forever release, waive, acquit, discharge, and covenant to indemnify, defend and hold harmless Capstone and any other person, form or corporation charged or chargeable with responsibility or liability, from any and all claims, demands, damages, costs, expenses, actions and causes of action, belonging to the said minor or the undersigned arising out of participation in any activity while a resident of Capstone Treatment Center, Inc.

The undersigned further agree that this Release and Waiver of Liability shall apply to all known and unknown and unanticipated injuries and damages directly and indirectly resulting from the identified minor's participation as a resident at Capstone Treatment Center, Inc. and/or his participation in activities during his course of treatment through Capstone Treatment Center, Inc.

Witness our hand(s) this _____ day of _____, 20_____.

_____
Name and Relationship

_____
Name and Relationship

_____
Witness

Suicidal Threat Policy

In the event of any suicidal threats, the resident will be isolated from the other residents. At that time the resident will be assessed by a Capstone therapist to determine he severity of the threat. The executive and clinical director will be contacted and included in this decision making. If the resident ranks high enough on the self-harm scale a referral will be made to Baptist Recover Teen in Little Rock, AR. The resident will then be transported to Baptist with two male staff members. If Baptist doesn't have openings then another psychiatric facility will be contacted. The parents will be contacted during this process and will be updated on new happenings. At the end of their stay at the psychiatric facility, the resident will be reassessed for appropriateness of treatment at Capstone Treatment Center. It is Capstone's hope that the resident return for completion of treatment here. However, if it is determined that the resident does not need to return to Capstone, the therapy team will assist the family in further planning.

I understand the above policy on Capstone Treatment Center's suicide threat policy.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

Client Legal And Human Rights

1. No hidden cameras or audio/visual techniques (i.e. one way mirrors, or hidden cameras) are used. Cameras are utilized in the residential programs for client protection and security. A photograph will be taken by admissions personnel and kept in each client's file for identification purposes only.

2. The client's presence in treatment will be kept confidential except when the client has given written authorization to release information or in the event of that emergency information must be released. Internal access to files is limited to the clinical and administrative staff of the program. External access to files is limited to the program's certification site visit review and information must be released if subpoenaed by the court and a ruling of "good cause" is issued.

3. Each client has the right to see his or her clinical record in the presence of the Clinical Director. A written request stating the reasons for the request is required. The request should be submitted to the client's counselor, then given to the Clinical Director who will schedule a time for review of the record.

4. Client's with grievances may make an appointment to discuss the grievance with the program manager. If the Manager's decision has not resolved the grievance, a written appeal to the Clinical Director should be submitted. The Clinical Director's decision will be final and given to the client in writing.

5. The program will use proven techniques to assist with drug or alcohol problems. No drugs, other than those specifically prescribed by a physician, or over the counter medications approved by the nursing staff, will be used by the client.

6. Capstone Treatment Center is an equal opportunity organization and promotes a strong non-discrimination policy in all aspects of the program

7. The client will receive treatment and care for drug related problems in a safe and humane environment.

8. The client will be informed of the need for parental or guardian consent for treatment, if appropriate.

9. The client will be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatment, services and types of providers of substance abuse services.

10. Informed consent will be received prior to being involved in research projects.

11. The client will manage personal financial affairs, unless legally determined otherwise.

12. The client will actively participate in treatment, including discharge planning, as appropriate.

13. Every reasonable and appropriate effort will be made for the client's overall safety and protection.

14. The client will receive the least restrictive treatment that is appropriate and available. Clients will also have the right to refuse treatment. If this occurs, the client will be informed of other appropriate substance abuse providers from which they may seek services.

15. Any cases of suspected abuse, neglect, exploitation of clients, regardless of age, being served in the program where the alleged perpetrator is an employee, client, or other person in the program will be reported to the local DHR office and SADS Director's office in accordance with applicable State law and DMH/MR abuse reporting procedures.

16. The client will be informed of the financial aspects and obligations of treatment.\

17. The client will have the right to refuse procedures deemed invasive such as blood screens, body searches, and searches of personal belongings. However, the client may be subject to discharge from the program due to concerns for safety of the client and others for search refusal.

_____ Date: _____/_____/_____
Client Signature

_____ Date: _____/_____/_____
Parent/Guardian Signature

_____ Date: _____/_____/_____
Parent/Guardian Signature

_____ Date: _____/_____/_____
Witness Signature

Capstone Treatment Center, Inc.
120 Meghan Lane
Judsonia, AR 72081
(501) 729-4479

FEE PAYMENT AGREEMENT AND SCHEDULE OF RATES AND CHARGES

Name of Resident:_____ Date:_____

Charges for services to the Resident are calculated as follows:

1. Treatment is provided at $400 per day. The average stay is 3-3 ½ months, but the actual term of treatment could be more or less than the average.
2. In addition to the daily rate, the responsible party agrees to pay a one time fee of $400 for the Wilderness Equipment.
3. Any additional costs for resident are due upon receipt (Medications, Nicotine supplements, etc.)

I/We understand that the cost of treatment, as set out above, is based on the daily rate charged per day during the treatment. Payments of the program fees are scheduled as follows:

1.	Payment due upon admission:	$12,000.00 plus $400 Wilderness Fee
2.	Payment due on 31st day of treatment	$12,000.00
3.	Payment due on 61st day of treatment	$12,000.00
3.	Payment due Monday of Family Retreat	Balance on account

In the event of discharge for any reason before completion of the program, the entire balance shall be due immediately upon discharge, based upon the daily rate. If payment is not made in full at discharge, the responsible party must sign a promissory note for the balance, which shall include a specific payment schedule. $1,500 shall be charged as an early withdrawal penalty for any resident not completing the program, in addition to all other scheduled fees and charges.

I/We, the undersigned resident and/or responsible party, understand that the fees are due on the schedule set out herein, and that past due accounts shall bear interest at the rate of 10% per annum. **ALL PAYMENTS ARE DUE FROM THE RESPONSIBLE PARTY. CAPSTONE WILL ASSIST YOU TO BE REIMBURSED BY INSURANCE, WHERE APPROPRIATE, AT THE COMPLETION OF THE PROGRAM. CAPSTONE DOES NOT RELY ON ANY INSURANCE PROGRAM FOR PAYMENT. PAYMENTS ARE THE RESPONSIBILITY OF THE UNDERSIGNED RESPONSIBLE PARTY.** In the event collection is required, I/We agree to pay all costs of collection, including litigation costs, and legal fees (legal fees not to exceed 10% of the balance to be collected). I/We also understand that, in addition to collection action, failure to pay as required and/or make reasonable arrangements acceptable to Capstone Treatment Center, Inc. to pay for services may result in dismissal from the program.

I/We understand that Capstone Treatment Center, Inc. will assist the undersigned in filing for benefits available to be reimbursed to us from any insurance plan at the conclusion of the program, but that I/We, the undersigned, are liable for the amounts and on the schedule and terms as set out above, without regard to any insurance payment. I/We acknowledge that Capstone Treatment Center, Inc. has no control over the amount of payment or terms of approval of insurance companies, and that I/We are not relying on insurance to pay the cost of this program.

_____ _____
Signature of responsible party Signature of responsible party

_____ _____
Social Security number Social Security number

Address:_____ Address:_____
_____ _____
_____ _____
Telephone: (___)_____ Telephone: (___)_____

Acknowledgement of Understanding of the Scheduling Policy

During the admission process the scheduling policy was gone over with me. It was stated that there are certain readiness criteria in order to go on Adventure Week and to graduate for the program successfully. Three to three and a half is the estimated length of stay. Adventure Week and graduation dates are contingent on my son and our family's readiness and if we are not ready, those dates could change. Scheduling is also worked around other families, staff, and holidays.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

_____ _____

Signature of Resident Date

Consent for Medications and Supplements

I/We, _____, give my/our permission for Capstone Treatment Center to administer supplements to my/our son, _____. This includes daily vitamins, weight gain and protein supplements, over the counter medication for allergies, pain, and illness, and supplements for sleep problems. I/We understand that Capstone Treatment Center will inform me/us if my/our son begins taking these on a regular basis and I/we will be charged for it. I/we understand that I/we will not be notified about medication or supplements that are administered on a need to have basis.

_____ _____
Signature Date

_____ _____
Signature Date

If my/our son is in need of a refill of an existing medication or is prescribed a medication for illness while at Capstone, I/we would prefer the following:

Please check one:

_____ to be notified, fill it at my/our home pharmacy and then mail it to Capstone.

_____ have it filled at Searcy Medical Center Pharmacy where my/our insurance will be billed and then I/we will be billed the co-pay or uncovered charges by SMC Pharmacy..

_____ have it filled at Walgreens where I/we have an Express Pay account set up or will set it up to be automatically charged by Walgreens for the co-pays.

_____ have it filled at Wal-Mart where I/we have an account set up or will set up an account to be automatically charged by Wal-Mart for the co-pays.

I give my permission for Capstone to release our insurance and billing information to the pharmacies listed above.

_____ _____
Signature Date

_____ _____
Signature Date

MAIL WAIVER

I/We, _____ release Capstone Treatment Center to screen my/our child's incoming and outgoing mail. I/We will make a list of approved persons. If mail is received from or sent to people other than those listed below, I/we understand that I/we will be contacted by Capstone. If that mail is not approved it will be held at Capstone and not given to my/our son.

_____
Parent

_____
Parent

_____
Witness

_____
Date

List of Approved Persons (Family and Family friends ONLY; No peers)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

Phone Policy

Basic Guidelines and Procedures

- Residents are allotted a total of 20 minutes of talk time per week (10 minutes each on Monday or Tuesday and Friday).
- Residents are only allowed to call numbers that have been approved on the list below. This list must be family ONLY.
- A resident must have resided at Capstone for one week before making a phone call.
- Residents must always be monitored while talking on the phone.
- The monitor of the phone call must dial the number, get the approved party on the line and enforce the 10-minute rule.
- The monitor must fill out the phone log and use the staff notes section to record any unusual activity or conversations. (When in doubt, document!!)

Approved Person(s)	Phone Number

HEALTH INSURANCE AUTHORIZATION FORM

CAPSTONE TREATMENT CENTER

_____

(CLIENT/RESIDENT)

In cases where the resident is covered for the cost of care and treatment, under an insurance plan, either his own or under that is the responsible person; it is necessary to obtain the signature of the policyholder on the following authorization before a claim may be submitted for payment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above treatment center to release medical information necessary to process this claim.

Date:_____ Signature:_____

_____

Please answer the following questions to the best of your ability.

Insured's Name:_____

Insured's Social Security Number:_____

Insured's Group Name:_____ Group #: _____

Insured's Employer:_____

Insured's Date of Birth:_____

If resident has other health insurance, health plan, or state assistance, enter its name, address, and policy or medical assistance number here:

_____
_____
_____
_____
_____
_____

***Please send/make a copy of the front and back of all insurance cards.

Acknowledgement of Physical Examinations and Medications

I understand that my/our son, _____, is required to have a physical examination, including a blood work-up for STD's and HIV, in order to participate fully in the Capstone Treatment Center program. I also understand that in the case of my/our son needing medication it will be filled at Searcy Medical Center Pharmacy.

I am fully aware and understand that I am responsible for payment of all expenses incurred by the physical and blood work not paid by my insurance company.

I am fully aware and understand that I am responsible for payment of all expenses incurred by medications filled at Searcy Medical Center Pharmacy not paid by my insurance company.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

CAPSTONE TREATMENT CENTER

P.O. Box 8241
Searcy, AR 72145

Authorization for Searcy Medical Center Treatment

Patient Name:_____

DOB:_____

Parent Name and Address:_____

_____

_____

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____

Insurance Information:

Company:_____

Policy Number:_____

Capstone Official authorizing treatment:_____

Resident Signature:_____

HIV/STD TESTING

I, _____ give my

permission to be tested for HIV/STD through Dr. Joe Dugger's office at Searcy Medical Center.

Please have results released to Capstone Treatment Center.

_____	_____
Parent Signature	Date
_____	_____
Parent Signature	Date
_____	_____
Resident Signature	Date
_____	_____
Witness Signature	Date

Education Assessment

(Only to be completed if resident is currently in school or will be doing school while in treatment)

Student Name:_____ Date of Birth:_____
Name of Parent/Guardian:_____
_____
Address:_____
_____
Email:_____
Home Phone:_____ Work Phone:_____
Current Grade Level:_____

Name and Address of School Last Attended:
_____
_____
_____

List all classes currently enrolled:
_____
_____
_____
_____

List any learning disabilities:
_____
_____

Does your son have an IEP? Circle one: Yes No

List any medical conditions:
_____
_____

List any medications:
_____
_____

Please give a brief school history:
_____
_____
_____
_____
_____

Please list educational goals for resident at Capstone:
_____
_____
_____
_____
_____

FAMILY INFORMATION FORM

Date: _____

Resident's name: _____

Parent's/Guardian's Name (s):_____

_____

Address: _____

_____

How long have you lived at this address? _____

(Mother) Birth date: _____ Place: _____

Occupation: _____Education: _____

Employer: _____

Length of Employment: _____ Unemployed: _____ How long? _____

Relationship to patient: _____

(Father) Birth date: _____ Place:_____

Occupation: _____Education: _____

Employer: _____

Length of Employment: _____ Unemployed: _____ How long? _____

Relationship to patient: _____

Questions:

Are you currently receiving any counseling and/or psychotherapy?

_____

Agency Name: _____

Are you now, or have you ever been involved in any self-help, 12-step or recovery program? _____

If so, please name: _____

_____

Religion: _____ What are the religious/spiritual practices of the family?

_____

_____

Are you aware of any involvement by your son in cults, etc.? _____

If so, please elaborate: _____

_____

Are you aware of any physical or sexual abuse?_____

_____

_____

Do you have a friend or relative who is recovering or struggling from alcoholism or chemical dependency?_____

_____

What is another major concern in your life right now, besides your child's chemical use:

_____

_____

_____

Who are the people living in your household?

Name	Relationship	Age/DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your present marital status? ____ Married ____ Single ____ Divorced ____ Widow/Widower

If married, date married: _____

If previously married, date(s) of marriage: _____

If spouse deceased, date of death: _____ Cause: _____

Names and birthdates of children outside your household:

_____

_____

_____

Is your child adopted? _____ Age at adoption:_____ Contact w/ birth parents?_____

_____

Is there a family member with whom your child has significant conflicts? _____

If yes, who? _____

How is your child disciplined and who does it?_____

_____

Are there any losses which have impacted your child? _____

_____

_____

List any medical conditions (cancer, diabetes, high blood pressure, etc.) of parent/child or blood relative and state relationship.

_____

_____

_____

_____

_____

Are you currently taking any medication? _____ If so, what medication? _____

_____

_____

Do you ever wonder about taking too many medications? _____

Do you ever question your own drinking or chemical use? _____

Do you ever question the use of alcohol or other drugs by some in your family? _____

Who?_____

_____

Questions regarding son's usage:

What is the problem with your son as you see it? (Check all that apply)

_____ Alcohol

_____ Prescription medications

_____ Cocaine

_____ Marijuana

_____ Methamphetamine

_____ Ecstasy

_____ Over-the-Counter medications

_____ Other drugs (please specify)_____

_____

Adolescent Awareness of Problem:

_____ No Awareness: "No Problem, I'm no worse than my friends, everybody's doing it".

_____ Minimal Awareness: "I can take it or leave it; I'm not too bad."

_____ Moderate Awareness: "It's not my fault." "Sometimes I get into trouble too much."

_____ Admits to Problem: "I can't help it." "Something is bothering me."

_____ Well aware of problem and accepts responsibility for change

How long do you believe the problem has existed?

_____ Less than a year

_____ 1 to 3 years

_____ 3 to 6 years

_____ 6 to 10 years

What other problems are you aware of that are related to the alcohol/drug problems in your son? (Check all that apply)

_____ School problems

_____ Legal problems

_____ Health problems

_____ Emotional problems

_____ Financial problems

_____ Peer relationship problems (friends)

_____ Family relationship problems

_____ Job/Occupational problems

_____ Other _____

Comments: _____

_____

_____

To the best of your knowledge, has the your son ever experienced any of the following because of the drug and/or alcohol use?

_____ Blackouts (a loss of memory without loss of consciousness)

_____ Arrests (Please describe) _____

_____

_____ School expulsion (Please describe) _____

_____

_____ Aggressive or abusive behavior (please describe) _____

_____

_____ Alibis for drinking (i.e. “All my friends drink.)

_____ Irresponsible; can’t predict what they will say or do.

_____ Memory problems

_____ Changes eating habits

_____ Loss or change in friends

_____ Personality change (describe) _____

_____

To the best of your knowledge, what is the longest period the patient has been drug and alcohol free since the problem began?

_____ Absolutely don't know

_____ Probably uses each day

_____ Probably a few days at a time

_____ Probably weeks at a time

Why do you think your child has sought treatment at this time?

_____ Felt problem was serious and treatment was needed

_____ To comply with someone else's wishes

_____ To avoid consequences of recent behavior

_____ To salvage school grades or job

What previous attempts at treatment have been tried?

Place	Name and Dates	Outcome
General Hospital	_____	_____
Alcohol/Drug Treatment Center	_____	_____
Detoxification	_____	_____
Alcoholics Anonymous	_____	_____
Narcotics Anonymous	_____	_____
Psychiatric Treatment Center	_____	_____
Out-Patient Counseling	_____	_____
Intensive Out-Patient	_____	_____
Other _____	_____	_____

Please answer the following True or False	True	False
1. Stress at work or family pressure makes people chemically dependent.	_____	_____
2. Families must not upset chemically dependent members in treatment in case they might start them drinking or taking drugs again.	_____	_____
3. Only people who lack willpower and determination become chemically dependent.	_____	_____
4. Once chemically dependent people get help and stop drinking and/or using drugs, those close to them are okay.	_____	_____
5. Families of chemically dependent find it just as difficult to accept this diagnosis as the addicted person.	_____	_____