

Treatment Services

Accountability Courts Participant Intake Form Date:

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| **Participant Information** | | | | | | |
| Name (First, Middle, Last, & Maiden): | DOB: | | | | | |
| Social Security Number: | Gender: | | | | | |
| Eye Color: | Hair Color: | | | | | |
| Height: | Weight: | | | | | |
| Ethnicity/Race: | Place of Birth (City & State): | | | | | |
| Are you a U.S. citizen? Yes No | Preferred Language: | | | | | |
| Preferred Religion: | Email Address: | | | | | |
| Home Phone Number: | Cell Phone: | | | | | |
| Sexual Orientation (Circle one): Homosexual Heterosexual Asexual Bisexual Other | | | | | | |
| Alias (other names or nick names): | | | | | | |
| Driver’s License State/Number: | | Driver’s License Issue Date: \_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_ | | | | |
| Is your driver’s license currently suspended? If yes, why? | | Do you have a limited permit? Yes No | | | | |
| **Residential Status** | | | | | | |
| **Housing status (circle one):** Own Rent Live with family Homeless Staying at a shelter Staying on someone’s couch Rehab Facility or Supervised Housing Section 8 Housing Supported Apartments | | | | | | |
| Address: | | | City/State/Zip: | | | |
| How long have you lived at the address above? | | | | | | |
| **Education Information** | | | | | | |
| Name of High School attended & graduation year: | | | | If you did not graduate high school, what is the highest grade level you completed? Year: | | |
| Do you have a GED? Yes or No. If yes, name of institution you received your GED and year you received your GED: | | | | | | |
| Did you attend college/technical school? Yes or No | | | | | | |
| Name of college or technical school: | | | | Did you graduate? Yes or No. If yes, what year? | | |
| **Relationship Status** | | | | | | |
| Marital Status: Single Married Separated Divorced Serious Relationship Widowed  Date of marriage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Date of Separation: \_\_\_\_\_\_\_\_\_\_ / Date of Divorce: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Spouses Name: Address: Phone Number: | | | | | | |
| **Dependents** | | | | | | |
| How many children do you have? | | | | | | |
| Gender and DOB of children:  Child #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Do you have custody of your children: Yes or No. If no, who has custody?  Child #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Is there any open DFCS case involving your children: Yes or No. If yes, what county is your DFCS case?  What is your case mangers name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your case number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Employment/Income Information** | | | | | | |
| Employment Status (circle one): Unemployed Employed Disabled Retired | | | | | | |
| Status start date (when did this status begin): | | | | | | |
| If employed, what is your employment type (circle one)? Full time Part time Volunteer Temporary | | | | | | |
| Name of employer: | | | | | | |
| What is your profession/ current position? | | | | | | |
| How many hours per week do you work? | | | | | | |
| What is your hourly rate or weekly pay? | | | | | | |
| Do you receive any of the following (circle all that apply): Food Stamps Unemployment TANF WIC Social Security Disability VA Benefits | | | | | | |
| If receiving disability, when did you start receiving benefits and what are you receiving disability for? | | | | | | |
| How much do you receive each month in disability benefits? | | | | | | |
| If receiving Food Stamps, Unemployment, TANF, or WIC, when did you start receiving these benefits and how much do you receive each month? | | | | | | |
| Do you pay child support? Yes or No  If yes, what is your court ordered monthly obligation?  If yes, are you behind on child support payments? If so, how much? | | | | | | |
| Do you receive child support? Yes or No. If yes, how much do you receive a month? | | | | | | |
| **Military Information** | | | | | | |
| Have you ever served in the Armed Forces? Yes No | | | | | | Branch of service? |
| Enlistment date: | | | | | | Discharge date: |
| Highest rank received: | | | | | | Discharge type: |
| MOS/Job Assignment: | | | | | | Total deployments: |
| Discharge reason: | | | | | Combat exposure? Yes No | |
| Are you eligible for VA benefits? Yes No Unsure | | | | | Conflict Type: | |
| Do you receive service connected benefits from the VA? Yes No | | | | | | |
| What percentage of disability do you receive? | | | | | | |
| Have you experienced any of the following (circle all that apply)?  PTSD Sexual Trauma IED Exposure Traumatic Brain Injury | | | | | | |
| List any medals/awards you received: | | | | | | |
| **Medical Information** | | | | | | |
| Have you ever been or are you currently receiving treatment for mental health issues? Yes No | | | | | | |
| If yes, where? | | | | | | |
| List any mental health diagnosis that you have received from a doctor: | | | | | | |
| List any medications you are currently taking: | | | | | | |
| Name of prescribing doctor: | | | | | | |
| How long have you been taking these medications? | | | | | | |
| Are you currently pregnant? Yes No | | | | | | |
| What is your first drug of choice? Age of first use: Date of last use: | | | | | | |
| What is your second drug of choice? Age of first use: Date of last use: | | | | | | |
| What is your third drug of choice? Age of first use: Date of last use: | | | | | | |
| How often were you using your first drug choice? Daily Weekly Monthly Route:  How often were you using your second drug choice? Daily Weekly Monthly Route:  How often were you using your first third choice? Daily Weekly Monthly Route: | | | | | | |
| Have you ever experienced any of the following (circle all that apply): Tremors, Delirium, Overdose, Blackouts, Intravenous (IV) Use | | | | | | |
| Does anyone in your family abuse drugs or alcohol? Yes No | | | | | | |
| How many times have you been in treatment for substance use prior to this program? | | | | | | |
| What kind of treatment (circle all that apply)? Inpatient Outpatient Rehab  Dates of treatment?  How long was that treatment? | | | | | | |
| **Legal Information** | | | | | | |
| Are you currently on misdemeanor probation? Yes or No. If yes, answer the following:  What county are on probation in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Probation Officer’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What are the charges? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When were you placed on probation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When does your probation end? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What are the conditions of your probation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you compliant? Yes or No | | | | | | |
| Are you currently on felony probation in another county? Yes or No  If yes, what’s your Officer’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Do you have any pending charges? If yes, what is the offense and the county/state? | | | | | | |
| Are you currently required to use any of the following (circle all that apply): Interlock GPS Ankle Monitor SCRAM | | | | | | |
| Are you need of resources? (Example: food, clothing, bus passes, job leads, child care etc.) | | | | | | |