

Name: _____
(please print)

[rev.07/01/08]

Please answer the following questions (front and back of page) as accurately as possible.

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|----|--|-----|----|
| 1 | Have you ever had a problem with your heart, either currently or in the past?
If yes, please explain. | Yes | No |
| 2 | Have you ever had a problem with high blood pressure, either currently or in the past?
If yes, please explain. | Yes | No |
| 3 | Do you have difficulty breathing such as shortness of breath, emphysema or bronchitis?
If yes, please explain. | Yes | No |
| 4 | Have you ever suffered from dizziness or fainting spells? If yes, please explain. | Yes | No |
| 5 | Have you ever been told you have a problem with your liver or pancreas?
If yes, please explain. | Yes | No |
| 6 | Have you ever suffered from withdrawal symptoms (e.g., sweating, headaches, nausea, shaking)?
If yes, please explain. | Yes | No |
| 7 | Have you ever been in detox? If yes, please list where and when. | Yes | No |
| 8 | Have you ever been in an alcohol or drug treatment program?
If yes, please list where, when and type of program. | Yes | No |
| 9 | Have you ever suffered a seizure? If yes, please explain.

If yes, was it alcohol related? | Yes | No |
| 10 | Have you ever been diagnosed with anxiety or depression? If yes, please explain. | Yes | No |
| 11 | Do you think you may suffer from anxiety or depression? If yes, please explain. | Yes | No |
| 12 | Have you ever been diagnosed with any psychological problems? If yes, please explain. | Yes | No |
| 13 | Do you or have you ever had thoughts of suicide? If yes, please explain. | Yes | No |
| 14 | Have you ever attempted suicide? If yes, please explain. | Yes | No |
| 15 | Are you currently seeing a psychiatrist, psychologist or counselor?
If yes, please list name(s), reason for seeing them and length of time you have been seeing them. | Yes | No |
| 16 | Have you seen a psychiatrist, psychologist or counselor in the past?
If yes, please list name(s), reason for seeing them and length of time you saw them. | Yes | No |
| 17 | Have you ever suffered from any type of head trauma? If yes, please explain. | Yes | No |
| 18 | Do you have any type of eating disorder? If yes, please explain. | Yes | No |
| 19 | Do you have any problem with your teeth? If yes, please explain. | Yes | No |

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|----|--|-----|----|
| 20 | Do you smoke? If yes, how much? For how long? | Yes | No |
| | Do you have the desire to quit? If yes, please explain. | Yes | No |
| 21 | Do you have any learning disabilities? If yes, please explain. | Yes | No |
| 22 | Have you ever had any type of major surgery? If yes, please explain. | Yes | No |
| 23 | Have you been hospitalized recently for either physical or psychiatric reasons? If yes, please list date(s) and reason(s). | Yes | No |
| 24 | Do you have a regular or primary care physician? If yes, please list name and phone number. | Yes | No |
| | When was the last time you saw a doctor? Please list date and reason. | | |
| 25 | Are you actively involved in aftercare? If yes, please list where and for how long. | Yes | No |
| 26 | Do you have any other medical or psychological problems we should know about? If yes, please explain. | Yes | No |
| 27 | Do you have any medical or psychological problems that you feel would keep you from completing the fourteen day DUII program? If, yes, please explain. | Yes | No |
| 28 | Please write anything else that you feel is important for your counselor to know about you that might be relevant to your treatment at DUII. | | |

For Women Only

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|---|---|-----|----|
| 1 | Do you have any problems with your menstrual cycle (such as irregular or heavy bleeding, missed periods or significant pain)? If yes, please explain. | Yes | No |
| 2 | Have you had a hysterectomy? If yes, please list when and your age at the time. | Yes | No |

Family & Alcohol

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|---|--|----------------------------------|----|
| 1 | Who raised you? If parents were divorced, how old were you? | | |
| 2 | How many brothers and sisters do you have? | | |
| 3 | Is there anyone in your family who has abused alcohol and/or drugs? | | |
| 4 | When was your heaviest period of drinking? List ages, how often and how much.
<i>(e.g., Age 25 - 35, 6 to 10 beers, 3 to 5 times per week.)</i> | | |
| 5 | Describe your most current drinking pattern - how much and how often. What do you drink? | | |
| 6 | Has there ever been a period in your adult life when you did not drink?
If yes, when and for how long? | Yes | No |
| 7 | When was your last drink? | What and how much did you drink? | |

signature of client

date