Southcentral Foundation

DENA A COY CUSTOMER PROFILE AND INTAKE

Name: _____ Date: _____

Maiden: _____ Date of Birth: _____

Marital Status: ☐married ☐living as married ☐widowed ☐separated
☐single (never married) ☐divorced; how long? ____

Race: ☐American Indian ☐Aleut ☐Athabascan ☐Haida ☐Inupiat/Inupiaq ☐Tlingit
☐Tsimshian ☐Yupik ☐Asian ☐Black/African American ☐Caucasian
☐Other Alaska Native ☐Native Hawaiian ☐Other ☐Pacific Islander

Ethnicity: ☐Chicano/other Hispanic ☐Cuban ☐Mexican American ☐Puerto Rican
☐Spanish/Hispanic Latino ☐Not Spanish/Hispanic/Latino/Mexican ☐Unknown

Military: ☐Active Duty; Combat ☐Active Duty; No Combat ☐Military Dependent
☐Never in Military ☐Retired from Military ☐Reserves or National Guard; Combat ☐
Reserves or National Guard; No Combat ☐Other _____

Legal Status: ☐OCS ☐Tribal Court ☐ASAP ☐Probation/Parole ☐Pending Charges
☐Outstanding warrants or cases pending ☐No involvement ☐don't know

Education: Highest grade completed: _____ ☐High School Diploma ☐GED ☐Baccalaureate Degree
☐College; # degree (# of years) _____ ☐Vocational Training Beyond High School
☐Degree/Certificates: _____

Employment: ☐Employed; part-time ☐Employed; full-time ☐Armed Forces ☐Seasonal (now) ☐Seasonal (done)
☐Unemployed; looking ☐Unemployed; not looking ☐Unemployed; disabled ☐Unemployed - Student
☐Homemaker ☐Not in labor force; Retired ☐Not in labor force; Inmate/Resident
☐Not seeking work ☐other

If employed, what type of work? _____

If unemployed, what is the date of your last job? _____

Readiness to Learn:

How do you like to learn? ☐watching ☐reading ☐listening ☐doing

What language is primarily spoken in your home? _____

Do you speak a second language? ☐no ☐yes; if yes, what language? _____

Do you need an Interpreter: ☐no ☐yes

Do you have any Special Needs? (Check all that apply)

☐Diagnosed memory and/or learning disabilities ☐Severe Hearing Loss or Deaf
Do you need auditory aides? _____ ☐hearing aids ☐other _____

☐Visual Impairment or Blind
Do you need visual aids? ☐magnifying glass ☐large print material ☐braille ☐other _____

☐Major Difficulty in Ambulating; physical limitations ☐Diagnosed chronic sleep problems
☐Organic brain disorder ☐Traumatic Brain Injury
☐other _____

How did you hear about this program? Who referred you?

What problem(s) brought you here today? (Check all that apply)

- ☐ Alcohol problems
- ☐ Drug problems
- ☐ Alcohol and Drug problems
- ☐ Legal Problems
- ☐ Domestic Violence
- ☐ Marital/Relationship Problems
- ☐ Family problems (non-marital)
- ☐ Social/Interpersonal (other than family)
- ☐ Other:
- ☐ Psychological/emotional problems
- ☐ Suicide Attempt/Threat
- ☐ Depression
- ☐ Victim of Child Abuse
- ☐ Victim of Sexual Abuse
- ☐ Perpetrator of Sexual Abuse
- ☐ Perpetrator of Child Abuse

What are the goals you would like to achieve to improve your quality of living or recovery environment?

- ☐ Regaining custody of children/parenting issues
- ☐ Social network problem (i.e. drug using friends/acquaintances)
- ☐ Lack of sober, social support
- ☐ Lack of self-esteem, self-confidence, or positive identity
- ☐ Shame and guilt about hurting family or need to make amends
- ☐ Lack of structure and time management skills
- ☐ Lack of stress management skills
- ☐ Education issues
- ☐ Poor communication skills and/or poor conflict management skills
- ☐ Lack of motivation or procrastination
- ☐ Housing, or appropriate place to live
- ☐ Financial concerns or unpaid bills

Family/Social History:

Where were you born? _____ Where were you raised? _____

Where do you live currently? _____

Living arrangement:

- ☐ alone
- ☐ with children
- ☐ with spouse/significant other
- ☐ with parents
- ☐ with other relatives
- ☐ with non-related persons – roommate or friend
- ☐ homeless
- ☐ incarcerated
- ☐ shelter

Where and with whom will you live after completing residential treatment?_____

Are you Pregnant? ☐ no ☐ yes If yes: What is your due date?_____

Do you have children? ☐ yes ☐ no

Please list **all** of your children:

Name	Date of Birth	Where does this child live?

Are you the primary caretaker for any of your children? ☐ yes ☐ no

If yes, have you made arrangements for childcare? ☐ yes ☐ no

How has your alcohol and/or drug use affected your family?

Substance Use:

What is your drug of choice?

When is the last time you used alcohol or other drugs?

Have you ever injected drugs ☐ yes ☐ no

Do you use Tobacco Products ☐ no ☐ cigarettes ☐ smokeless tobacco (chew) ☐ other_____

Have you received substance abuse treatment services in the past 12 months? ☐ no ☐ yes If yes, please where:

What do you think will help you to stay clean and sober/prevent you from relapsing?

List your goal or goals for the future:

Describe your positive qualities or strengths:

Describe your personal challenges or things that make it difficult to reach your goals:

What would you like to gain from treatment that would support your recovery goals?

Spirituality:

During the past month, how would you rate your sense of connectedness, spirituality or relationship with a higher power?

☐ excellent ☐ good/improving ☐ fair/not changing
☐ not good ☐ very bad ☐ other:

How important is spirituality in your life?

☐ very important ☐ somewhat important ☐ not very important
☐ not at all important

How often do you spend time on religious or spiritual practices?

☐ every day or almost every day ☐ several times a month
☐ occasionally ☐ very rarely ☐ not at all

What is your religious affiliation? _____

Is there anything else that you would like us to know about your religious/cultural/spiritual practices?

Community Support:

Are you attending community self-help programs, e.g., AA, NA, etc**.?** ☐yes ☐no
If yes, how many times have you attended in the past 30 days? _____
Do you have a sponsor or mentor in the community? ☐yes ☐ no

How supportive would you say the people closest to you are of your seeking substance abuse treatment at this time?

☐not very supportive ☐somewhat supportive ☐very supportive ☐not supportive or against

Who is your primary support in the community?

Mental health Summary:

Prior mental health treatment history: (Check all that apply)
☐no history ☐counseling ☐medication management ☐hospitalization

Are you currently involved in mental health services? ☐no ☐yes If yes, who/where?

During the past 12 months, did you take any prescription medication that was prescribed to treat a mental health or emotional condition? ☐no ☐yes
If yes, list type and dosage:

Physical Health Summary:

In general how would you describe your current health? ☐excellent ☐very good ☐good ☐fair ☐poor

Have you had any unplanned weight changes in the last 12 months? ☐no ☐yes If yes, please explain:

Do you have nutritional concerns? ☐no ☐yes If yes, please explain:

Do you have a primary medical provider? ☐no ☐yes If yes, who?

If you do not have health benefits, what is your financial plan for prescribed medications?

Do you have any allergies to foods or medications? ☐no ☐yes If yes, list:

Do you have any chronic health or pain issues? ☐no ☐yes If yes, please explain