Hello Welcome and Congratulations.

You have made an extremely important and life changing decision to apply for substance abuse recovery treatment with Dr. Grossman at **YOU Didn't Get "HOOKED" From Breathing!™.**

I am here to help you.

Before we begin with an in person interview to see if and how I can help you and to answer any questions you have about our program, I need to ask you some very important personal questions.

Please know that your answers are strictly confidential. I will not share them with anyone outside this program without your written permission and only with other qualified professionals who have been or will be involved with your care.

Rule number one. I need to know the truth about everything and anything I ask. Please don't be so afraid or ashamed of your answers that they prevent you from telling me the truth, now and in treatment.

I understand shame and fear. I also know that these feelings are normal for people with substance abuse problems coming to see me.

Please know that I can help you if and when I know the truth. Without the truth, we will land up building a treatment plan that addresses the story that you created and we then treat that story you created rather than treating the truth that we need to help you get and remain sober and for the rest of your life. That leads to disrespectful and wasteful failure on both sides.

In addition to my knowing identifying and background information about you, I am looking for medical, psychiatric and psychological problems that need to be addressed as part of your recovery and sobriety. If left untreated, they can and often will undermine our mutual success. We need to identify them now, to see what to do about them before I work with you; before I help you develop your personalized recovery plan.

Rule Number Two, Repeat Rule Number One. Rule Number One is non-negotiable.

If you agree, please continue, if you can't or won't, this program is not meant for you at this time. I wish you success in your quest for sobriety. Should you ever change your mind and wish to include me in the truth later, you can always reapply.

So let's begin! This will take a while to complete, so, please be patient.

Thank you in advance for your time, cooperation and honesty. I will review your responses and get back to you ASAP.

Dr. Gary

Gary S. Grossman Ph.D.

Social History and Health Questionnaire (18 AND OLDER)

CLIENT NAME: _____ **EMAIL:** _____**DATE:**_____

PHONE :_____ **Name of person completing form for client:** _____

(Please take your time and complete the entire form. The information will help me understand you better)

FULL NAME	Age	Living with?	If Deceased, Year/cause
Parents _____			
_____			
Spouse/Partner: _____			
Children and _____			
Step-children: _____			
_____			
_____			
_____			
_____			
_____			
_____			

MARITAL STATUS:

- — Unmarried How many years? __
- — Married How many years? __
- — Separated How many years? __
- — Divorced How many years? __
- — Widow/er How many years? __
- — Live together How many years? __

Number of times married: ___Number of brothers/sisters: ____ # living: _____

Family members you are close to now: _____

EDUCATION:

Last grade completed: _____ Degree: _____

In school now? _____ For what? _____

Special training or skills: _____

Hope/plan to go to school? _____For what? _____

Have a learning difficulty? _____

EMPLOYMENT:

What do you do for a living? _____

Employer: _____ Years on job: _____

If no job, when did you last work? _____

Are you looking for work now? _____Any job problems now? _____

Ever been fired? _____ How many times: _____

Why? _____

FINANCIAL:

Do you have any financial problems? _____

Can you afford this program without it causing any financial hardship? _____

ETHNIC:

Background: _____

Any ethnic problems/concerns? _____

RELIGIOUS/SPIRITUAL:

Background: _____

Current religious/spiritual activity: _____

Do you have any spiritual concerns now? _____

If, so, what are they?_____

LEGAL HISTORY:

Arrest Date	Charge	Convicted?	Sentence

Are you currently on Probation? _____ Parole? _____

Ending Date: _____

Are you involved in any lawsuits?_____

Any upcoming Court dates?_____

For what?_____ When?_____

MILITARY SERVICE: Type: _____ When: _____

Honorable discharge? _____

If not, why? _____

Describe any combat experience:_____

Are you troubled now by your experience in the military? _____

How? _____

INTERESTS/ACTIVITIES:

- — Television
- — Be with friends
- — Shopping
- — Fix/things
- — Movies/DVDs
- — Be with family
- — School
- — Sew/knit/crafts
- — Music listening
- — Be alone
- — Get high
- — Build/decorate
- — Play instrument
- — Cooking/eating
- — Exercise
- — Gardening
- — Singing
- — Go to museums
- — Play sports
- — Photography
- — Dancing
- — Volunteer work
- — Watch sports
- — Video Games
- — Reading
- — Travel/sight-see
- — Hiking
- — Elder care
- — Writing
- — Prayer/Church
- — Gambling
- — Child-care
- — Drawing
- — Camping
- — Sex
- — Nothing

List interests/activities as well as those not listed above: _____

_____

Have you recently lost interest in activities you normally enjoy? _____

Do you feel you spend enough time on your interests or non-work activity? _____

What **RECENTLY HAPPENED** to make you decide to seek help now?

_____

_____

What would you like this program to do for you?

_____

_____

ALCOHOL AND DRUG HISTORY:

What is your substance of choice, your main drug or drink that you have the most problems with?

_____

How many days a month do you drink _____or use non-prescribed drugs?_____

On the days that you drink or use drugs, about how much do you drink in ounces (including beer) or use in drugs?_____

How many times a month do you drink more than you planned to? _____

Do you ever experience blackouts (memory lapses) when drinking? _____

Have you ever overdosed _____ or experienced withdrawal symptoms? _____

Explain:_____

_____

How much alcohol and drugs have you used in the last 48 hours?

Alcohol: _____Drugs: _____

What's the longest period you remained totally alcohol/drug-free? _____

What helped you to stay clean? _____

Did you ever receive HOSPITAL or RESIDENTIAL treatment for an alcohol or drug-related problem? _____How many times? _____

Where/When: _____

Have you ever received any OUTPATIENT alcohol/drug treatment? _____

Where/When: _____

Ever involved in alcohol/drug Support groups (AA, NA, etc.)? _____

Where/When: _____ Helpful?_____

Has any family member/loved one ever had a drinking or drug problem? _____

Who? _____ Please describe: _____

Has drinking or drugs ever caused problems in any of the following areas:

- family
- employment
- legal
- emotional
- social
- financial
- behavior
- physical

Does a relative, loved one, friend, court or employer think so? _____

TYPE OF DRUG	AGE OF 1ST USE	AGE YOU STARTED USING IT ON A REGULAR BASIS	AVERAGE NUMBER OF DAYS USED EACH WEEK	ABOUT HOW MUCH WOULD YOU USE EACH DAY	# DAYS USED PAST 30 DAYS	LAST DATE YOU USED
Beer,Wine,Liquor						
Marijuana						
Crack /Cocaine						
Heroin						
Methadone						
Pain Medication Type:						
Tylenol #3 or 4						
Muscle Relaxers Soma, Flexeril						
Valium, Librium Other:						
Glue,Poppers, Aerosols						
PCP, LSD, Mescaline						
Meth-amphetamine						
Phenobarbital Sleeping pills						
Steroids						
Other						

HEALTH HISTORY Check off any of the following symptoms that apply to you now or within the past month (feel free to explain):

- — Depression
- — Increased alcohol use
- — Nervous/Anxious
- — Crying spells
- — Increased drug usage
- — Panic attacks
- — Hopelessness
- — Blackouts/memory loss
- — Can't concentrate
- — Relationship breakup
- — Withdrawal symptoms
- — Confusion
- — Loneliness
- — Financial worries
- — Mood swings
- — Emptiness
- — Loss of control in:
- — Racing thoughts
- — Loss of appetite
- — Alcohol/drug use
- — Fear of dying
- — Sleep disturbance
- — Overeating/binging
- — Job stress
- — Nightmares
- — Purging
- — Decreased activity
- — Thoughts of harming self
- — Yelling/breaking
- — Not seeing friends
- — Thoughts of harming others
- — Hitting people
- — Feel controlled
- — Suicide attempts/injuries
- — Endangering self
- — Feel talked about
- — Hearing voices
- — Endangering others
- — Guilt/shame
- — Seeing things others don't
- — Excessive spending
- — Sexual problems
- — Unusual thoughts
- — Gambling
- — School problems

Please list and explain here:

_____

_____

_____

_____

PREVIOUS MENTAL HEALTH TREATMENT:

Have you **ever been treated** by any doctor, psychiatrist, psychologist or therapist for any form of mental illness, from psychiatric medications to psychotherapy? Yes ____ No ____

If yes: When? _____
For what? Please be specific.

_____
_____

By whom?
Name: _____

Address: _____

Phone Number: _____

If you have been treated multiple times with different practitioners, I need a detailed list of the same for all practitioners.

_____

_____

Did you successfully complete treatment at that/those time(s)? Yes ___ No ___

Have any of those symptoms reappeared. Yes ___ No___

Which symptoms?

_____

_____

Have they been or are they being treated now? Yes ___ No ___

Are they under control or still causing problems in your life? Yes ___ No ___

Which symptoms do you still have problems with?

_____

_____

Can we contact that treating professional(s)? Yes___ No___
If no, why not?

_____

_____

Have you ever attempted to commit SUICIDE or seriously harm yourself? _____

When? _____ How? _____

Has anyone in your family attempted suicide? _____ Committed suicide? _____ Who?_____

Explain:

_____

_____

Have you ever attempted to kill or seriously harm someone else? _____

Who? _____

Explain:_____

_____

Have you ever hit, slapped or choked any of your loved ones? _____

During arguments/fights do you threaten, throw or break things, punch the walls or slam doors, yell or scream at your partner or children?_____

Describe: _____

Is your partner afraid of you sometimes? _____Are your children? _____

Do you feel guilty about your behavior afterward? _____

Explain: _____

Have you ever been the victim of physical, sexual or verbal abuse? _____

Describe: _____

Were you ever <u>HOSPITALIZED</u> for depression, hearing voices or other mental or emotional problems? _____

How many times? _____ Any involuntary? _____ Year of first admission: _____

Where: _____

Reason: _____

Year of last admission: _____ Where: _____

Reason: _____

Have you received any OUTPATIENT Mental Health counseling? _____

Where/when: _____

Reason: _____

Have you ever been involved in any support groups (AA, NA, CA, CODA, Emotions Anonymous, Recovery, Weight-Watcher, Incest Survivors, ACOA, Alanon, etc.)? _____

When? _____Type of Group: _____

Reason: _____

Was it helpful? _____

Has anyone in your FAMILY ever been hospitalized for depression or any other mental or emotional problems? _____

Please explain who, when and reason: _____

_____

PHYSICAL HEALTH:

CHECK THE NUMBER FOR EACH ITEM THAT APPLIED TO YOU IN THE PAST OR NOW, AND THEN EXPLAIN BELOW:

1. ___ Allergies
2. ___ Asthma
3. ___ Ulcers
4. ___ Cancer
5. ___ Stomach problems
6. ___ Pancreatitis
7. ___ Chronic pain
8. ___ Heart disease
9. ___ Bacterial endocarditis
10. ___ Seizures
11. ___ High Blood Pressure
12. ___ Low Blood Pressure
13. ___ Diabetes
14. ___ Hypoglycemia (Low blood sugar)
15. ___ Thyroid Problems
16. ___ Liver Disease
17. ___ Vision problems
18. ___ Hearing problems
19. ___ Speech problems
20. ___ Dental problems
21. ___ Weight loss
22. ___ Weight gain
23. ___ Severe headaches/migraines
24. ___ Frequent neck/shoulder pain
25. ___ Head injuries
26. ___ Physical Abuse
27. ___ Sexual abuse
28. ___ Premenstrual syndrome
29. ___ Sexually transmitted diseases
30. ___ Positive HIV
31. ___ AIDS
32. ___ Tuberculosis
33. ___ Hepatitis
34. ___ Major surgeries
35. ___ Chronic fatigue syndrome
36. ___ Impotence
37. ___ Prolapsed mitral valve
38. ___Circulation problems
39. ___ High Cholesterol
40. ___ Irritable bowel
41. ___ Broken bones
42. ___ Accidents
43. _____
44. _____

Are they being treated if the problems are current? _____

If not, why not: _____

Date of last physical: _____ Results: _____

Do you eat a regular balanced diet? _____ Do you skip meals? _____

Any poor eating/junk-food habits? _____

Do you exercise regularly? _____ How often? _____

Do you have a plan for stress relief? _____

Do you have any sleep problems? _____ What? _____

FOR WOMEN: Number of pregnancies? _____ Live births: _____ Adoptions: _____

Normal menstrual cycle? _____ Are you pregnant?_____

Premenstrual syndrome? _____Menopause? ____ Hormone therapy? _____

Again, thank you in advance for your time, cooperation and honesty. I will review your responses and get back to you ASAP.

Dr. Gary

Gary S. Grossman Ph.D.