

Chemical History / Intake Form

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Please keep in mind, the more information and details you provide will better assist New Promises Foundation, Inc. to assess and address your needs. You may fax Intake package, but please mail in the original.

**\*FAILURE TO DISCLOSE INFORMATION ON INTAKE PACKAGE WILL RESULT IN IMMEDIATE TERMINATION OF RESIDENCY\***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age at present: \_\_\_\_\_  
(dd/mm/yy)

Address: \_\_\_\_\_

Phone Number \_\_\_\_\_

Clean Date / Sobriety Date \_\_\_\_\_

Do you have Health Insurance / Medicaid? \_\_\_\_\_ Health Card Number: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Other Agency Involvement:  
(i.e.: ICFS, Social Services, Welfare, CYF, etc.)

Agency Name: \_\_\_\_\_

Worker Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who referred you to New Promises Foundation? (Name of person, hospital, agency, etc. - please include name, address and phone number of contact):

\_\_\_\_\_

Are you currently employed? \_\_\_\_\_ If yes, please list place of employment \_\_\_\_\_

If not currently employed, what are your plans for securing gainful employment? \_\_\_\_\_

\_\_\_\_\_

Are you currently working with OVR? \_\_\_\_\_ If yes, in what capacity? \_\_\_\_\_

**Family History:**

Mother's Name \_\_\_\_\_ Still Living?: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Still Living?: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

Names and ages of siblings:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Religious Beliefs: Traditional \_\_\_\_\_ Other (specify): \_\_\_\_\_

**Relationships:**

Do you have a significant other? (i.e., Spouse, boyfriend, girlfriend, etc.) If yes, please describe relationship with that person as it stands today \_\_\_\_\_

Name and Phone # of significant other \_\_\_\_\_

Do you have contact with anyone in jail? \_\_\_\_\_ If yes, who? \_\_\_\_\_

How do you stay in contact with this person? (I.e., visit, phone, letter, etc.) \_\_\_\_\_

Who were you residing with prior to today?:

Spouse \_\_\_\_\_ Significant Other \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_ Friends \_\_\_\_\_ Alone \_\_\_\_\_

Extended Family, if so, who? \_\_\_\_\_

Do you have children? \_\_\_\_\_

Please list information about children (names, ages, where they currently live) \_\_\_\_\_  
\_\_\_\_\_

Do you see your children? \_\_\_\_\_

Are there any conditions/restrictions regarding your children? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

How do you get along with family members? \_\_\_\_\_

Who do you feel closest to? \_\_\_\_\_

Do you have any close friends? (Please provide names and phone numbers)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a sponsor? \_\_\_\_\_ If yes, please list name & phone number: \_\_\_\_\_  
\_\_\_\_\_

Do you have a Home Group? \_\_\_\_\_ If yes, please list day, time, and location: \_\_\_\_\_  
\_\_\_\_\_

Are you sexually active? \_\_\_\_\_

Have you been tested for STD's (including Hepatitis)? If yes, what were the results?  
\_\_\_\_\_

Do you talk to a Counselor/Therapist? \_\_\_\_\_ If yes, please provide Counselor/Therapist name, address, and phone number.  
\_\_\_\_\_  
\_\_\_\_\_

How long have you been seeing this therapist/counselor? \_\_\_\_\_

**Education:**

Are you currently attending school? Yes \_\_\_ No \_\_\_

If No, when did you last attend school? \_\_\_\_\_

Name of last school attended: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Date completed: \_\_\_\_\_

**Medical History:**

Do you have any medical problems? (Please specify) \_\_\_\_\_  
\_\_\_\_\_

Name, Address, Phone of Family Doctor: \_\_\_\_\_

Are you currently taking any medications? (If yes, please provide a list and dosage amounts. Please include vitamins, energy pills, as well as all over the counter pain relievers). **Please note: It is VERY important that you list ALL medications taken in the last 7 days, regardless if you think it is important. Failure to list a drug that could show up on a drug screen will result in immediate termination from program).**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies? (If yes, please specify) \_\_\_\_\_

**Chemical Use History:**

At what age did you start using alcohol? \_\_\_\_\_ Drugs? \_\_\_\_\_

**Have you ever used any of the following? (Please be specific)**

SUBSTANCE NAME	YES, USED	NO, NEVER USED	YEAR OF FIRST USE?	DATE OF LAST USE?	METHOD? (i.e., snort, smoke, inject)	IS THIS YOUR PREFERRED SUBSTANCE?
Alcohol						
Marijuana						
Pain Pills (i.e., Ultram, Vicodin, OxyContin, Demerol, Percocet, Darvocet, etc.)						
Benzodiazapines / Tranquilizers (i.e., Xanax, Klonopin, Serax, Ativan, Valium, etc.)						
Powder Cocaine						
Crack Cocaine						
Heroin						
Methadone						
Suboxone						
Hallucinogens (i.e., acid, PCP, mushrooms, etc.)						
Crystal Meth						
Special K. / Ketamine						
Ecstasy						
Solvents (I.E., "wet," glue, gasoline, etc.) Please specify						
Other (please explain)						

Do you reside with any family members who drink and/or use substances? \_\_\_\_\_

If so, who uses? What do they use? How frequently? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever caused serious injury to others while on drugs and/or alcohol? If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any medical, physical, psychological, emotional problems because of the use of drugs/alcohol? (If so, please elaborate) \_\_\_\_\_

Do you believe 100% you have lost control over the use of drugs/alcohol? \_\_\_\_\_

Have you ever considered quitting or reducing using? If yes, how many times?

What makes this time different? \_\_\_\_\_

Have you ever been in any treatment programs (detoxes, rehabs, hospitals, etc.) for your use of drugs/alcohol? (If so, provide name, location, and dates) \_\_\_\_\_

What is the longest amount of clean time / sober time you have had? When? \_\_\_\_\_

**Psychological Functioning:**

Do you presently feel like harming yourself or someone else? (If yes, please explain.)

Have you ever attempted to kill yourself? (If so, When? How? How many times?) \_\_\_\_\_

Have you ever been diagnosed with:

- Depression? \_\_\_\_\_
- Bipolar Disorder? \_\_\_\_\_
- Borderline Personality Disorder? \_\_\_\_\_
- An Eating Disorder? \_\_\_\_\_
- Schizophrenia? \_\_\_\_\_

Would you consider yourself:

- Depressed? \_\_\_\_\_
- Anxious? \_\_\_\_\_
- Anorexic? \_\_\_\_\_ (If yes, when was the last time you restricted? \_\_\_\_\_)
- Bulimic? \_\_\_\_\_ (If yes, when was the last time you binged and purged? \_\_\_\_\_)

Are you presently or have you ever been a “cutter?” (If yes, when was the last time you cut?) \_\_\_\_\_

Are you sad/unhappy? \_\_\_\_\_

Do you have a history of being a victim of sexual abuse? \_\_\_\_\_

Do you have a history of being a victim of physical abuse? \_\_\_\_\_

Do you have a history of being a victim of emotional abuse? \_\_\_\_\_

Please explain (ie: at what age? Was it reported and what is the outcome or current status?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family:**

How do you spend your leisure time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What effects does the abuse of drugs, alcohol have on your family? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any supportive persons (relatives and/or counselors) and agencies in the community that you could have contact with to help her/him be successful in treatment and after treatment is completed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Legal Issues:**

Have you ever had any dealings with the law? (If yes, please provide a list of all offenses, dates and disposition). PLEASE NOTE: Signing this form gives New Promises the right to perform background checks on all residents. Failure to disclose information found on a background check will result in immediate termination of residency.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been charged with / arrested for endangering the welfare of a child? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Are you a registered sex offender? \_\_\_\_\_

Are you currently on probation, on a court order, house arrest, or on parole? Provide offense and details \_\_\_\_\_  
\_\_\_\_\_

Name of Probation Officer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Probation Order: From \_\_\_\_\_ To \_\_\_\_\_

Conditions: \_\_\_\_\_

**\*\*ANY ORDERS MUST BE ATTACHED**

By signing below, you confirm that:

All information supplied by you is true and factual.

You completely understand all questions you have answered.

You understand you will be immediately terminated from residency with no refund if you fail to disclose any requested information.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
New Promises Foundation, Inc. / Director