MID-OHIO VALLEY FELLOWSHIP HOME

Resident Assessment Form

Children ______________ **Last use** ________________ **CPS**__________________________

Date: ______________ Time: ____________ Assessment Taken By: ______________________________

Caller's Name:_______________________________ Agency (if applicable)___________________________

Address:____

County_____________________

Relationship to Patient: ___________________________________Phone#_____________________

Resident's Name:____ Age:_________ D.O.B.:____________

Resident's Address:___________________________________ Phone# (H)____________ (W)____________

Current Residence (if other than above)______________________________Phone# ________________

Sex: M. F Marital Status: M S W D Sep. Employer: ____________________Address: ______________

SS #: _________________________ Resident Pregnant? ☐ No ☐ Yes If Yes, how many months?__________

Are you a veteran? ☐ No ☐ Yes_________________________

SOURCE OF AWARENESS - HOW DID YOU HEAR ABOUT US?

☐ Phone Book ☐ Radio ☐ Word of Mouth ______________________________

☐ Physician ________________________ ☐ Other ____________________________________

SUBSTANCE ABUSE HISTORY

1.) Information obtained from: ☐ Resident ☐ Other ____________________________________

2.) Why do you want treatment now? (Why now? What is going on?) ______________________________

____

____

3.) Are you currently using drugs? ☐ Yes ☐ No Are you currently using alcohol? ☐ Yes ☐ No

4.) Drug History: Have you used?

☐ **Alcohol** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month

Amount ______________ Last Use ________________ Drink(s) of Choice________________

☐ **Cocaine** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month

Amount ______________ Last Use ________________ Route __________________________

☐ **Heroin** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month
Amount ______________ Last Use________________ Route ________________________

☐ **Marijuana** ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ less than 1x/month

Opiates
☐ ____________ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month
Amount ______________ Last Use__________________ Route_______________________

Benzos
☐ ____________ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month
Amount ______________ Last Use__________________ Route_______________________

☐ ____________ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month
Amount ______________ Last Use__________________ Route_______________________

☐ ____________ ☐ daily ☐ 3-5 x/wk ☐ wkends ☐ 1-8 x/month ☐ 1-8 x/month
Amount ______________ Last Use__________________ Route_______________________

5.) What is your drug of choice?____
6.) How old were you when you had your first drink____________________ Drugs?__________
7.) How long have you been using at this level?__________________________________
8.) Have you ever tried to quit in the past?_________________ How many times?____________
Longest time you quit ____
9.) In the last 6 months what is the longest period of time you have gone without using drugs or alcohol?_____
____

10.) Previous inpatient treatment for drug/alcohol problems? ☐ Yes ☐ No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FOR HOW LONG?

11.) Have you ever had prior outpatient treatment for drug/alcohol problems? ☐ Yes ☐ No

WHERE	WHEN	LENGTH OF TIME	ABSTINENT FOR HOW LONG?

12.) Have you attended AA or NA or other support group? ☐ Yes ☐ No

MEDICAL HISTORY

1.) When you stop drinking or using have you experienced any of the following?

☐ tremors ☐ hallucinations audio/visual/tactile ☐ seizures ☐ agitation ☐ nausea/vomiting ☐ blackouts

☐ delirium tremors ☐ insomnia ☐ sweats ☐ irritability ☐ mood swings ☐ muscle aches

☐ other ______________________________

2.) Have you ever been diagnosed with any of the following conditions?

☐ high blood pressure ☐ cirrhosis ☐ hepatitis ☐ liver disease ☐ diabetes ☐ tuberculosis

☐ heart problems__________ ☐ coronary artery disease ☐ pancreatitis ☐ breathing problems__________

☐ difficulty walking ☐ GI bleeding ☐ renal failure ☐ inability to take oral meds

☐ other medical conditions ______________________________

3.) Have you been hospitalized for any of these conditions? Which ones? ______________

4.) Do you have any disabilities, limitations or special needs? ☐ Yes ☐ No If yes, explain them:

____

5.) Medical Doctor:______________ Ph#__________ Last Seen:__________

6.) What prescribed medicines are you currently taking? ☐ None

NAME	DOSE	FREQUENCY	LAST TAKEN	REASON FOR

7.) Are you allergic to any medications? ______________________________

Any Foods?______________________ Other?______________

8.) Have you ever been diagnosed with an eating disorder? ______________________

If yes, please explain. ______________________________

8a.) Do you feel your eating habits are healthy? ______________________

PSYCHIATRIC HISTORY

1.) Have you ever seen a psychiatrist or currently under the care of one now? ☐ Yes ☐ No If yes, please identify the name and date of psychiatrist:

2.) Have you ever been treated or hospitalized for any psychiatric problems? ☐ Yes ☐ No If yes, when, where, what for and for how long?

3.) Are you currently depressed? ☐ Yes ☐ No When you are depressed what symptoms do you have?
☐ recent wt loss or gain (how much__________ ☐ insomnia ☐ sleeping all the time ☐ fatigue ☐ loss of energy
☐ feelings or worthlessness ☐ excessive guilt ☐ diminished ability to think or concentrate
☐ other symptoms described

4.) Are you currently suicidal? ☐ Yes ☐ No If yes, do you have a plan? ☐ Yes ☐ No If yes, what is the plan?

5.) Have you ever had suicidal thoughts? ☐ Yes ☐ No If yes, when?
Any past attempts? ☐ Yes ☐ No If yes, when and how?

6.) Have you ever displayed violent behavior? ☐ Yes ☐ No If yes, describe

7.) Any homicidal thoughts? ☐ Yes ☐ No If yes, describe

LEGAL INFORMATION

1.) Have you ever had any legal problems related to use of alcohol or drugs? (i.e., DUI, assault, burglary, theft)
☐ Yes ☐ No If yes, describe

2.) Any current legal charges pending? ☐ Yes ☐ No If yes, explain

3.) Have you ever been charged or convicted of Domestic Violence or Assaults or violent behaviors?
☐ Yes ☐ No If yes, explain:

4.) Are you currently on Probation or Parole? ☐ Yes ☐ No If yes, list conviction(s)

5.) Any scheduled hearing dates?

OTHER

1.) What areas (other than remaining sober) would you like to work on while living here?

2.) Are you currently in a significant relationship? ☐ Yes ☐ No If yes, explain.

3.) Do you have children? ☐ Yes ☐ No Do you claim them on your Federal Tax Return? ☐ Yes ☐ No

If yes, how many and what ages?

4.) Describe your family and your relationship with them:

Resident's Name: ____________________________________

5.) What is the last grade you completed in school?____

6.) How long would you be willing to live here if accepted? ____

Have you ever lived in or been interviewed for placement at another residential program? ☐ Yes ☐ No

If yes, where and when? ____

____

8) If accepted, MOVFH charges a non-refundable processing fee of $100.00. How will I pay the $300.00 a month residential fee and this first month's processing fee?

____

9.) I understand that participating in this assessment I am stating that all information I have given MOVFH is the truth. I agree to provide MOVFH with all legal paperwork, court documents etc. False information of any kind could result in disqualification before acceptance or discharge after admittance. I have read or had this statement read to me and I agree to these conditions. Yes: ________ No: _________

OFFICE USE ONLY

Recommended for Residency _____Yes _____ No Anticipated Admission Date ______________________

By: ____
Staff Signature

Admission Date ________________________________

Approved by ____
Patrice M. Pooler, Executive Director