

**THE SHOULDER
SCREENING APPLICATION**

IDENTIFYING DATA:

Name: _____ Today's date: _____

Address: _____ Inmate # _____

Phone # _____ (City) _____ (County) _____ (State) _____ (Zip) _____
Cell # _____ Work # _____

Social Security # _____ Date of Birth _____ Age _____ Gender: M/F

Race/Ethnic Background _____

Health Insurance: _____

Marital Status: Never Married/ Married/ Divorced/ Separated/ Common Law Number of Marriages: _____

Living Arrangements: Independent Living/Reside with Family/Jail or Correctional Facility/Homeless/Shelter

Do you have dependent children? Yes / No If yes, give sex and age of each: _____

Highest Level of Education: _____

Military Experience _____

Religious Preference _____

Referral Source _____ Reason for Referral _____

Person to be contacted in case of emergency: Name of Contact: _____

Relationship: _____ Phone # _____

TREATMENT HISTORY (Including both treatment programs and self-help attendance):

Age of First Use: _____ Drug(s) of choice: _____

Longest period of non use: _____

OCCUPATION HISTORY:

Current Employer/Position: _____

Years with this employer: _____ Number of jobs in the last 2 years _____

Past Employers: _____

Have you lost a job due to substance use? Y / N If yes, please explain: _____

My principal source of income is: Disability Public Assistance Retirement/Pension Wages/Salary None Other

Annual Income: _____

MEDICAL HISTORY:

Do you have a primary care Doctor? Y/N, if yes- Dr.'s name/address: _____

Date of last doctor's visit and reason: _____

Do you have major concerns about your health? Y/N If yes, explain: _____

Do you have any longstanding health issues that still cause you concern? Y/N If yes, explain: _____

List Current Medications you should or do take: _____

Are you currently taking your medications as prescribed? If no, explain: _____

Do you have any physical problems that would cause you difficulty in treatment or prevent employment? Y/N

If yes, explain: _____

Have you had any health problems related to drinking or using? Yes /No If yes, explain: _____

During the last 2 years have you been exposed to someone with active TB – Yes - No

Have you ever been tested for TB: Yes – No Results _____

Have you ever been tested for HIV: Yes – No Results: _____

EMOTIONAL/BEHAVIORAL HISTORY:

Mental Health History:

Have you ever been treated for any of the following mental health illnesses?

Mood Changes

Depression

Anxiety

Anger issues

Prescribing Doctor: _____

History of medications for any of the above: _____

History of Mental Health Counseling: When: _____ Where: _____

What specifically were you treated for: _____

Has anyone in your family been treated for Mental Health Issues? Y/N if yes, explain: _____

In the past year have you thought about hurting/killing yourself? If yes, explain: _____

In the past year have you thought about hurting/killing someone else? If yes, explain: _____

In the past year have you experienced hallucinations or had difficulty telling what is real from that which is not?

If yes, explain: _____

LEGAL HISTORY:

DUI Arrest History: _____

Other Arrest History: _____

Additional Legal Information: _____

History of Incarceration up to and including length of current incarceration: _____

CRO: _____ Attorney: _____

Judge: _____ Next Court Date: _____

Color Code: _____

Valid Driver's License: yes no

ALCOHOL/DRUG USE HISTORY: List exact substance used; how much used and how often used.

Alcohol: _____

Date of last use: _____

Cocaine: _____
_____ **Date of last use:** _____

Cannabis: _____

Date of last use: _____

Opiates: _____
_____ **Date of last use:** _____

Benzo's: _____
_____ **Date of last use:** _____

Amphetamines: _____

Date of last use: _____

Hallucinogens (including ecstasy): _____
_____ **Date of last use:** _____

Other substances: _____
_____ **Date of last use:** _____

Nicotine use history: _____ **Date of last use:** _____

History of withdrawal symptoms: _____
