INTAKE FORM

General Information		
Name:		Date of Birth:
Social Security Number:		City/State of Birth:
Have you used another name, including a maiden name or married name? ❑ Yes ❑ No If yes, please list: _____		
Height:	Weight:	Gender: _____
Hair Color:	Eye Color:	Scars/tattoos:
Race or Ethnic Background: ❑ African American/Black ❑ American Indian ❑ Anglo/White Caucasian ❑ Asian/Pacific Islander		❑ Hispanic ❑ Other (specify) _____
Home phone:	Cell phone:	Email address:
Marital Status: ❑ Never married ❑ Legally married (spouse name) _____ ❑ Separated ❑ Divorced ❑ Widowed		

Children:

Name (Last, First)	Date of Birth	Legal Guardian	Other Parent's name

Do you provide financial support to any of your minor children? ❑ Yes ❑ No

Is there a court order that requires you to pay child support? ❑ Yes ❑ No
If yes, list child, amount, and payee:

Is there a court order that requires you to pay alimony? ❑ Yes ❑ No
If yes, list amount, and payee:
_____

Do you currently have a DFACS case? ❑ Yes ❑ No

If yes, name of Caseworker:

Have you ever served in the military? ❑ Yes ❑ No
If yes,
Military Branch: _____ Dates of Service: _____

Do you receive the following federal or state assistance:
❑ Disability ❑ Medicaid ❑ WIC ❑ TANF ❑ SNAP ❑ Unemployment
❑ Other (specify) _____

Do you currently have a valid driver's license? ❑ Yes (number) _____ ❑ No
State of Issue _____ Expiration date_____

Do you own a vehicle? ❑ Yes (make/model/year) _____ ❑ No
Color _____ Tag number _____

If you do not own a vehicle, what is your primary mode of transportation?
_____

Emergency Contact: _____ Relationship: _____
Contact Information: _____

Residence and Home Life

County of Residence:

Address:	City/State:	County:	ZIP Code:

Directions to address from Courthouse:

Type of Residence: ❑ House ❑ Apartment ❑ Trailer ❑ Other (specify)_____

I (choose one): ❑ own ❑ rent ❑ stay for free	Monthly payment: $ _____	How long have you been living at this address? _____

Other Occupants in Residence (name, age, relationship to you):

Is anyone in the residence currently on probation or parole? ❑ Yes ❑ No

If yes, list name(s):

Has anyone in the residence ever been convicted of a crime? ❑ Yes ❑ No

If yes, list name(s) and the offense for which they received the conviction:

Does anyone in the home have an alcohol/drug abuse problem? ❑ Yes ❑ No ❑ Unknown

Are there any firearms in the home? ❑ Yes ❑ No ❑ Unknown	
Is there any alcohol in the home? ❑ Yes ❑ No ❑ Unknown	
Are there any animals/pets at the home? ❑ Yes ❑ No ❑ Unknown	
If yes, type of animal(s)/pet(s):	
Education	
Highest grade completed in school:	_____
Have you graduated from high school?	❑ Yes ❑ No
Have you completed your GED?	❑ Yes ❑ No
Are you currently working on your GED?	❑ Yes ❑ No
Have you complete a vocational or technical training program?	❑ Yes ❑ No
Are you currently working on a vocational or technical training program?	❑ Yes ❑ No
Have you attended any college?	❑ Yes ❑ No
Do you have a college degree?	❑ Yes ❑ No
List any degrees, certificates, or professional licenses you currently hold:	
Criminal History	
Age at first arrest _____	
Number of total arrests _____ (times you remember being taken into custody or to the police station)	
How many of your arrests do you think are related to your mental illness? _____	
How many times have you been to prison?	For how long?
Are you currently on parole? ❑ Yes ❑ No	County _____
Are you currently on probation? ❑ Yes ❑ No	City/County _____
County(s) currently on probation/parole?	
Do you have charges pending in any city or county? ❑ Yes ❑ No	
If yes, which city or county do you currently have charges pending in?	
Are you a member of a gang?	❑ Yes ❑ No
Have you ever been a member of a gang?	❑ Yes ❑ No
Attorney Information	
Attorney Name:	
Attorney Address:	

Attorney Phone number:

Employment

Which best describes your current employment status?

- ❑ Employed full time (35+ hours/week)
- ❑ Employed, part time
- ❑ Unemployed, looking for work
- ❑ Unemployed, not looking for work
- ❑ Other (specify) _____
- ❑ Unemployed, disabled
- ❑ Unemployed, in school
- ❑ Retired
- ❑ Homemaker

If employed, complete the following:

Employer:	Job Title:		
Start Date:	Wage:		
Supervisor Name:	Supervisor Phone:		
Work Address:	City:	State	Zip Code:

Health

Do you have medical/health insurance?	❑ Yes ❑ No
Have you been seen by a physician in the past year? If yes, physician's name _____	❑ Yes ❑ No
Do you have any physical health conditions for which you require treatment? If yes, list _____ _____	❑ Yes ❑ No
Have you ever been hospitalized? If yes, list dates, and reason for hospitalization_____ _____	❑ Yes ❑ No
Do you have difficulty urinating? If yes, please explain health condition _____	❑ Yes ❑ No
What is the result of your most recent HIV/AIDS test?	❑ Positive ❑ Negative ❑ Never been tested
What is the result of your most recent Hepatitis test?	❑ Positive ❑ Negative ❑ Never been tested
Would you like to be tested for HIV/AIDS or Hepatitis?	❑ Yes ❑ No
Do you use needles, have unprotected sex, or otherwise engage in behavior that may have exposed you to HIV/AIDS or Hepatitis?	❑ Yes ❑ No
Have you ever been diagnosed with any psychological/emotional health conditions? If yes, list the condition and date of diagnosis _____	❑ Yes ❑ No

_____ _____ _____	

Have you ever received any of the following treatments for a psychological/emotional health condition? If yes, please provide date of treatment, location, and provider.

Treatment Type	Dates	Location and Provider
❑ Counseling/Therapy		
❑ Intensive Outpatient Treatment or Partial Hospitalization		
❑ Hospitalization		
❑ Medication Management		

Have you taken any prescribed medications or supplements ***in the past 12 months***? If yes, list _____ _____	❑ Yes ❑ No
Are you currently (***within the past week)*** taking any prescription medications or supplements? If yes, list _____ _____	❑ Yes ❑ No
Have you ever been attacked with a weapon, beaten, sexually abused, or emotionally abused?	❑ Yes ❑ No

Drug/Alcohol Use and Treatment

Have you ever drunk alcohol? ❑ Yes ❑ No
If yes, how old were you when you first drank alcohol? _____

Have you ever used any of the substances listed below? ❑ Yes ❑ No
If yes, check all that you have used.

❑ Alcohol	❑ GHB/Rohypnol
❑ Marijuana, THC, Hashish	❑ Heroin
❑ Salvia, K2	❑ Opium
❑ Cocaine	❑ Street Methadone
❑ Crack	❑ Librium, Valium, Xanax, Other Benzodiazepines
❑ Methamphetamine/Speed/Ice/Crystal	❑ Ambien, Lunesta, Other Sleep Meds
❑ Adderall, Diet Pills, Ritalin, Other Amphetamines/Uppers	❑ Codeine, Morphine, Oxycodone, Vicodin, Lortab, Other Pain Relievers
❑ MDMA/Ecstasy	❑ Other Prescription drugs (list)
❑ Bath Salts	_____
❑ Barbiturates	❑ Cough Medicine
❑ Inhalants (glue, paint, etc.)	❑ Other over the counter drugs (list)
❑ Anabolic Steroids	_____

❑ Hypnotics/Quaaludes ❑ Ketamine/Special K ❑ LSD/Mescaline/Mushrooms ❑ PCP/Angel Dust	_____ ❑ Other (list) _____ _____
Do you smoke cigarettes or otherwise use tobacco?	❑ Yes ❑ No
Have you ever entered a residential treatment facility?	❑ Yes ❑ No
If yes, What program(s)? _____ When? _____ What was the result? _____	
Have you ever participated in alcohol or drug treatment not described above?	❑ Yes ❑ No
If yes, What program(s)? _____ When? _____ What was the result? _____	
Have you ever gone to the emergency room or hospital as a result of your drug or alcohol use?	❑ Yes ❑ No
How many times have you ever tried to quit alcohol or other drugs for three months or longer? _____ (Do not include if times you have been in jail or prison)	
What is the longest that you have ever stayed clean?	
Have you ever gone to self-help meetings like AA, NA, etc.?	❑ Yes ❑ No

I certify that the information given in this application is true and complete to the best of my knowledge. I understand that any untrue statement in this application can result in my termination from Treatment Accountability Court if I am accepted.

Signature _____ Date _____

Upon Completion, please return to:

Coordinator, Treatment Accountability Court, 154 North St., Canton, GA 30114