

**Cherokee Count Treatment Accountability Court**

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____			
Height:	Weight:	Gender: _____	
Hair Color:	Eye Color:	Scars/tattoos:	
Race or Ethnic Background:			
<input type="checkbox"/> African American/Black		<input type="checkbox"/> Hispanic	
<input type="checkbox"/> American Indian		<input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Anglo/White Caucasian			
<input type="checkbox"/> Asian/Pacific Islander			
Home phone:	Cell phone:	Email address:	
Marital Status:			
<input type="checkbox"/> Never married <input type="checkbox"/> Legally married (spouse name) _____			
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is there a court order that requires you to pay child support? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list child, amount, and payee:			
Is there a court order that requires you to pay alimony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list amount, and payee:			
Do you currently have a DFACS case? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Caseworker:			

Have you ever served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, Military Branch: _____ Dates of Service: _____			
Do you receive the following federal or state assistance: <input type="checkbox"/> Disability <input type="checkbox"/> Medicaid <input type="checkbox"/> WIC <input type="checkbox"/> TANF <input type="checkbox"/> SNAP <input type="checkbox"/> Unemployment <input type="checkbox"/> Other (specify) _____			
Do you currently have a valid driver's license? <input type="checkbox"/> Yes (number) _____ <input type="checkbox"/> No State of Issue _____ Expiration date _____			
Do you own a vehicle? <input type="checkbox"/> Yes (make/model/year) _____ <input type="checkbox"/> No Color _____ Tag number _____			
If you do not own a vehicle, what is your primary mode of transportation? _____			
Emergency Contact: _____ Relationship: _____ Contact Information: _____			
<b>Residence and Home Life</b>			
County of Residence: _____			
Address: _____	City/State: _____	County: _____	ZIP Code: _____
Directions to address from Courthouse: _____			
Type of Residence: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Trailer <input type="checkbox"/> Other (specify) _____			
I (choose one): <input type="checkbox"/> own <input type="checkbox"/> rent <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list name(s): _____			
Has anyone in the residence ever been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Are there any firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Is there any alcohol in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Are there any animals/pets at the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, type of animal(s)/pet(s):	
<b>Education</b>	
Highest grade completed in school:	_____
Have you graduated from high school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you completed your GED?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently working on your GED?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you complete a vocational or technical training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently working on a vocational or technical training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you attended any college?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a college degree?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List any degrees, certificates, or professional licenses you currently hold:	
<b>Criminal History</b>	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	County _____
Are you currently on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	City/County _____
County(s) currently on probation/parole?	
Do you have charges pending in any city or county? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, which city or county do you currently have charges pending in?	
Are you a member of a gang?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been a member of a gang?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Attorney Information</b>	
Attorney Name:	
Attorney Address:	
Attorney Phone number:	

<b>Employment</b>			
Which best describes your current employment status?			
<input type="checkbox"/> Employed full time (35+ hours/week)	<input type="checkbox"/> Unemployed, disabled		
<input type="checkbox"/> Employed, part time	<input type="checkbox"/> Unemployed, in school		
<input type="checkbox"/> Unemployed, looking for work	<input type="checkbox"/> Retired		
<input type="checkbox"/> Unemployed, not looking for work	<input type="checkbox"/> Homemaker		
<input type="checkbox"/> Other (specify) _____			
If employed, complete the following:			
Employer:	Job Title:		
Start Date:	Wage:		
Supervisor Name:	Supervisor Phone:		
Work Address:	City:	State	Zip Code:
<b>Health</b>			
Do you have medical/health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been seen by a physician in the past year? If yes, physician's name _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have any physical health conditions for which you require treatment? If yes, list _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been hospitalized? If yes, list dates, and reason for hospitalization _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have difficulty urinating? If yes, please explain health condition _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the result of your most recent HIV/AIDS test?	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Never been tested		
What is the result of your most recent Hepatitis test?	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Never been tested		
Would you like to be tested for HIV/AIDS or Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use needles, have unprotected sex, or otherwise engage in behavior that may have exposed you to HIV/AIDS or Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed with any psychological/emotional health conditions? If yes, list the condition and date of diagnosis _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<u>Treatment Type</u>	<u>Dates</u>	<u>Location and Provider</u>
<input type="checkbox"/> Counseling/Therapy		
<input type="checkbox"/> Intensive Outpatient Treatment or Partial Hospitalization		
<input type="checkbox"/> Hospitalization		
<input type="checkbox"/> Medication Management		

Have you taken any prescribed medications or supplements *in the past 12 months*?  Yes  No  
 If yes, list \_\_\_\_\_

Are you currently (*within the past week*) taking any prescription medications or supplements?  Yes  No  
 If yes, list \_\_\_\_\_

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.

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol<br><input type="checkbox"/> Marijuana, THC, Hashish<br><input type="checkbox"/> Salvia, K2<br><input type="checkbox"/> Cocaine<br><input type="checkbox"/> Crack<br><input type="checkbox"/> Methamphetamine/Speed/Ice/Crystal<br><input type="checkbox"/> Adderall, Diet Pills, Ritalin, Other Amphetamines/Uppers<br><input type="checkbox"/> MDMA/Ecstasy<br><input type="checkbox"/> Bath Salts<br><input type="checkbox"/> Barbiturates<br><input type="checkbox"/> Inhalants (glue, paint, etc.)<br><input type="checkbox"/> Anabolic Steroids<br><input type="checkbox"/> Hypnotics/Quaaludes<br><input type="checkbox"/> Ketamine/Special K<br><input type="checkbox"/> LSD/Mescaline/Mushrooms<br><input type="checkbox"/> PCP/Angel Dust | <input type="checkbox"/> GHB/Rohypnol<br><input type="checkbox"/> Heroin<br><input type="checkbox"/> Opium<br><input type="checkbox"/> Street Methadone<br><input type="checkbox"/> Librium, Valium, Xanax, Other Benzodiazepines<br><input type="checkbox"/> Ambien, Lunesta, Other Sleep Meds<br><input type="checkbox"/> Codeine, Morphine, Oxycodone, Vicodin, Lortab, Other Pain Relievers<br><input type="checkbox"/> Other Prescription drugs (list)<br>_____<br><input type="checkbox"/> Cough Medicine<br><input type="checkbox"/> Other over the counter drugs (list)<br>_____<br><input type="checkbox"/> Other (list)<br>_____<br>_____ |
|---|---|

Do you smoke cigarettes or otherwise use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever entered a residential treatment facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, What program(s)? _____ When? _____ What was the result? _____	
Have you ever participated in alcohol or drug treatment not described above?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.?	<input type="checkbox"/> Yes <input type="checkbox"/> 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, 90 North Street, Suite 370, Canton, GA 30114***