Family Questionnaire

Name: _____

Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list all family members, their age and relationship to patient:

NAME	AGE	RELATIONSHIP

I. Chemical Dependency History

A. Why do you think the patient is seeking treatment at this time? _____

_____

_____

_____

B. Type of mood-altering chemicals used by patient:

❑ Alcohol ❑ Amphetamines ❑ Opiates ❑ Cocaine ❑ Marijuana ❑ Hallucinogenics ❑ Anti-Anxiety

❑ Sleeping Pills ❑ Other: _____

C. What is the patient's longest period of sobriety? _____ When? _____

Pacific Coast Recovery

Mission Hospital Laguna Beach

ST. JOSEPH HEALTH SYSTEM

A Ministry of the Sisters of St. Joseph of Orange

Family Questionnaire

D. Has the patient ever been in treatment before? ❑ Yes ❑ No

If yes, what kind of program? ❑ Inpatient ❑ Outpatient ❑ Residential

Please list facilities and dates of treatment: _____

_____

_____

E. Did the patient remain sober following treatment? ❑ Yes ❑ No If yes, how long? _____

F. Does the patient see a Psychiatrist? ❑ Yes ❑ No If yes, please give name: _____

G. Does the patient see a Psychologist / Therapist? ❑ Yes ❑ No

If yes, please give name: _____

H. Has the patient been involved in 12-Step Groups? ❑ AA ❑ NA ❑ CA

❑ Other: _____

II. Personal and Social Assessment

A. Do you believe the patient suffers/has suffered from depression? ❑ Yes ❑ No

B. Has the patient had any psychiatric hospitalizations? ❑ Yes ❑ No

C. Do you know what medications are prescribed for the patient? ❑ Yes ❑ No

If yes, please list: _____

_____

_____

_____

D. Has the patient exhibited any verbal or physical abuse? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

E. Has the patient demonstrated any unsafe/dangerous behaviors? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

Family Questionnaire

III. Patient's Family of Origin

A. Does the patient's family have problems with alcohol or drugs? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

B. How do you see the patient's relationship with:

Mother: _____

Father: _____

Sibling: _____

Sibling: _____

Friends: _____

IV. Sexual

A. Has the patient ever sexually abused anyone, or been accused of it? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

B. Has there ever been any Child Protective Services involvement? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

V. Strengths and Weaknesses

A. What do you see as the patient's strengths? _____

_____

B. What do you see as the patient's weaknesses? _____

_____

Family Questionnaire

VI. Legal

A. Does the patient have a history of legal problems? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

B. Does the patient have any legal issues pending? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

VII. Family Psychosocial Addiction History

A. Have you ever used drugs or alcohol with the patient? ❑ Yes ❑ No

B. Do you believe you have a problem with drugs or alcohol? ❑ Yes ❑ No

C. Have you ever been treated for an addiction? ❑ Yes ❑ No

❑ Alcohol ❑ Food ❑ Prescribed Medications ❑ Street Drugs ❑ Gambling ❑ Shopping/Spending

❑ Other (explain): _____

D. Have you ever attended: ❑ Al-Anon ❑ Coc-Anon ❑ Narc-Anon ❑ CODA

E. How would you describe your relationship with the patient? _____

_____

_____

F. Who has the patient's addiction affected? _____

_____

_____

G. **Spouses Only**

Have you ever sought Marriage Counseling? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

H. Do you have children?

NAME	AGE	NAME	AGE

Family Questionnaire

I. Are any of your children involved with the use of drugs or alcohol? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

J. What do you do for leisure as a family? _____

_____

_____

K. What would you like to do as a family in the future? _____

_____

_____

VIII. Family Concept of Chemical Dependency

A. How has addiction affected your relationship with the patient? _____

_____

B. What are other concerns or issues in the family? _____

_____

C. Are you willing to participate in the Family Program? ❑ Yes ❑ No

If not, please explain: _____

_____

D. Which other family members would be willing to participate? _____

_____

IX. Career

A. How has addiction affected the patient's job, career, finances? _____

_____

X. Other

A. Is there anything else we should know? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

Family Member/Significant Other Signature: _____ Date: _____ Time: _____

Staff Member Signature: _____ Date: _____ Time: _____