CRDC / NEARRC

DEMOGRAPHIC INFORMATION:

Applicant – Full Name: _____ SSN: _____

Address: _____ Phone #: _____

City, State, Zip Code: _____

Sex: _____ DOB: _____ Race/Ethnicity: _____

Education Level: _____ Marital Status: _____

Occupation: _____ Employment Status: _____

County of Residence: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

INSURANCE:

Medical Insurance: Yes ___ No ___ Alcohol / Drug Coverage: Yes ___ No ___

Company: _____ Policy and Group #: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Location: _____

Phone Number: _____

Reason for Last Visit: _____

HISTORY OF SUBSTANCE ABUSE:

Substance: _____	_____	_____
How Often: _____	_____	_____
How Much: _____	_____	_____
Date of Last Use: _____	_____	_____
By IV?: _____	_____	_____
Age of First Use: _____	_____	_____
Length of Abuse: _____	_____	_____

MEDICAL INFORMATION:
List any known or reported allergies or other medical / mental health alerts:

_____

Current Weight: _____ Current Height: _____ Current Age: _____

Hair Color: _____ Eye Color: _____ Number or Tattoos: _____

Do you now have or have you ever had:		**Describe / Explain:**
01. Eye Problems?	Yes ___ No ___	_____
02. Hearing Problems?	Yes ___ No ___	_____
03. Fainting Spells?	Yes ___ No ___	_____
04. Dizzy Spells?	Yes ___ No ___	_____
05. Convulsions?	Yes ___ No ___	_____
06. Epilepsy?	Yes ___ No ___	_____
07. Head Injury?	Yes ___ No ___	_____
08. Bad / Severe Headaches?	Yes ___ No ___	_____
09. Body Parts Paralyzed?	Yes ___ No ___	_____
10. Thyroid Problems?	Yes ___ No ___	_____
11. Chest Pains?	Yes ___ No ___	_____
12. High Blood Pressure?	Yes ___ No ___	_____
13. Swelling of Hands/Feet/Ankles?	Yes ___ No ___	_____
14. Kidney Problems?	Yes ___ No ___	_____
15. Ulcers / Stomach Problem?	Yes ___ No ___	_____
16. Liver Problems?	Yes ___ No ___	_____
17. Recent Appetite Change?	Yes ___ No ___	_____
18. Constipation / Diarrhea?	Yes ___ No ___	_____
19. Recent Sleeping Problems?	Yes ___ No ___	_____
20. Diabetes?	Yes ___ No ___	_____
21. Tuberculosis?	Yes ___ No ___	_____
22. Cancer?	Yes ___ No ___	_____
23. Surgery?	Yes ___ No ___	_____
24. Medical Disabilities?	Yes ___ No ___	_____

MENSTRUAL / PREGNANCY DATE (This section for females only)

Are you experiencing or have you ever experienced:

A Menstrual Cycle?	Yes ___ No ___	_____
A Difficult Menstrual Cycle?	Yes ___ No ___	_____
A Pregnancy?	Yes ___ No ___	_____
A Difficult/Problem Pregnancy?	Yes ___ No ___	_____

Are you Pregnant? _____ Due Date? _____

CURRENT MEDICATIONS:

Name:	_____	_____	_____	_____
	_____	_____	_____	_____
Strength:	_____	_____	_____	_____
	_____	_____	_____	_____
Frequency:	_____	_____	_____	_____
	_____	_____	_____	_____
Purpose:	_____	_____	_____	_____
	_____	_____	_____	_____

HEALTH STATEMENT:

Describe in your own words the current state of your overall, general health:

_____

_____

_____

MENTAL HEALTH HISTORY:

Have you received mental health or substance abuse treatment in the past? (If so, where/when/what for? Please include any mental health diagnoses):

_____

_____

_____

_____

Are you currently under any outpatient care? (If so, where?): _____

LEGAL:

Do you have any prior violent charges/convictions? (If yes, please explain.):

_____

_____

_____

Are you required to register as a sex offender? (Yes/No): _____

SELF-HARM HISTORY:

Do you have any previous suicide or self-harm attempts? (If so, please explain each attempt including when it happened):

_____

_____

_____

_____

I attest that all the information above is factual and accurate.

Signature: _____ Date: _____