

# Capstone Treatment Center Profile Sheet

Name: \_\_\_\_\_ Case #: \_\_\_\_\_ DOA: \_\_\_\_\_ TOA: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ SSN: \_\_\_\_\_ Therapist: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

Email Address 1: \_\_\_\_\_

Email Address 2: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name and Relationship of Legal Guardian: \_\_\_\_\_

Billing Address if Different from above: \_\_\_\_\_

How were you referred to Capstone: \_\_\_\_\_

- |               |                                   |              |                  |                 |
|---------------|-----------------------------------|--------------|------------------|-----------------|
| 1. DOC: _____ | Age at 1 <sup>st</sup> use: _____ | Route: _____ | Frequency: _____ | Last use: _____ |
| 2. DOC: _____ | Age at 1 <sup>st</sup> use: _____ | Route: _____ | Frequency: _____ | Last use: _____ |
| 3. DOC: _____ | Age at 1 <sup>st</sup> use: _____ | Route: _____ | Frequency: _____ | Last use: _____ |
| 4. DOC: _____ | Age at 1 <sup>st</sup> use: _____ | Route: _____ | Frequency: _____ | Last use: _____ |
| 5. DOC: _____ | Age at 1 <sup>st</sup> use: _____ | Route: _____ | Frequency: _____ | Last use: _____ |

DSM: Code	Name of Disorder	Specifier
Axis I:	_____	_____
_____	_____	_____
_____	_____	_____

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: Current GAF: \_\_\_\_\_ Highest GAF in the past 12 months: \_\_\_\_\_

## Discharge

Type: \_\_\_\_\_ Days in Treatment: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Discharge: \_\_\_\_\_

Hours: Group \_\_\_\_\_ Individual \_\_\_\_\_ Family \_\_\_\_\_ Phone \_\_\_\_\_ Adventure \_\_\_\_\_ Aftercare \_\_\_\_\_

Discharge GAF: \_\_\_\_\_

# ADMISSION AGREEMENT

\_\_\_\_\_ is being admitted to Capstone Treatment Center on \_\_\_\_\_ for an evaluation period for the following reasons, but not limited to: (check appropriate spaces) \_\_\_\_\_ Family Conflict; \_\_\_\_\_ Substance Abuse/Dependency; \_\_\_\_\_ Parent/Child Relationship Problems; \_\_\_\_\_ Adjustment Disorder; \_\_\_\_\_ Anger Management; \_\_\_\_\_ Depression; \_\_\_\_\_ Oppositional Defiance; \_\_\_\_\_ other.

I, \_\_\_\_\_, understand that he will be evaluated monthly for appropriateness of placement. If at any time it is determined that he has been inappropriately placed at Capstone Treatment Center, he is subject to discharge. In the event of discharge, Capstone shall comply with regulatory requirements on advance notice to parents.

Continued placement will be determined on the basis of, but limited to:

- Hospitalization beyond 10 calendar days
- The cost for care for the resident becomes prohibitive
- Family or legal guardian does not consent to the course of treatment recommended by Capstone Treatment Center
- Placement is no longer appropriate

I understand the above statements and agree to the terms outlined.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Resident

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**NOTICE TO RESIDENT CONCERNING  
CONFIDENTIALTY OF  
ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

The confidentiality of alcohol and drug abuse patient records maintained by Capstone Treatment Center is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

- 1) The patient consents in writing; OR
- 2) The disclosure is allowed by a court order; OR
- 3) The disclosure is made by medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
- 4) The patient commits or threatens to commit a crime either at the program against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(see 42 USC Sections 290dd-22 for Federal laws and  
42 CFR Part 2 for Federal regulations)

I acknowledge receipt of the Notice.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Signature of Parent

## **Understanding of Mandated Reporters**

I/we understand that all Capstone employees are mandated child abuse and neglect reporters. In the case of abuse or neglect disclosure they must contact appropriate authorities.

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Signature of Parent

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Date

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Signature of Parent

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Date

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Signature of Resident

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Date

**CAPSTONE TREATMENT CENTER, INC.**  
**RELEASE AND WAIVER OF LIABILITY**

KNOW ALL MEN BY THESE PRESENTS:

All residents of Capstone Treatment Center (collectively, with its owners, directors, officers, employees, representatives and/or agents, referred to herein as "Capstone") will be actively involved in activities at various locations that may be dangerous and that may involve an inherent risk of physical injury, illness or death. These activities include, but are not limited to, participating in a ropes course, weight lifting, canoeing, hiking, trekking, mountaineering, rappelling, rock climbing, solo time in the wilderness, backpacking, swimming, fishing, and various other activities.

This Release and Waiver of Liability is provided as a condition of enrollment as a resident at Capstone Treatment Center. Acceptance as a resident at Capstone is the sole compensation for this Release and Waiver of Liability.

Without limitation of the causes of physical injury, the undersigned acknowledges that the inherent danger of participation in activities at Capstone can include, but is not limited to: falls; cold weather related injuries such as frostbite and hypothermia; heart related injuries such as heat exhaustion and heat stroke; acts of nature which may include, among other things, cave-ins, rock slides, high winds, crevice falls, severe weather, hail and lightning; river crossings, fording, or travel including travel to and from activities; risks associated with crossing, climbing or down-climbing rocks and mountains; risks associated with canoeing and water sports; risks such as muscle strain, stress fracture, other fractures and tears, associated with weight lifting, ropes course participation, and other activities; and equipment failure.

The undersigned acknowledges that certain foreseeable and unforeseeable events may contribute to the unpredictability of any activity. The undersigned acknowledges that personal property may be lost, and that he may suffer an accident or illness in remote places where there is no medical facility immediately available, and acknowledges that wearing a helmet, wearing appropriate clothing, and following safety instructions provided by Capstone are basic safety precautions. The undersigned further acknowledges that he will comply with any safety precautions required by Capstone, but that such precautions may not adequately protect him against all risks of injury, illness or death.

By enrolling as a resident at Capstone and signing below, you acknowledge that (i) these risks have been adequately explained to you, (ii) you comprehend and appreciate the nature of these risks, (iii) you understand and have voluntarily consented to accept these risks, and (iv) you hereby forever release, waive, acquit, discharge, and covenant to indemnify, defend and hold harmless Capstone from and against all actions, rights, and causes of action, expenses, costs, claims and demands whatsoever that may exist or hereafter accrue against Capstone and any other person, corporation, association or partnership who or which may be charged with responsibility for injuries to the undersigned person, the treatment thereof, and all consequences flowing there from, as a result of participation in any activity at any property or location while a resident at Capstone Treatment Center. The foregoing waiver, release and indemnity shall also apply with respect to any injury, illness or death resulting from the undersigned's receipt of medical care with respect to any injury or illness occurring through participation in the activities that are the subject to this Release and Waiver of Liability.

As a potential participant in actives during the course of your treatment by Capstone Treatment Center, you have the right to ask to see the safety record and know of accidents and incidents of past residents at Capstone Treatment Center.

Initial \_\_\_\_\_

The undersigned warrants that no promise or inducement has been offered for this Release and Waiver of Liability except as set out herein; that the undersigned is of legal age (or signature of a responsible adult parent or guardian accompanies his signature) and is competent to sign this Release and Waiver of Liability, and he accepts full responsibility therefore.

Witness my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of resident

\_\_\_\_\_  
Signature of Witness

**PARENT/GUARDIAN RELEASE AND WAIVER OF LIABILITY**

I/We, the undersigned parent(s) or legal guardian(s) of \_\_\_\_\_, a minor, acknowledge that we have read the forgoing Release and Waiver of Liability, that we agree with the provisions set out therein in all respects, and that we acknowledge receipt of valuable consideration for this release, that being the acceptance of the identified minor as a resident at Capstone Treatment Center.

I/We forever release, waive, acquit, discharge, and covenant to indemnify, defend and hold harmless Capstone and any other person, firm or corporation charged or chargeable with responsibility or liability, from any and all claims, demands, damages, costs, expenses, actions and causes of action, belonging to the said minor or the undersigned arising out of participation in any activity while a resident of Capstone Treatment Center.

The undersigned further agree that this Release and Waiver of Liability shall apply to all known and unknown and unanticipated injuries and damages directly and indirectly resulting from the identified minor's participation as a resident at Capstone Treatment Center and/or his participation in activities during his course of treatment through Capstone Treatment Center.

Witness our hand(s) this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Witness

## **Suicidal Threat Policy**

In the event of any suicidal threats, the resident will be isolated from the other residents. At that time the resident will be assessed by a Capstone therapist to determine the severity of the threat. The executive and clinical director will be contacted and included in this decision making. If the resident ranks high enough on the self-harm scale a referral will be made to Baptist Recover Teen in Little Rock, AR. The resident will then be transported to Baptist with two male staff members. If Baptist doesn't have openings then another psychiatric facility will be contacted. The parents will be contacted during this process and will be updated on new happenings. At the end of their stay at the psychiatric facility, the resident will be reassessed for appropriateness of treatment at Capstone Treatment Center. It is Capstone's hope that the resident return for completion of treatment here. However, if it is determined that the resident does not need to return to Capstone, the therapy team will assist the family in further planning.

I understand the above policy on Capstone Treatment Center's suicide threat policy.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

# Client Legal And Human Rights

1. No hidden cameras or audio/visual techniques (i.e. one way mirrors, or hidden cameras) are used. Cameras are utilized in the residential programs for client protection and security. A photograph will be taken by admissions personnel and kept in each client's file for identification purposes only.
2. The client's presence in treatment will be kept confidential except when the client has given written authorization to release information or in the event of that emergency information must be released. Internal access to files is limited to the clinical and administrative staff of the program. External access to files is limited to the program's certification site visit review and information must be released if subpoenaed by the court and a ruling of "good cause" is issued.
3. Each client has the right to see his or her clinical record in the presence of the Clinical Director. A written request stating the reasons for the request is required. The request should be submitted to the client's counselor, then given to the Clinical Director who will schedule a time for review of the record.
4. Client's with grievances may make an appointment to discuss the grievance with the program manager. If the Manager's decision has not resolved the grievance, a written appeal to the Clinical Director should be submitted. The Clinical Director's decision will be final and given to the client in writing.
5. The program will use proven techniques to assist with drug or alcohol problems. No drugs, other than those specifically prescribed by a physician, or over the counter medications approved by the nursing staff, will be used by the client.
6. Capstone Treatment Center is an equal opportunity organization and promotes a strong non-discrimination policy in all aspects of the program
7. The client will receive treatment and care for drug related problems in a safe and humane environment.
8. The client will be informed of the need for parental or guardian consent for treatment, if appropriate.
9. The client will be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatment, services and types of providers of substance abuse services.
10. Informed consent will be received prior to being involved in research projects.
11. The client will manage personal financial affairs, unless legally determined otherwise.
12. The client will actively participate in treatment, including discharge planning, as appropriate.
13. Every reasonable and appropriate effort will be made for the client's overall safety and protection.
14. The client will receive the least restrictive treatment that is appropriate and available. Clients will also have the right to refuse treatment. If this occurs, the client will be informed of other appropriate substance abuse providers from which they may seek services.
15. Any cases of suspected abuse, neglect, exploitation of clients, regardless of age, being served in the program where the alleged perpetrator is an employee, client, or other person in the program will be reported to the local DHR office and SADS Director's office in accordance with applicable State law and DMH/MR abuse reporting procedures.
16. The client will be informed of the financial aspects and obligations of treatment.\
17. The client will have the right to refuse procedures deemed invasive such as blood screens, body searches, and searches of personal belongings. However, the client may be subject to discharge from the program due to concerns for safety of the client and others for search refusal.

\_\_\_\_\_  
Client Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Witness Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Capstone Ministries d/b/a Capstone Treatment Center**  
**120 Meghan Lane**  
**Judsonia, AR 72081**  
**(501) 729-4479**

**FEE PAYMENT AGREEMENT AND**  
**SCHEDULE OF RATES AND CHARGES**

Name of Resident: \_\_\_\_\_ Date: \_\_\_\_\_

Charges for services to the Resident are calculated as follows:

1. Treatment is provided at \$400 per day. The average stay is 3-3 1/2 months, but the actual term of treatment could be more or less than the average.
2. In addition to the daily rate, the responsible party agrees to pay a one time fee of \$400 for the Wilderness Equipment.
3. Any additional costs for resident are due upon receipt (Medications, Nicotine supplements, etc.)

I/We understand that the cost of treatment, as set out above, is based on the daily rate charged per day during the treatment. Payments of the program fees are scheduled as follows:

- |    |  |                                       |
|----|--|---------------------------------------|
| 1. | Payment due upon admission:                      | \$12,000.00 plus \$400 Wilderness Fee |
| 2. | Payment due on 31 <sup>st</sup> day of treatment | \$12,000.00                           |
| 3. | Payment due on 61 <sup>st</sup> day of treatment | \$12,000.00                           |
| 3. | Payment due Monday of Family Retreat             | Balance on account                    |

In the event of discharge for any reason before completion of the program, the entire balance shall be due immediately upon discharge, based upon the daily rate. If payment is not made in full at discharge, the responsible party must sign a promissory note for the balance, which shall include a specific payment schedule. \$1,500 shall be charged as an early withdrawal penalty for any resident not completing the program, in addition to all other scheduled fees and charges. Additionally, aftercare services is forfeited for any resident not completing the program.

I/We, the undersigned resident and/or responsible party, understand that the fees are due on the schedule set out herein, and that past due accounts shall bear interest at the rate of 10% per annum. **ALL PAYMENTS ARE DUE FROM THE RESPONSIBLE PARTY. CAPSTONE WILL ASSIST YOU TO BE REIMBURSED BY INSURANCE, WHERE APPROPRIATE, AT THE COMPLETION OF THE PROGRAM. CAPSTONE DOES NOT RELY ON ANY INSURANCE PROGRAM FOR PAYMENT. PAYMENTS ARE THE RESPONSIBILITY OF THE UNDERSIGNED RESPONSIBLE PARTY.** In the event collection is required, I/We agree to pay all costs of collection, including litigation costs, and legal fees (legal fees not to exceed 10% of the balance to be collected). I/We also understand that, in addition to collection action, failure to pay as required and/or make reasonable arrangements acceptable to Capstone Treatment Center to pay for services may result in dismissal from the program.

I/We understand that Capstone Treatment Center will assist the undersigned in filing for benefits available to be reimbursed to us from any insurance plan at the conclusion of the program, but that I/We, the undersigned, are liable for the amounts and on the schedule and terms as set out above, without regard to any insurance payment. I/We acknowledge that Capstone Treatment Center has no control over the amount of payment or terms of approval of insurance companies, and that I/We are not relying on insurance to pay the cost of this program.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Telephone: ( )

\_\_\_\_\_  
Telephone: ( )

# Acknowledgement of Understanding of the Fee Payment & Scheduling Policy

During the admission process, the fee payment policy was reviewed, and I/We understand the following:

1. I will be charged a daily rate of \$400 for treatment.

\_\_\_\_\_  
Initial

2. I will be charged a one time \$400 Wilderness Fee.

\_\_\_\_\_  
Initial

3. I understand that the average length of the program is 3 to 3-1/2 months and that I am responsible for payment for **ALL** of the days the resident is at Capstone Treatment Center.

\_\_\_\_\_  
Initial

4. I understand that there is a \$1,500 early withdrawal penalty for any resident who does not complete the program .

\_\_\_\_\_  
Initial

5. I understand that the right to aftercare services is forfeited in the event the resident does not complete the treatment program.

\_\_\_\_\_  
Initial

6. I understand Adventure Week and graduation dates are contingent on my son and our family's readiness and if we are not ready, those dates could change.

\_\_\_\_\_  
Initial

7. I understand that the scheduling of family week, adventure week and family retreat are worked around other families, staff, and holidays.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Date

## Consent for Medications and Supplements

I/We, \_\_\_\_\_, give my/our permission for Capstone Treatment Center to administer supplements to my/our son, \_\_\_\_\_ . This includes daily vitamins, weight gain and protein supplements, over the counter medication for allergies, pain, and illness, and supplements for sleep problems. I/We understand that Capstone Treatment Center will inform me/us if my/our son begins taking these on a regular basis and I/we will be charged for it. I/we understand that I/we will not be notified about medication or supplements that are administered on a need to have basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If my/our son is in need of a refill of an existing medication or is prescribed a medication for illness while at Capstone, I/we would prefer the following:

Please check one:

\_\_\_\_\_ to be notified, fill it at my/our home pharmacy and then mail it to Capstone.

\_\_\_\_\_ have it filled at Searcy Medical Center Pharmacy where my/our insurance will be billed and then I/we will be billed the co-pay or uncovered charges by SMC Pharmacy..

\_\_\_\_\_ have it filled at Walgreens where I/we have an Express Pay account set up or will set it up to be automatically charged by Walgreens for the co-pays.

I give my permission for Capstone to release our insurance and billing information to the pharmacies listed above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## MAIL WAIVER

I/We, \_\_\_\_\_ release Capstone Treatment Center to screen my/our child's incoming and outgoing mail. I/We will make a list of approved persons. If mail is received from or sent to people other than those listed below, I/we understand that I/we will be contacted by Capstone. If that mail is not approved it will be held at Capstone and not given to my/our son.

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **List of Approved Persons (Family and Family friends ONLY; No peers)**

- |    |     |
|----|-----|
| 1. | 8.  |
| 2. | 9.  |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

# Phone Policy

## **Basic Guidelines and Procedures**

- Residents are allotted a total of 20 minutes of talk time per week (10 minutes each on Monday or Tuesday and Friday).
- Residents are only allowed to call numbers that have been approved on the list below. This list must be family ONLY.
- A resident must have resided at Capstone for one week before making a phone call.
- Residents must always be monitored while talking on the phone.
- The monitor of the phone call must dial the number, get the approved party on the line and enforce the 10-minute rule.
- The monitor must fill out the phone log and use the staff notes section to record any unusual activity or conversations. (When in doubt, document!!)

<b>Approved Person(s)</b>	<b>Phone Number</b>

# **HEALTH INSURANCE AUTHORIZATION FORM**

## **CAPSTONE TREATMENT CENTER**

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(CLIENT/RESIDENT)

In cases where the resident is covered for the cost of care and treatment, under an insurance plan, either his own or under that is the responsible person; it is necessary to obtain the signature of the policyholder on the following authorization before a claim may be submitted for payment.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the above treatment center to release medical information necessary to process this claim.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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Please answer the following questions to the best of your ability.

Insured's Name: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_

Insured's Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

If resident has other health insurance, health plan, or state assistance, enter its name, address, and policy or medical assistance number here:

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\*\*\*Please send/make a copy of the front and back of all insurance cards.

**Acknowledgement of Physical Examinations and Medications**

I understand that my/our son, \_\_\_\_\_, is required to have a physical examination, including a blood work-up for STD's and HIV, in order to participate fully in the Capstone Treatment Center program. I also understand that in the case of my/our son needing medication it will be filled at Searcy Medical Center Pharmacy.

I am fully aware and understand that I am responsible for payment of all expenses incurred by the physical and blood work not paid by my insurance company.

I am fully aware and understand that I am responsible for payment of all expenses incurred by medications filled at Searcy Medical Center Pharmacy not paid by my insurance company.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

**CAPSTONE TREATMENT CENTER**

**P.O. Box 8241  
Searcy, AR 72145**

**Authorization for Searcy Medical Center Treatment**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Parent Name and Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Information:**

Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Capstone Official authorizing treatment: \_\_\_\_\_

Resident Signature: \_\_\_\_\_

**HIV/STD TESTING**

I, \_\_\_\_\_ give my  
permission to be tested for HIV/STD through Dr. Joe Dugger's office at Searcy Medical Center.  
Please have results released to Capstone Treatment Center.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# **Education Assessment**

**(Only to be completed if resident is currently in school or will be doing school while in treatment)**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_

Name and Address of School Last Attended:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all classes currently enrolled:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any learning disabilities:

\_\_\_\_\_  
\_\_\_\_\_

Does your son have an IEP? Circle one: Yes No

List any medical conditions:

\_\_\_\_\_  
\_\_\_\_\_

List any medications:

\_\_\_\_\_  
\_\_\_\_\_

Please give a brief school history:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list educational goals for resident at Capstone:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# **FAMILY INFORMATION FORM**

Date: \_\_\_\_\_

Resident's name: \_\_\_\_\_

Parent's/Guardian's Name (s): \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_

**(Mother)** Birth date: \_\_\_\_\_ Place: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Employer: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Unemployed: \_\_\_\_\_ How long? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**(Father)** Birth date: \_\_\_\_\_ Place: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Employer: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Unemployed: \_\_\_\_\_ How long? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

## **Questions:**

Are you currently receiving any counseling and/or psychotherapy?

\_\_\_\_\_

Agency Name: \_\_\_\_\_

Are you now, or have you ever been involved in any self-help, 12-step or recovery program? \_\_\_\_\_

If so, please name: \_\_\_\_\_

\_\_\_\_\_

Religion: \_\_\_\_\_ What are the religious/spiritual practices of the family?

\_\_\_\_\_

\_\_\_\_\_

Are you aware of any involvement by your son in cults, etc.? \_\_\_\_\_

If so, please elaborate: \_\_\_\_\_

\_\_\_\_\_

Are you aware of any physical or sexual abuse? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a friend or relative who is recovering or struggling from alcoholism or chemical dependency?

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What is another major concern in your life right now, besides your child's chemical use:

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Who are the people living in your household?

Name	Relationship	Age/DOB
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<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

What is your present marital status? \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widow/Widower

If married, date married: \_\_\_\_\_

If previously married, date(s) of marriage: \_\_\_\_\_

If spouse deceased, date of death: \_\_\_\_\_ Cause: \_\_\_\_\_

Names and birthdates of children outside your household:

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Is your child adopted? \_\_\_\_\_ Age at adoption: \_\_\_\_\_ Contact w/ birth parents? \_\_\_\_\_

Is there a family member with whom your child has significant conflicts? \_\_\_\_\_

If yes, who? \_\_\_\_\_

How is your child disciplined and who does it? \_\_\_\_\_

Are there any losses which have impacted your child? \_\_\_\_\_

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List any medical conditions (cancer, diabetes, high blood pressure, etc.) of parent/child or blood relative and state relationship.

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Are you currently taking any medication? \_\_\_\_\_ If so, what medication? \_\_\_\_\_

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Do you ever wonder about taking too many medications? \_\_\_\_\_

Do you ever question your own drinking or chemical use? \_\_\_\_\_

Do you ever question the use of alcohol or other drugs by some in your family? \_\_\_\_\_

Who? \_\_\_\_\_

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**Questions regarding son's usage:**

What is the problem with your son as you see it? (Check all that apply)

- \_\_\_\_\_ Alcohol
- \_\_\_\_\_ Prescription medications
- \_\_\_\_\_ Cocaine
- \_\_\_\_\_ Marijuana
- \_\_\_\_\_ Methamphetamine
- \_\_\_\_\_ Ecstasy
- \_\_\_\_\_ Over-the-Counter medications
- \_\_\_\_\_ Other drugs (please specify) \_\_\_\_\_

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Adolescent Awareness of Problem:

- \_\_\_\_\_ No Awareness: "No Problem, I'm no worse than my friends, everybody's doing it".
- \_\_\_\_\_ Minimal Awareness: "I can take it or leave it; I'm not too bad."
- \_\_\_\_\_ Moderate Awareness: "It's not my fault." "Sometimes I get into trouble too much."
- \_\_\_\_\_ Admits to Problem: "I can't help it." "Something is bothering me."
- \_\_\_\_\_ Well aware of problem and accepts responsibility for change

How long do you believe the problem has existed?

- Less than a year
- 1 to 3 years
- 3 to 6 years
- 6 to 10 years

What other problems are you aware of that are related to the alcohol/drug problems in your son?

(Check all that apply)

- School problems
- Legal problems
- Health problems
- Emotional problems
- Financial problems
- Peer relationship problems (friends)
- Family relationship problems
- Job/Occupational problems
- Other \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge, has the your son ever experienced any of the following because of the drug and/or alcohol use?

- Blackouts (a loss of memory without loss of consciousness)
- Arrests (Please describe) \_\_\_\_\_  
\_\_\_\_\_
- School expulsion (Please describe) \_\_\_\_\_  
\_\_\_\_\_
- Aggressive or abusive behavior (please describe) \_\_\_\_\_  
\_\_\_\_\_
- Alibis for drinking (i.e. "All my friends drink.)
- Irresponsible; can't predict what they will say or do.
- Memory problems
- Changes eating habits
- Loss or change in friends
- Personality change (describe) \_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge, what is the longest period the patient has been drug and alcohol free since the problem began?

\_\_\_\_\_ Absolutely don't know

\_\_\_\_\_ Probably uses each day

\_\_\_\_\_ Probably a few days at a time

\_\_\_\_\_ Probably weeks at a time

Why do you think your child has sought treatment at this time?

\_\_\_\_\_ Felt problem was serious and treatment was needed

\_\_\_\_\_ To comply with someone else's wishes

\_\_\_\_\_ To avoid consequences of recent behavior

\_\_\_\_\_ To salvage school grades or job

What previous attempts at treatment have been tried?

Place	Name and Dates	Outcome
General Hospital	_____	_____
Alcohol/Drug Treatment Center	_____	_____
Detoxification	_____	_____
Alcoholics Anonymous	_____	_____
Narcotics Anonymous	_____	_____
Psychiatric Treatment Center	_____	_____
Out-Patient Counseling	_____	_____
Intensive Out-Patient	_____	_____
Other _____	_____	_____

Please answer the following True or False

1. Stress at work or family pressure makes people chemically dependent.
2. Families must not upset chemically dependent members in treatment in case they might start them drinking or taking drugs again.
3. Only people who lack willpower and determination become chemically dependent.
4. Once chemically dependent people get help and stop drinking and/or using drugs, those close to them are okay.
5. Families of chemically dependent find it just as difficult to accept this diagnosis as the addicted person.

True

False

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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