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: ____________________________________