Troup County Family Treatment Court
Application

Our program does not discriminate or refuse treatment on any basis unrelated to recovery issues. Your complete disclosure and honesty will allow our staff to determine how we can provide you the quality services you deserve. ***Please note that this form must be completed in full.***

PART I. GENERAL DATA

Date: _____ Complete Name:_____

DOB: _____ Age: _____ SS#: _____ Driver's License #:_____

Ethnicity: _____ Citizenship / Nationality: _____

Language(s) Spoken:_____ Primary Language:_____

Were you ever in the Armed Forces? ☐ Yes ☐ No If yes, Branch:_____

Dates of Service: _____ Discharge Type:_____

Current Relationship Status: _____ How Long? _____ Number of Marriages: _____

Spouse/Partner/Significant Other's Name:_____

High school diploma? ☐ Yes ☐ No; GED? ☐ Yes ☐ No; Level of Education Completed: _____
Name of High School_____

Name of College/Tech School_____

Current Physical Address (include city, zip): _____

How long have you lived there? _____

Current Mailing Address (if different from above): _____

Current Phone Number(s) (including area code): _____

If accepted in Family Treatment Court, who will be residing with you? _____

_____

Are there other substance abusers in the household? ☐ Yes ☐ No If yes, who? _____

_____

Is there anyone who is in recovery in your home? ☐ Yes ☐ No If yes, who? _____

Have you ever been the victim of any type of trauma? ☐ Yes ☐ No

If yes, Please Describe_____

_____

What changes, positive or negative have recently occurred in your family situation? _____

_____

What is your means of transportation to treatment?

_____

Who is willing to be involved in your treatment? Is it o.k. if we contact them? ☐ Yes ☐ No

1. _____ Relationship _____ Phone # _____

2. _____ Relationship _____ Phone # _____

3. _____ Relationship _____ Phone # _____

Emergency Contact Information

Name: _____Relationship:_____

Telephone: Work (_____)_____ Home (_____)_____
Cell (_____)_____ Other (_____)_____

PART II. CHILD(REN) DATA

Children	DOB	Father	Currently Living With
1.			
2.			
3.			
4.			
5.			

Family Members (Potential family placement, if necessary):

Relative Name	Age	Address	Phone Number
1.			
2.			
3.			
4.			
5.			

Custody of children: ☐ Parent(s) ☐ Relative ☐ DFACS ☐ Other _____
Do you have a primary care doctor for your child(ren)? ☐ Yes ☐ No

If yes, Name:_____

Address:_____ Phone #:_____

Do you have a dentist for your child(ren)? ☐ Yes ☐ No

If yes, Name:_____

Address:_____ Phone #:_____

DFACS Caseworker: _____

Telephone: Work (_____)_____ Cell (_____)_____

PART III. SUBSTANCE USE HISTORY

DRUG	YES /NO	METHOD	HOW OFTEN	DATE/AGE OF 1ST USE	DATE/AGE OF LAST USE
Alcohol					
Marijuana (Pot)					
Cocaine / Crack					
Amphetamines					
Prescription Drugs:					
Hallucinogens					
Inhalants					
Narcotics					
Nicotine					
Synthetics:					

Have you participated in substance abuse treatment before? ☐ Yes ☐ No

If yes, when and where?_____

_____

If yes, why do you believe your previous efforts towards recovery failed? _____

_____

Have you ever been hospitalized for withdrawal and or detox? ☐ Yes ☐ No

If yes, when and where?_____

_____

What is your family history regarding substance abuse? _____

Do you see your substance use as a problem? ☐ Yes ☐ No If yes, how long? _____

Have you attempted to stop use? ☐ Yes ☐ No Longest period of abstinence: _____

PART IV. MEDICAL HISTORY

Do you have any current medical problems? ☐ Yes ☐ No If yes, please list:

_____

If yes, what treatment and/or medications are you taking?

_____

_____

Are you currently pregnant? ☐ Yes ☐ No If yes, how far along are you? _____

Who is your treating physician? _____ Phone Number:_____

Would your medical problems interfere with your treatment responsibilities? ☐ Yes ☐ No If yes, explain:

_____

_____

Previous Medical Hospitalizations (where and when?) _____

_____

Do you have any current psychiatric problems? ☐ Yes ☐ No If yes, please list:

_____

Have you ever been diagnosed with a psychiatric problem? ☐ Yes ☐ No If yes, please list:

_____

Are you currently or have you ever taken medications for depression, anxiety attacks, panic attacks, mood swings, or other emotional problems? ☐ Yes ☐ No

If so, please list your medications, dosage, and the dates taken_____

_____

_____

Previous Psychiatric Hospitalizations (where and when?) _____

_____

PART V. LEGAL BACKGROUND

Do you have any pending charges or court dates? ☐ Yes ☐ No If Yes, when and what for? _____

_____

Do you have any felony convictions? ☐ Yes ☐ No If yes, detail below:

Convicted of:_____ DATE:_____

Location:_____ If more than one, use back of this form.

If you are currently on probation, list your probation officer's name and phone number: _____

_____

PART V. EMPLOYMENT HISTORY/FINANCIAL BACKGROUND

Position	**Employer / Phone #**	**Dates: To-From**	**Reason for Leaving**
1.			
2.			
3.			
4.			
5.			

If you are not currently working, why not?_____
_____

List your skills and training:_____
_____

Do you have any additional income sources? ☐ Yes ☐ No If yes, what? _____

What was your total annual income last year? _____ Did you file a tax return? ☐ Yes ☐ No

Are you or anyone in your household currently or previously receiving any public assistance? ☐ Yes ☐ No

If yes, describe and how long? _____

Do you have insurance (including Medicaid, Medicare) ☐ Yes ☐ No
If yes, with who? _____

Do you receive Social Security? ☐ Yes ☐ No

Are you currently receiving or paying child support ☐ Yes ☐ No
Do you have any civil judgments (Bankruptcies, Divorces, Law Suits) resolved or pending? ☐ Yes ☐ No

If yes, describe _____

PART VI.

Thank you for your help and honesty. If we have overlooked any information that you feel is important to our consideration of you for this program, please let us know.

I _____ attest that the information that I have provided the Troup County Family
NAME

Dependency Treatment Court is true and accurate.

_____ _____
SIGNATURE DATE