CONFIDENTIAL

FAMILY DATA FORM

Please fill out and mail or fax the attached questionnaire as soon as possible. The patient will be confronted with this information in order to help him or her recognize their problems more realistically. Perhaps for the first time, they can hear your perspective.

Your open and honest response will assist us in evaluating and confronting this patient.

Please be specific (give dates, etc.) in your answers. (If not enough space, please write on the back).

Palmetto Addiction Recovery Center
86 Palmetto Road, Rayville, LA 71269

Fax: 318-728-2272

Patient Name: _____

Your Name: _____

Relationship To Patient: _____

How long have you realized there is a problem? (Include type of problem, frequency and duration.)

_____

_____

_____

_____

Personality Changes: Describe how patient acts when intoxicated; describe any deterioration in behavior including any incidents of verbal and/or physical abuse. What do you MOST object to about their behavior? Also include any behaviors that concern you whether or not you believe them to be related to addiction.

_____

_____

_____

_____

Job Problems: Include how much absenteeism, accidents on the job, performance problems, missing promotions, job terminations, problems with supervisors and/or coworkers, periods of unemployment. Also how has spouse's job, children's job (or school) been affected?

_____

_____

_____

_____

What action would you take or are willing to take if addiction continues? (e.g. divorce or making patient find another residence)

_____

_____

_____

_____

What difference do you want this treatment to make in the life of the patient?

Which of the problems related to addiction that you've listed do you believe to be the MOST serious? WHY?

What changes need to occur in the patient's lifestyle for him/her to stay well and responsible?

Describe how you would like your relationship with the patient to be? What would be different?

Please check all that apply.

PATIENT'S AWARENESS OF PROBLEM/DENIAL:

- ❑ None: "No problem", "Don't bother me" or "Leave me alone"
- ❑ Little Awareness: "I'm no worse than anyone else" or "I'm not hurting anyone"
- ❑ Moderate Awareness: "I know I have a problem, but I can handle it", or "It's not my fault something is bothering me"
- ❑ Well aware of problem and willing to accept help

WHY DO YOU THINK PATIENT SOUGHT TREATMENT AT THIS TIME?

- ❑ Felt the problem was serious and treatment was necessary
- ❑ To avoid divorce/separation
- ❑ To salvage job
- ❑ To comply with someone else's wish (If so, who?_____)
- ❑ Legal problems
- ❑ Other reasons—describe the CRISIS that brought patient to treatment:

_____

_____

_____

_____

HOW DO YOU FEEL TOWARD THE PATIENT?

- ❑ Worry: "Job security, accidents, arrest"
- ❑ Guilt: "If I had only done something sooner"
- ❑ Impatience: "I've known help was needed for a long time"
- ❑ Resentment
- ❑ Other feelings or comments:

_____

_____

_____

_____

WHAT IS YOUR ATTITUDE TOWARD THE POSSIBILITY OF RECOVERY?

- ❑ No hope
- ❑ Skeptical

Remarks:

_____

_____

_____

_____

_____

PREVIOUS ATTEMPTS AT TREATMENT:

- ❑ General hospital care/medical care (List hospitalizations including dates and reasons.)
- ❑ Psychiatric treatment
- ❑ Alcoholism/drug treatment centers
- ❑ 12-Step group meetings
- ❑ Self

Comments: (i.e. dates, places, etc.)

_____

_____

_____

_____

_____

HOW DOES PATIENT FEEL TOWARD AA?

- ❑ No knowledge
- ❑ Avoidance
- ❑ Critical of members or program
- ❑ Good program for OTHER people
- ❑ Group meeting will help me

HOW DO YOU FEEL ABOUT AL-ANON? (Program for family members/friend of alcoholics)

- ❑ No knowledge
- ❑ Some experience
- ❑ Active participation; how long: _____
- ❑ No intention of becoming involved

ARE YOU INTERESTED IN FAMILY COUNSELING? ❑ YES ❑ NO

ARE YOU PLANNING TO ATTEND AL-ANON? ❑ YES ❑ NO

Comments: _____

The following is a list of symptoms that occur frequently in the lives of some of our patients. Please check the items listed below. (Items below apply to alcohol and/or other drugs).

YES	NO	
❑	❑	Grandiose behavior
❑	❑	Aggressive behavior-physical or verbal
❑	❑	Loss or threat of job or clients
❑	❑	Unreasonable resentments
❑	❑	Hiding bottles or pills
❑	❑	Illogical, paranoid type thinking
❑	❑	Ethical deterioration
❑	❑	Loss of friendship
❑	❑	Persistent remorse or guilt
❑	❑	Changes in family habits or behavior
❑	❑	Sleeping too much or too little
❑	❑	Frequent waking in the middle of night
❑	❑	Eating too much or too little
❑	❑	Inability to function at work or school
❑	❑	Headaches, digestive disorders, nausea, pain with no medical basis
❑	❑	Excessive crying
❑	❑	Thoughts of death or suicide
❑	❑	Lack of energy, constant fatigue
❑	❑	Slowed thinking
❑	❑	Difficulty in concentration, remembering, making decisions
❑	❑	Loss of interest in daily activities
❑	❑	Loss of sex drive
❑	❑	Persistent feelings of sadness
❑	❑	Restlessness, agitation, irritability
❑	❑	Feelings of inappropriate guilt or worthlessness

Comments: _____

_____

Could you come to PARC for consultation with a staff member if you were asked?

Telephone numbers:

Home _____ Work _____

Cell _____

SIGNED: _____

If you feel there is any other information we should know, please write it on the back of this sheet.