INFORMATION QUESTIONAIRE

All this information is confidential and will only be used for assessment purposes. Nothing will be divulged to any third party without your express permission.

ABOUT YOU…

YOUR NAME					
AGE	GENDER				
RELATIONSHIP STATUS • Married • Separated • Single • Stable relationship • Divorced • Widowed • Other	Any comments about your relationship:				
LIST THE AGE OF YOUR CHILDREN (if applicable)	1	2	3	4	5
YOUR EMAIL ADDRESS					
CONTACT TELEPHONE NUMBER					
YOUR CURRENT RESIDENTIAL LOCATION (city only):					
WHOM DO YOU LIVE WITH					
YOUR CURRENT OCCUPATION (if employed)					

ABOUT THE PROBLEM…

List the main substances or addictive behaviours that are causing you problems	1		
	2		
	3		
What are the two main problems in your life currently caused by your substance use or addictive behaviour?	1		
	2		
Do you think you will require a detox?	Yes	No	Maybe
Could you describe the events that have precipitated this treatment enquiry			
Please list most recent residential (inpatient) addiction treatment, the approximate date of the treatment and the duration	facility	date	duration

OTHER INFORMATION ABOUT YOU…

Have you been diagnosed and/or treated for any mental health disorder eg ADHD, Bipolar Disorder, Borderline PD, Depression?	1		
	2		
	3		
Do you have any current active medical or physical problems for which you receive or require treatment	1		
	2		
	3		
Please list all your current regular prescribed medications	1		
	2		
	3		
	4		
	5		
Are you currently in counselling or therapy	yes	no	
Do have a history of: • Violent behaviour • Ongoing suicidal thoughts • Suicide attempts • Self-harm and mutilation eg cutting • Accidental overdose • Risky sexual behaviour • Eating disorder	Any comments that you might wish to make:		
Are you in any trouble with the law in a way that might affect your treatment			
Do you require assistance with personal care and hygiene			
Do you have special dietary requirements			
Is this treatment enquiry your own choice	willingly	reluctantly	external pressures

Any other additional information or comments that you believe we should know about you:

FINANCIAL MATTERS

Treatment will be funded by:	Private Pay	Medical Aid	Third Party
Medical Aid:		Third Party Name:	

NAME OF PERSON COMPLETING THIS FORM	
RELATIONSHIP TO PATIENT (if you are not the patient)	
TODAYS DATE	
FAX TO: +27 (0) 866 281043 or email to: help@tharagay.co.za	