

SIGNIFICANT OTHER QUESTIONNAIRE

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST OR ADMISSIONS COUNSELOR.

YOUR NAME _____ DATE _____

HOME PHONE _____ WORK PHONE _____

YOUR AGE _____ YOUR OCCUPATION _____

NAME OF THE CLIENT _____

YOUR RELATIONSHIP TO THE CLIENT? _____ HOW LONG IN THE RELATIONSHIP? _____

ABOUT YOU

DID ANYONE IN THE FAMILY YOU GREW UP IN-HAVE A PROBLEM WITH ALCOHOL OR DRUGS, INCLUDING PRESCRIPTION DRUGS? YES _____ NO _____

IF YES, WHOM? FATHER _____ MOTHER _____ SISTER _____ BROTHER _____ GRANDMOTHER _____ GRANDFATHER _____ CHILD _____ OTHER _____

PLEASE DESCRIBE WHAT LIFE WAS LIKE IN THE FAMILY YOU GREW UP IN: _____

DO YOU WANT THE RELATIONSHIP WITH THE CLIENT TO CONTINUE? YES _____ NO _____

HAVE YOU HAD MORE THAN ONE MARRIAGE? YES _____ NO _____ PLEASE DESCRIBE EACH MARRIAGE, BRIEFLY, WITH EMPHASIS ON PROBLEMS, INCLUDING ALCOHOL AND DRUG USE:

WHAT KINDS OF PROBLEMS DO YOU THINK YOU HAVE AS A RESULT OF LIVING WITH A CHEMICALLY DEPENDENT PERSON, OR BEING INVOLVED WITH A CHEMICALLY DEPENDENT PERSON?

HAS ANYONE IN YOUR FAMILY, OR FRIENDS TOLD YOU THAT YOU HAVE CHANGED IN THE LAST YEAR? _____ IF YES, HOW? _____

HAVE YOU FELT FEELINGS OF GUILT, REMORSE, DEPRESSION, ANXIETY, SUICIDE? YES _____ NO _____

HAVE YOU HAD PREVIOUS TREATMENT OR COUNSELING FOR YOURSELF? YES _____ NO _____ IF YES,

PLEASE DESCRIBE: _____

PLEASE DESCRIBE YOUR OWN USE OF ALCOHOLIC BEVERAGES OR DRUGS, INCLUDING PRESCRIPTION MEDICATION: _____

HAVE YOU AT TIMES DRANK TO EXCESS, OR USED DRUGS WITH THE CLIENT? YES _____ NO _____
DO YOU SOMETIMES FEEL RESPONSIBLE FOR THE CLIENT'S DRINKING/DRUG USE? YES _____ NO _____

IF YES, IN WHAT WAYS? _____

HOW DO YOU FEEL ABOUT THE CLIENT BEING IN TREATMENT? _____

WHAT DO YOU EXPECT IN LONG TERM RECOVERY FOR THE CLIENT? _____

WHAT DO YOU THINK YOU NEED TO DO FOR THE CLIENT'S RECOVERY? _____

WHAT ARE YOU WILLING TO DO FOR YOURSELF? _____

WOULD YOU AGREE TO ATTEND FAMILY GROUPS HERE? YES _____ NO _____ IF NOT, WHY NOT? _____

HAVE YOU EVER ATTENDED AL-ANON? YES _____ NO _____ WHAT IS YOUR ATTITUDE TOWARD AL-ANON? _____

WHAT DO YOU CONSIDER YOUR MAIN ROBLEM? _____

ABOUT THE CLIENT

HOW WAS THE CLIENT REFERRED FOR TREATMENT? _____

WHAT WAS THE CRISIS WHICH LED TO ADMISSION? _____

PLEASE LIST THE CHEMICALS, INCLUDING ALCOHOL, THE CLIENT HAS USED: _____

PATTERN OF USE? DAILY _____ BINGE _____ WEEKEND ONLY _____

HOW LONG HAS THE CLIENT BEEN DRINKING AND/OR USING CHEMICALS? _____

HOW LONG HAVE YOU BEEN CONCERNED? _____

PLEASE DESCRIBE THE CLIENT'S ALCOHOL AND/OR DRUG USE, INCLUDING PRESCRIPTION DRUGS, AND THEIR BEHAVIOR IN THE LAST 6 MONTHS TO DATE. _____

HAS THE CLIENT BEEN TREATED BEFORE? YES ____ NO ____ IF YES, WHEN AND WHERE?

HAVE THEY TRIED A.A.? YES ____ NO ____ THEIR ATTITUDE TOWARD AA? _____

HAVE THEY EVER HAD A PERIOD OF SOBRIETY? YES ____ NO ____ IF YES, WHEN _____
HOW? AND FOR HOW LONG?

ARE THERE OTHER MEMBERS OF THE CLIENT'S FAMILY WITH ALCOHOL/DRUG PROBLEMS?

YES ____ NO ____ IF YES, WHO _____

IS THE CLIENT EMPLOYED? YES ____ NO ____ WHERE? _____

FOR HOW LONG? _____ HOW MANY JOBS IN THE LAST 2 YEARS? _____

ARE YOU CURRENTLY LIVING WITH THE CLIENT? YES ____ NO ____ HAS THE CLIENT HAD MORE THAN
ONE MARRIAGE? YES ____ NO ____ IF YES HOW MANY? _____

REASON FOR BREAK-UP OF PAST MARRIAGES? _____

NUMBER OF CHILDREN IN THE CLIENT'S FAMILY: _____

<u>NAMES</u>	<u>AGE</u>	<u>LIVING AT HOME</u>
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DO ANY OF THE CHILDREN HAVE EMOTIONAL, BEHAVIORAL, PERSONALITY, OR CHEMICAL
DEPENDENCE PROBLEMS? YES ____ NO ____ IF YES, WHO DESCRIBE THE PROBLEM: _____

WHAT ARE THE CLIENT'S STRENGTHS? _____

WEAKNESSES? _____

WHAT ARE THE MAJOR PROBLEM AREAS, AS YOU SEE THEM, AT THIS TIME? _____

VISITATION DEPENDS ON ATTENDANCE AT FAMILY PROGRAMS. PLEASE REFER TO THE FAMILY HANDBOOK
FOR SCHEDULE.