Florida Safety Council

Orlando, FL

Special Supervision Services Personal History

Please Print Your Responses **Date** ________________

Please answer each of the following questions by filling in the blanks with the information requested. For those questions that are followed by numbered choices, select the choice which most closely describes your answer. For questions such as age, fill in the correct number. For some short answer questions, such as your occupation, simply write in the correct answer.

1. My name is: ____
   (Last Name) *(First Name)* *(Middle/Maiden)*
2. I was born in: ____________________________________ on ________________
   (City/State) *(Date)*
3. My currrent address is: ____
   (Street/City/State/Zip)
4. My home telephone number is ______________________
5. My office telephone number is ______________________
6. I am currently employed as: ______________________
7. I have worked for ____________years.
8. Check one: ☐ I have ☐ I have not been in the military
   ☐ I am ☐ I am not retired from the military service
9. I have been arrested a total of ______times in my lifetime.
   The number of arrests where alcohol and/or drugs were involved was______.
   The number of arrests for driving under the influence of alcohol was ______ .
   My age at my first arrests for driving under the influence of alcohol was ______.
   My age at my first arrest was _______. My age at my first alcohol-related arrest was _____.
10. Check your marital status and answer the question (if any)
    ☐ Single, never married
    ☐ Married (How many times? _____)
    ☐ Separated (How many times? _____)
    ☐ Divorced (How many times? _____)
    ☐ Widowed
    ☐ Living Together
11. How long have you been married?________
12. How many children do you have (Put "0" for none)________
13. How many brothers do you have?_________
14. How many sisters do you have? _________

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Special Supervision Services Personal History

15. Do any reside in this area?__________
16. Do you have any other relatives living in this area? _________
17. What is the highest grade completed in school? ________
18. What has been your main occupation during most of your adult life? __________________________
19. What other kinds of work have you done in the past? ______________________________________
20. How long have you been at your current job? (Put "0" if unemployed)
21. How many months/years were you at your last job? ______________________
22. Circle which of the following best describes your work history?

    ☐ Worked little or none
    ☐ Worked sporadically (off and on)
    ☐ Worked steadily, but not always full time
    ☐ Worked fairly steadily for full time

23. How much do you like your work on a scale from 1 to 10 with 1 meaning not at all and ten meaning very much: ________.
24. Does your spouse/partner work? ______If yes, what type of work? ___________________________
25. My general health is ______Good ______ Fair _______ Poor
26. In an average week (7) days, on how many days do you:

    eat breakfast? ________.
    eat lunch? ________.
    eat an evening meal? ________.

27. On a daily basis, how often do you eat additional snacks beside regular meals? ___________
28. If you over-eat sometimes, what factors are most likely to lead you to over-eat (i.e situation, kinds of food, feelings, etc.) ____
____

29. How many caffeine drinks do you have in an average day?

    cups of coffee________.
    cups of tea ________.
    cups of soda ________.

Special Supervision Services Personal History

30. Put the number of times you have been treated for each of the following:

Heart trouble _____ Stomach trouble _____ Sleep problems _____

Kidney trouble _____ Diabetes _____ G.I. problem _____

Liver trouble _____ Alcoholism _____ Diet problem _____

Lungs_____ Hypertension_____ Allergy _____

Other _____

None of the above _____

31. Put the number of medications you have ever taken, for each of the following:

Heart trouble _____ Stomach trouble _____ Sleep problems _____

Kidney trouble _____ Diabetes _____ G.I. problem _____

Liver trouble _____ Alcoholism _____ Diet problem _____

Lungs_____ Hypertension_____ Allergy _____

None of the above _____

32. Please list any medications you currently take: ____

____

33. Have you ever suffered from any of the following on-going types of pain? (Check all that apply):

Back pain _____ Premenstrual Syndrome _____ None _____

Headache _____ Stomach _____

Neck pain _____ Other_____

34. How many times have you been hospitalized? ______

Special Supervision Services Personal History

35. Check the following things that you enjoy doing:

Eat a meal _____	Gamble _____	Go to school_____
Read _____	Play cards _____	Work _____
Watch TV _____	Sports _____	Dance _____
Theater_____	Animal care_____	Smoke_____
Party_____	Sleep_____	
Exercise_____	Be alone_____	

Other (Please specify) ___________________________________

36. Do you have close friends that you can confide in? (check one)

- ☐ No friends
- ☐ Only casual acquaintances
- ☐ One or more close friends

37. How often would you describe yourself as being lonely? (check one)

☐ Never	☐ Sometimes
☐ Seldom	☐ Most of the time

38. Do you feel over-stressed or anxious? (check one)

☐ Never	☐ Sometimes
☐ Seldom	☐ Most of the time

39. Do you feel that your life is difficult to manage? (check one)

☐ Never	☐ Sometimes
☐ Seldom	☐ Most of the time

40. How would you describe yourself? (check any that are applicable)

High strung and restless_____	Moody and depressed _____	Getting along_____
Ambitious _____	Concerned about the future _____	None of the above_____
Tired and overworked _____	Happy and well adjusted _____	

41. How would you describe your home life? (check any that are applicable)

Happy_________.
Okay _________.
Unhappy _________.

42. When was the last time you had anything to drink which contained alcohol?_________________

Special Supervision Services Personal History

43. Do you feel that drinking is causing you, or has caused, any problems in the following areas of your life? (place yes "Y", or no "N", in spaces below)

Marriage_____ Job or employment _____

Health _____ Court or other legal difficulties _____

44. How many times a week did you drink alcohol?________________

45. How many drinks did you have in an average week?________________

46. How did you usually drink? (check one)

Alone _______

With others who were drinking ________

With others who were not drinking ________

47. Where did you do most of your drinking? (check one)

At home _____ In your car_____

At work _____ In bars _____

On the street _____ Other places (where)? _______________________

48. When did you do most of your drinking? (check any that apply)

Before work _____ At night_____

During work _____ At parties _____

After work_____ Day and night ______

49. Check any of the following which best describes your past drinking behavior:

Drink a lot one day per week_____ Drink heavily every day_____

Drink a little once in a while _____ Drink a lot several days per week _____

Drink a little every day _____ Other drinking pattern _________________________

____

50. Has your drinking ever caused arguments? __________

51. Have the arguments resulted from your drinking, or someone elses?

Self _____ Other_____ Both _____ Neither _____

52. Did you ever feel that it was easier to start something after you had a drink?________________

____

Special Supervision Services Personal History

53. Did you drink to feel less self-conscious, and more at ease, around people?________________

____

54. Did drinking sometimes give you courage or self-confidence?____________________________

____

55. Did you feel more quarrelsome or angry after you had several drinks?______________________

____

56. Have you ever been told that you become rowdy or noisy when drinking too much?__________

____

57. Have you ever destroyed property or gotten into physical fights when you were drinking?

____

58. Have you ever thought about cutting down on drinking?__________________________________

59. Have you ever felt bad, or guilty, about your drinking?___________________________________

60. Have you ever found when awakening (waking up) that you can't remember, or wonder what you did the night before, when you were drinking?____

61. After drinking the night before, have you ever decided not to go to work the next morning? Yes or No ______. If yes, how many times a year did this happen? _____________.

62. Have you ever found that your hands shake and tremble in the morning? ____________

63. Have you ever vomited or been very sick to your stomach, not while drinking, but the morning after drinking? ____

64. Did you ever drink in the morning before breakfast, or before going to work? ________________

65. Did you feel that your health would be better if you decreased or stopped your drinking?

____

Special Supervision Services Personal History

66. Did you ever take tranquilizers, anti-depressants, or pep pills? ___________________________
    ____

67. Have you ever been told by a medical person that your drinking was injuring your liver?
    ____

68. What is the longest time (in days) that you have gone without drinking in the last five years? ______
    What led up to this (or caused it)? ____

69. Do you usually have alcohol in your home? (This includes so-called non-alcoholic beer or wine which contain less than .5% of alcohol.)____

70. Indicate, in the spaces provided, the number of previous treatments you have received for alcohol problems, from each of the following:

    Hospital (any kind) _______ AA meetings _____ Private doctor:
    Outpatient clinic _____ V.A. Hospital _____ MD_____
    Detox facility_____ Other____________________ Psychiatrist_____
    Psychologist_____

71. How would you describe your spouse's / partner's drinking?

    Non-drinker _______ Moderate drinker _____
    Occasional _____ Heavy drinker _____
    Social Drinker_____ Alcoholic ______

72. Has your spouse / partner, employer or friend, ever complained about your drinking?
    ____

73. Please write below the names and addresses of three persons that know you well, and who we may contact, to confirm this information which you have given on this form:

Name: ____ Phone: __________________
Address ____ Relationship ______________

Name: ____ Phone: __________________
Address ____ Relationship ______________

Name: ____ Phone: __________________
Address ____ Relationship ______________

Under penalties of perjury, I declare that I have read the foregoing document, and that the facts stated in it are true.

Client Signature _____________________________________ Date: _________________________