



Ellis County Veterans' Treatment Court

INITIAL SCREENING FORM (PRINT LEGIBLY)

FULL NAME: _____ DATE: ____/____/____

NAME YOU WERE ARRESTED UNDER (IF DIFFERENT) _____

DOB: ____/____/____ SSN: ____-____-____ SEX: _____

HAIR COLOR: _____ EYE COLOR: _____ HEIGHT: _____ WEIGHT: _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

LENGTH OF RESIDENCY: _____ DO YOU OWN OR RENT (CIRCLE ONE)

HOME PHONE: (____) _____-_____ CELL: (____) _____-_____

NAME(S) OF WHOM YOU LIVE WITH: _____

DRIVER'S LICENSE: STATE _____ NUMBER _____ EXP DATE _____

ARE YOU A U.S. CITIZEN? _____ IF NOT, DO YOU HAVE LEGAL DOCUMENTS? _____

WHAT TYPE OF LEGAL DOCUMENTS DO YOU HAVE? _____

HOW LONG HAVE YOU LIVED IN THE UNITED STATES? _____

DO YOU **OWN** or **DRIVE** or **HAVE ACCESS TO A VEHICLE**? _____

YEAR: _____ MAKE: _____ MODEL: _____ STATE REGISTERED IN: _____

LICENSE PLATE: _____ VIN: _____

IF YOU DON'T HAVE ACCESS TO A VEHICLE, HOW DO YOU PLAN TO REPORT AND MAKE APPOINTMENTS? _____

EMPLOYMENT

EMPLOYER: _____ POSITION: _____ HOW LONG: _____

DO YOU WORK: **FULL TIME** or **PART TIME** or **TEMPORARY (CIRCLE ONE)**

MONTHLY INCOME? _____

WORK PHONE: (____) _____-_____ OK TO CONTACT YOU AT WORK? _____



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DO YOU RECEIVE ANY OTHER INCOME? **YES OR NO** WHAT KIND? _____

HOW MUCH DO YOU RECEIVE? _____ HOW OFTEN? _____

DO YOU HAVE HEALTH INSURANCE? _____ PROVIDER: _____

DO YOU RECEIVE MEDICARE OR MEDICAID? **YES OR NO** _____

IF YOU RECEIVE SSI / SSDI ARE YOU THE PAYEE? **YES OR NO** IF NOT WHO IS? _____

MILITARY

WHICH BRANCH OF THE MILITARY ARE / WERE YOU IN? _____

DISCHARGE DATE: _____ TYPE OF DISCHARGE: _____

RANK AT DISCHARGE: _____ WERE YOU DEPLOYED: **YES OR NO**

IF YOU ANSWERED YES, WHEN AND WHERE: _____

EDUCATION

DID YOU GRADUATE HIGH SCHOOL? _____ YEAR OF GRADUATION: _____

HIGHEST GRADE COMPLETED: _____ DO YOU HAVE A GED? _____ YEAR: _____

HIGH SCHOOL NAME: _____

COLLEGE / UNIVERSITY: _____

CITY: _____ STATE: _____ HIGHEST LEVEL COMPLETED: _____

ARE YOU CURRENTLY IN SCHOOL? _____ NUMBER OF HOURS: _____

DEPENDANTS

MARITAL STATUS: **SINGLE** or **MARRIED** or **DIVORCED** or **SEPARATED** or **WIDOWED**

HOW LONG: _____ SPOUSE'S NAME: _____

NUMBER OF CHILDREN: _____

DO YOU PROVIDE FINANCIAL SUPPORT FOR YOUR CHILDREN? **YES OR NO**

HOW MUCH DO YOU PROVIDE? _____ HOW OFTEN? _____



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Name of Child:

Live with you?
(Circle one)

Gender
(Circle one)

Date of Birth

_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____

DRUG / ALCOHOL HISTORY

1. NAME OF DRUG: _____

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER _____

HOW OFTEN DID YOU USE IT? _____

WHAT AMOUNT DID YOU USUALLY USE? _____ \$ _____

AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

2. NAME OF DRUG: _____

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER _____

HOW OFTEN DID YOU USE IT? _____

WHAT AMOUNT DID YOU USUALLY USE? _____ \$ _____

AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

3. NAME OF DRUG: _____

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER _____

HOW OFTEN DID YOU USE IT? _____

WHAT AMOUNT DID YOU USUALLY USE? _____ \$ _____

AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

4. NAME OF DRUG: _____

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER _____

HOW OFTEN DID YOU USE IT? _____

WHAT AMOUNT DID YOU USUALLY USE? _____ \$ _____

AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____



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MENTAL HEALTH AND/OR SUBSTANCE USE/ABUSE HISTORY

HAVE YOU HAD PRIOR TREATMENT FOR SUBSTANCE /ABUSE OR A MENTAL ILLNESS?

<u>Dates of Admission</u>	<u>Name of Hospital</u>	<u>City</u>	<u>State</u>	<u>Reason for Admission</u>

CURRENT MEDICAL DIAGNOSIS: _____

CURRENT PSYCHIATRIC DIAGNOSIS _____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? **YES OR NO**

NAME OF DOCTOR: _____ REASON FOR CARE: _____

NAME OF DOCTOR: _____ REASON FOR CARE: _____

NAME OF DOCTOR: _____ REASON FOR CARE: _____

ARE YOU CURRENTLY TAKING MEDICATION(S)? **YES OR NO**

MEDICATION: _____ PRESCRIBING DOCTOR: _____



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REFERENCES AND SUPPORT NETWORK (family / friends)

NAME: _____ RELATIONSHIP TO YOU? _____

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ - _____ PHONE: (_____) _____ - _____

NAME: _____ RELATIONSHIP TO YOU? _____

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ - _____ PHONE: (_____) _____ - _____

NAME: _____ RELATIONSHIP TO YOU? _____

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ - _____ PHONE: (_____) _____ - _____

ATTORNEY INFORMATION

NAME: _____ PHONE: (_____) _____ - _____

EMAIL ADDRESS: _____

I HEREBY ACKNOWLEDGE AND CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS ABOVE AND THAT THE INFORMATION IS TRUE AND CORRECT.

Applicant Signature

Date