We Are With You at Chy Application form

Client Name:		Date:	Completed by
Previous names:		Male Female	
Address 1:		Disability: Yes No Visual Impairment__ Hearing Impairment__ Physical Disability__ Learning Disability___	
Date of Birth:		Place of Birth:	
Postcode:	District:	Place of Childhood Residence	
Okay to send post to this address?		Marital Status: Single __ Married__ Separated___ Co-Habituating ___ Divorce ___ Single___	
Address 2:		Ethnic group:	
		Nationality:	
		Religion:	
Postcode:	District	Sexual orientation: Heterosexual__ Homosexual__ Bisexual____ Other____	
Okay to send post to this address?		Home Telephone Number: Mobile Number	
Next of Kin Name: Relationship Contact Details:		GP Name Surgery Name: Address Postcode	

Housing

Homeowner __ Tenant __ Family/Friends__ B&B__ Licensee (living in a hostel) ___ Traveller ___

NFA __ Supported Housing __ Temporary Accommodation __ Rough Sleeping__ Squatting__ Other___

Accommodation Needs

Are you homeless or is your current accommodation having a negative impact on you? Yes___ No___
If yes, explain:

Is your substance use having a negative impact on your accommodation? Yes ____ No____
If yes, explain:

Please fill this form in correctly as we can then effectively review your needs to the service we provide

Employment/Education/Training needs

Age on leaving school:

Education History:

Employment History:

Employment Status:

Benefit Status:

Current Employment/Educational/Training needs:

Future employment/training/educational aspirations:

SUBSTANCE HISTORY

Are you currently experiencing problems with your substance use? If so what kind of problems?

Have you ever received any type of intervention for your drug or alcohol use? Yes N o
(please include brief details including who, where, when and age)

Current substance use

Main Drug/Alcohol _____ Route_____ Frequency_____

Amount_____ Cost_____ Age First Use_____ Age of daily use _____

Comments:

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2nd Drug_____ Route_____ Frequency_____

Amount_____ Cost_____ Age First Use_____ Age of daily use_____

Comments:

3RD Drug_____ Route_____ Frequency_____

Amount_____ Cost_____ Age First Use_____ Age of daily use __

Comments::

Alcohol Use in last 28 days	Drinking Days in a Week	Average Units/Week

Current Detox/Residential Treatment Need

Do you require/need a Detox? Yes No

Comments:

Prescribed Medication Yes No

Are you taking any prescribed?		
Are you taking over the counter medication?		
Homeopathic or Herbal Remedies		

(if YES, please detail below)

Drug	Prescriber	Route	Dose

Current Use (how frequently have used/drank in the last week?)

	Substance	Morning	Afternoon	Evening
Today				
Yesterday				
2 days ago				
3 days ago				

Please fill this form in correctly as we can then effectively review your needs to the service we provide

4 days ago				
5 days ago				

Is this typical of your regular use? Yes__ No___. If not is it: More__ Less__

Why? (If different)

Is there a typical time of day use starts?

Why?

PSYCHOSOCIAL HISTORY

Life development line: *(Background; include parents jobs, home life, siblings, significant events etc)*

Family tree

Please fill this form in correctly as we can then effectively review your needs to the service we provide

Children: (Refer to hidden harm protocol) *(Include details of all children, where they live, your access to them and all children living with you)*

Name/DOB	Age	Sex	Address	Lives with	Have contact with

Relevant Family Health History

(Include major physical/mental health illnesses, drug/alcohol problems of parents/siblings children as primary carer,)

PHYSICAL HEALTH

HEALTH PROBLEMS CAUSED BY DRUG OR ALCOHOL USE

CURRENT PHYSICAL HEALTH

Do you have any concerns regarding your physical health? Yes____ No ___

Describe any Current Concerns:

Are you currently being treated for any of the below:

Epilepsy Yes___ No___ Asthma Yes___ No___ Liver disease Yes___ No__

If yes, by whom?_____@_____

Dental Health Concerns: Yes____ No___

Do you have any allergies? (If YES please detail)

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Do you Smoke tobacco? Yes___ No___ If yes how much_____

Have you ever taken an overdose of any drug *(please tick as appropriate)*:

1. Accidentally YES____ NO ____ 2. Deliberately YES____ NO____

If YES please detail:

3. Have you ever deliberately harmed yourself? YES____ NO____

If YES please detail:

CURRENT MENTAL HEALTH

Do you have any concerns regarding your Mental Health? Yes____ No ___
Detail any mental health problems i.e. anxiety, depression, deliberate self harm, panic attacks)

Are You currently being treated for any mental health issues? Yes___ No__ If Yes, by

whom_____@_____

PAST MENTAL HEALTH HISTORY

(Detail any mental health problems i.e. anxiety, depression, deliberate self harm, panic attacks any treatment received and approximate dates)

Do you commit criminal activity?

Yes No Comments:

Please detail any other convictions, year, outcome, and periods in custody:

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Do you currently have: ***(tick appropriate boxes)***

	Bail		Community Supervision order		Court case pending		Outstanding fines

CONCERNS/DESIRED CHANGES REGARDING SUBSTANCE MISUSE

What concerns you most about your substance use?

What do you want to achieve/desired changes you like to make regarding your substance use?

Are you in contact with any other agency/Professional? *(Please tick appropriate boxes)*

		Keyworker	Contact no.			Keyworker	Contact no.
We Are With You				Fresh-fields			
CDAT			.	Probation			
CMHT			.	Social Services			
CJIT							
GP				Other			

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