

General Consumer Information:

This information is used to complete the required assessment information and to have a clear, accurate way in which to reach you should the need arise to change an appointment time or complete some of the assessment information.

1. **Last Name:** _____
2. **First Name:** _____
3. **Middle Name:** _____
4. **Maiden Name:** _____
5. **Mailing Address:** _____
6. **City:** _____ **State:** _____
7. **Zip:** _____
8. **Home Phone:** (_____) _____
9. **Work Phone:** (_____) _____
10. **Cell Phone:** (_____) _____
11. **Email address:** _____
12. **Date of Birth:** _____ **Gender:** Male or Female
13. **Race: (Circle appropriate choice)** American Indian/Alaskan Native Asian
Black or African American Native Hawaiian / Other Pacific Islander
White
14. **Ethnicity (Circle appropriate choice)** Hispanic Puerto Rican
Hispanic Mexican American Hispanic Cuban Hispanic Other
Not of Hispanic origin
15. **Language Preference:** English Spanish Other

16. **Marital Status: (Circle appropriate choice)** Never Married

Now Married Divorced Separated Widowed

17. **Education Completed: (Circle appropriate choice)** less than 6th grade

Less than 9th grade Less than 12th grade High School degree/GED

Some college Bachelor's Degree Graduate Degree or higher

18. **Employment Status: (Circle appropriate choice)**

Full time (working > 35 hours per week) Part time (working < 35 hours per week)

Unemployed (Looking for work in last 30 days) Not in labor force

19. **Type of health insurance: (Circle appropriate choice)** Private Insurance

Blue Cross Medicare Medicaid

NC Health Choice for children Health Maintenance Organization (HMO)

Other, e.g. Tricare, Champus None

20. **Name of your family physician:** _____

21. **Do you take medications?** Yes No

a. **If yes, please list medications and who prescribes them.**

22. **Are you allergic to any medications?** Yes No

a. **If yes, please list allergies** _____

23. **How long has it been since your last physical?** _____

24. Were any concerns voiced at the time of your last physical? Yes No

a. If yes, what were they? _____

25. Do you have any pending Court charges? Yes No

a. If yes, what are they? _____

26. Driver license number: _____ State of issuance: _____

27. Docket number of your case (if known): _____

28. Social Security Number: (needed for DMV license check) _____

(DWI Assessments only – complete the following)

By my signature, I affirm that I have not sought assessment for this specific charge in the past with any other provider.

Signature

Date