

SCREENING DOCUMENT

(PLEASE PRINT CLEARLY)

Participant Name: _____ Date _____ SS#: _____

Address: Street: _____ City: _____ State: _____

Zip: _____ County: _____ Age: _____ Date of Birth _____

Phone Home: _____ Work: _____ Cell: _____

Email (personal): _____ (work): _____

Sex: Female Male **Marital Status:** Married Separated Single Divorced Widowed

List persons living with you (list additional persons on the back of this form)

Name	Relationship	Age

Emergency Contact: _____ Phone: _____

Professional History

Referral Source: _____ Board Investigator: _____ DHEC _____

Profession _____ License Number _____

Do you hold a license in another state? Yes No (list): _____

Employment History:(List past five years, use back of page if needed)

Current/Most Recent Employer: _____ Dates: _____ Job Title: _____ Supervisor: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ If no longer employed reason for leaving:
Employer: _____ Dates: _____ to _____ Job Title: _____ Supervisor: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Reason for leaving:
Employer: _____ Dates: _____ to _____ Job Title: _____ Supervisor: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Reason for leaving:

Describe the events that brought you to RPP: (Use additional space on back, if necessary)

Have you ever been arrested, charged or convicted of any crime? Yes No (If yes list.)

Have you previously participated with RPP or similar program? Yes No (If yes list)

Have you had prior licensing board involvement/action? Yes No (If yes list)

Drug Use History

Please list substances used in a way **other than prescribed**.

Substance	Date of first use	Date of last use	Frequency of use	Quantity Used
Alcohol				
Opiates (please list)				
Benzodiazepines (please list)				
Barbiturates (please list)				
Cocaine				
Cannabis				
Other (please list)				

Counseling History

List all Mental Health, Substance Abuse Treatment and other Counseling (use back if needed)

Dates	Agency/Provider Name	Reason for Services

Are there any members of your family with an Alcohol, Drug or Psychiatric History?
Yes No (If yes describe)

Health Care Providers

List all Health Providers that you have used in the past year

Health Care Provider Name	Reason for Visit

List all medications you currently use. (Include prescription and over-the-counter)

Medication	Dose	Reason for use	Prescriber

Is there anything else we need to know about you or your situation? Yes No (If yes describe)

Name Date
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