

***READ THIS FIRST:*** The information you provide in this questionnaire will not be held against you in a court of law. Please answer each question as truthfully as possible. This information is strictly for the use of the Bexar County Felony Drug Court Tracking Specialist. Again, *you will not get in trouble* for any information you give on this form, so **PLEASE BE HONEST.**



**Bexar County Felony Drug Court Program**  
Information Questionnaire

**DATE:** \_\_\_\_\_

**PARTICIPANT INFORMATION**

Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Last Name) (Initial) (First Name)

1. A.K.A. \_\_\_\_\_
2. Address: \_\_\_\_\_
3. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. Phone#: \_\_\_\_\_
5. Contact Person: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Relationship of Contact Person: \_\_\_\_\_

6. Social Security #: \_\_\_\_\_

**7. Date of Birth:** \_\_\_\_\_

8. Age:
- 17-18
  - 19-21
  - 22-30
  - 31-40
  - 41+

9. **Gender:**
- MALE
  - FEMALE

10. **Ethnicity**
- Hispanic
  - Non-Hispanic

11. **Race:**
- African American
  - Caucasian (Anglo-Saxon: No African American History)
  - Asian (Pacific Islander / Alaskan Native)
  - Native American / American Indian
  - Multiracial

12. Marital Status
- Married
  - Single
  - Divorced
  - Separated
  - Living as Married
  - Widow(er)

- 
13. Are you pregnant?
- Yes
  - No
  - Unknown
  - N/A

14. How many children do you have? \_\_\_\_\_

15. How many children do you have to support? \_\_\_\_\_

16. How many people live in your home? \_\_\_\_\_

---

17. Who has custody of these children?

- I do.
- My wife/husband
- My mother/father
- My ex-wife/ex-husband
- The State of Texas
- Other: \_\_\_\_\_

18. Did you lose custody because of a legal problem?

- Yes
- No
- N/A

19. Is gaining the custody of your children part of your treatment goal?

- Yes
- No
- N/A

## **B) EDUCATION**

1. How many years of education do you have? \_\_\_\_\_

2. **What level of education have you completed?**

- Some High School (Less than 12th Grade)
- High School Diploma
- GED
- Vocational School
- Some college
- Post High School Degree (Bachelor's, Master's, Associates)

3. Are you attending school right now?

- Yes, and the name of the school is: \_\_\_\_\_
- No.

4. Do you think you have any difficulties in the following areas?

- Reading
- Writing
- Adding / Subtracting
- Concentrating
- No problems with these areas.

## **C) EMPLOYMENT**

1. Are you employed?

- Yes
- No

2. If **Unemployed**, how long have you been unemployed?

- \_\_\_\_\_ Months
- \_\_\_\_\_ Years

3. Are you receiving Public Assistance?  
 Yes  
 No  
 Pending
4. How long you been receiving Public Assistance? \_\_\_\_\_ Months \_\_\_\_\_ Years

If you are **EMPLOYED** answer questions **5 – 11**, if you are **NOT EMPLOYED** skip to question **12**.

5. Where do you work? \_\_\_\_\_
6. What do you do there? \_\_\_\_\_
7. What's your work phone number? \_\_\_\_\_
8. Do you enjoy your job?  
 Yes  
 No
9. How much were you paid per hour? \$ \_\_\_\_\_/hr.
10. About how much income do you earn a year from employment?  
 \$0 - \$999  
 \$1,000 - \$4,999  
 \$5,000 - \$9,999  
 \$10,000 - \$19,999  
 \$20,000 - \$29,999  
 \$30,000 - \$44,999  
 \$45,000 - \$59,999  
 \$60,000 +
11. What is the average number of hours you worked each week? \_\_\_\_\_ hr(s).

12. If not employed, what is source of income?  
 SSI  
 Family  
 Significant Other  
 Public Assistance  
 Social Security Pension  
 Other \_\_\_\_\_

13. Are you currently looking for a job?  
 Yes  
 No

14. What are some of the challenges of getting this job? (**Check as many as apply**)
- |   |   |
|---|---|
| <input type="checkbox"/> Probation          | <input type="checkbox"/> Health problems          |
| <input type="checkbox"/> Addiction          | <input type="checkbox"/> Already employed         |
| <input type="checkbox"/> No Education       | <input type="checkbox"/> School schedule          |
| <input type="checkbox"/> No Experience      | <input type="checkbox"/> Transportation           |
| <input type="checkbox"/> No training        | <input type="checkbox"/> No childcare             |
| <input type="checkbox"/> Incarceration      | <input type="checkbox"/> Pregnant                 |
| <input type="checkbox"/> Criminal Record    | <input type="checkbox"/> Family responsibilities. |
| <input type="checkbox"/> No I.D.            | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Treatment schedule | _____   |
| <input type="checkbox"/> Personal injury    | _____   |

15. Have you ever received special job training?  
 Yes  
 No
16. What kinds of special training have you received? \_\_\_\_\_

**D) LEGAL**

1. Have you ever been arrested for arson?  
 Yes  
 No
2. Have you ever been arrested for a violent crime?  
 Yes  
 No

3. How old were you when you first were arrested? \_\_\_\_\_ years old.
4. How many times were you arrested in the last 2 years? \_\_\_\_\_ times.
5. How many times were you arrested for reasons related to drugs? \_\_\_\_\_ times.
6. How many months were you in jail or incarcerated in the last 2 years? \_\_\_\_\_ months.
7. Do you have any other pending cases?
  - Yes
  - No
8. If you do, what is it for \_\_\_\_\_  
 What court is it in? \_\_\_\_\_
9. Is there a protection order against you?
  - Yes
  - No

**E) MEDICAL**

- 1) Do you have medical insurance?
  - Yes
  - No
- 2) Who is your medical insurance provider? \_\_\_\_\_
- 3) Are you covered by more than one insurance company?
  - Yes
  - No
- 4) If yes, who is your secondary insurance provider? \_\_\_\_\_
- 5) Are you a veteran?
  - Yes
  - No
- 6) Were you honorably discharged?
  - Yes
  - No
  - N/A
- 7) Who is your primary care physician? \_\_\_\_\_
- 8) What's their phone number? \_\_\_\_\_
- 9) Do you have any medical problems? \_\_\_\_\_  
 \_\_\_\_\_
- 10) Please list any prescribed medication you take.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**G) MENTAL HEALTH**

1. Have you ever had a *mental health evaluation*?
  - Yes
  - No
2. If yes, what was the *diagnosis*? \_\_\_\_\_
3. Have you ever been *hospitalized* for a mental health reason?
  - Yes
  - No
4. How *long* did you stay there? \_\_\_\_\_ days \_\_\_\_\_ months
5. When was the *last time* you were hospitalized for a mental health reason? \_\_\_\_\_
6. Are you *currently receiving* mental health counseling?
  - Yes
  - No
7. If so, where? \_\_\_\_\_

8. Have you been prescribed any **medication** for your mental health diagnosis?  
 Yes  
 No
9. If so, what medications? \_\_\_\_\_
10. Have you ever tried to harm **yourself**?  
 Yes  
 No
11. Have you ever tried to harm **others**?  
 Yes  
 No
12. Do you **currently** think about harming yourself?  
 Yes  
 No
13. If yes, please briefly describe the situation. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
14. Have you ever been abused?  
 Yes  
 No
15. If yes please specify any of the following:  
 Sexually  
 Physically  
 Emotionally (Being yelled at, put down, neglected).

**PRE-LINK**

- 1 Are you currently in treatment?  
 Yes  
 No
- 2 If Yes, who is the treatment provider? \_\_\_\_\_
- 3 How many months have you been there? \_\_\_\_\_
- 4 Have you ever been in Treatment before?  
 Yes  
 No
- 5 If Yes, how long ago did you attend? \_\_\_\_\_ months.
- 6 If Yes, where? \_\_\_\_\_
- 7 How many months did you attend treatment? \_\_\_\_\_
- 8 Have you ever been in an Inpatient Facility? (Detox, Rehab, Residential)  
 Yes  
 No
- 9 If Yes, how long ago were you inpatient? \_\_\_\_\_
- 10 If Yes, where? \_\_\_\_\_
- 11 How many months did you spend inpatient? \_\_\_\_\_
- 12 Did you complete the program?  
 Yes  
 No
- 13 Would you be willing to go to an inpatient facility for 28 days?  
 Yes  
 No

H) **DRUG INFORMATION** - Please mark each of the drugs which you most frequently use and answer the corresponding questions.

## Alcohol

- Yes
- No

What kind of alcohol do you usually drink? (Check all that apply)

- Beer
- Liquor
- Wine

How much do (or DID) you drink when you drink?

- 1-2 drinks
- 3-4 drinks
- 5-6 drinks
- 7-8 drinks
- 9-10 drinks
- 11 or more drinks

How often do (or DID) you drink alcohol?

- Once a month
- Twice a month
- Every two weeks
- Once time a week
- 2 times a week
- 3 times a week
- 4 times a week
- 5 times a week
- 6 times a week
- Daily
- Only on the WEEKENDS

At what age did you first start using alcohol?

- 1-16
- 17-20
- 21-25
- 26-30
- 31+

When was the last time that you used alcohol?

- Within 1 day
- Within 2 days
- Within 3 days
- Within 1 week
- Within 2 weeks
- Within 1 month
- Within 3 months
- Within 6 months
- Within 1 year
- More than a year

How much did you drink the last time you used alcohol?

- 1-2 drinks
- 3-4 drinks
- 5-6 drinks
- 7-8 drinks
- 9-10 drinks
- 11 or more drinks

# Cocaine

- Yes
- No

What kind of cocaine do you use? (Check all that apply)

- Crack
- Powder cocaine

How do you take it? (Check all that apply)

- Smoke
- Sniff
- IV
- Other \_\_\_\_\_

How much do (or DID) you use when you regularly use cocaine at a time?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +

How often do (or DID) you use cocaine?

- Once a month
- Twice a month
- Every two weeks
- Once time a week
- 2 times a week
- 3 times a week
- 4 times a week
- 5 times a week
- 6 times a week
- Daily
- Only on the WEEKENDS

At what age did you first start using cocaine?

- 1-16
- 17-20
- 21-25
- 26-30
- 31+

When was the last time that you used cocaine?

- Within 1 day
- Within 2 days
- Within 3 days
- Within 1 week
- Within 2 weeks
- Within 1 month
- Within 3 months
- Within 6 months
- Within 1 year
- More than a year

How much did you use the last time you used cocaine?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +

# Opiates (Heroin, pain killers, etc.)

- Yes- If yes, what kind(s)? \_\_\_\_\_
- No

How do you take it? (Check all that apply)

- Smoke
- Sniff
- IV
- Swallow
- Other \_\_\_\_\_

How much do (or DID) you use when you regularly use opiates at a time?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +

How often do (or DID) you use opiates?

- Once a month
- Twice a month
- Every two weeks
- Once time a week
- 2 times a week
- 3 times a week
- 4 times a week
- 5 times a week
- 6 times a week
- Daily
- Only on the WEEKENDS

At what age did you first start using opiates?

- 1-16
- 17-20
- 21-25
- 26-30
- 31+

When was the last time that you used opiates?

- Within 1 day
- Within 2 days
- Within 3 days
- Within 1 week
- Within 2 weeks
- Within 1 month
- Within 3 months
- Within 6 months
- Within 1 year
- More than a year

How much did you use the last time you used opiates?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +



# Methamphetamines

- Yes
- No

How do you take it? (Check all that apply)

- Smoke
- Sniff
- Other \_\_\_\_\_

How much do (or DID) you use when you regularly use methamphetamines at a time?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +

How often do (or DID) you use methamphetamines?

- Once a month
- Twice a month
- Every two weeks
- Once time a week
- 2 times a week
- 3 times a week
- 4 times a week
- 5 times a week
- 6 times a week
- Daily
- Only on the WEEKENDS

At what age did you first start using methamphetamines?

- 1-16
- 17-20
- 21-25
- 26-30
- 31+

When was the last time that you used methamphetamines?

- Within 1 day
- Within 2 days
- Within 3 days
- Within 1 week
- Within 2 weeks
- Within 1 month
- Within 3 months
- Within 6 months
- Within 1 year
- More than a year

How much did you use the last time you used methamphetamines?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +

# THC (Marijuana)

- Yes
- No

How do you take it?

- Smoke
- Eat/Cook with it
- Other \_\_\_\_\_

How much do (or DID) you use when you regularly use marijuana at a time?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100 +

How often do (or DID) you use marijuana?

- Once a month
- Twice a month
- Every two weeks
- Once time a week
- 2 times a week
- 3 times a week
- 4 times a week
- 5 times a week
- 6 times a week
- Daily
- Only on the WEEKENDS

At what age did you first start using marijuana?

- 1-16
- 17-20
- 21-25
- 26-30
- 31+

When was the last time that you used marijuana?

- Within 1 day
- Within 2 days
- Within 3 days
- Within 1 week
- Within 2 weeks
- Within 1 month
- Within 3 months
- Within 6 months
- Within 1 year
- More than a year

How much did you use the last time you used marijuana?

- \$0-\$4
- \$5-\$9
- \$10-\$14
- \$15-\$19
- \$20-\$29
- \$30-\$49
- \$50-\$99
- \$100

## Any Other Drugs

1. What kinds of other drugs? \_\_\_\_\_  
\_\_\_\_\_
  2. How much do (or DID) you use when you use them? \_\_\_\_\_  
How often do (or DID) you use when you use them? \_\_\_\_\_
  3. What age did you first begin? \_\_\_\_\_
  4. When was the last time you used this drug? \_\_\_\_\_
  5. How much did you use at this time? \_\_\_\_\_
- 

Which ONE of these drugs would you say causes (or caused) the most problems in your life?  
(Please, mark only ONE)

- Alcohol
- Cocaine
- Opiates
- Methamphetamines
- THC
- Other: \_\_\_\_\_

### 3. What are your top three drugs of choice in order of your...

- First drug of choice: \_\_\_\_\_  
Second drug of choice: \_\_\_\_\_  
Third drug of choice: \_\_\_\_\_

### 4. How would you rate your drug problem?

- No Problem
- Mild Problem
- Moderate Problem
- Severe Problem

### 5. What is the main TRIGGER or TRIGGERS that make you want to use drugs or alcohol? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> I use for <b>good feeling</b> the drug gives me when I use it.                                       | <input type="checkbox"/> I use drugs/alcohol to deal with stress I related to my <b>health</b> .                         |
| <input type="checkbox"/> I use to help the <b>bad feelings</b> I get when I don't use.  | <input type="checkbox"/> I use drugs/alcohol because I feel <b>generally stressed</b> , but not for a particular reason. |
| <input type="checkbox"/> I use because I see the drug/alcohol on <b>TV</b> or in a <b>picture</b> .                           | <input type="checkbox"/> I use drugs/alcohol because I have too much <b>time on my hands</b> .                           |
| <input type="checkbox"/> I use because I see the drug/alcohol in <b>real life</b> .   | <input type="checkbox"/> I use drugs/alcohol because I feel <b>hopeless about the future</b> .                           |
| <input type="checkbox"/> I use drugs/alcohol to fit in with <b>friends</b> .  | <input type="checkbox"/> I use drugs/alcohol because I have thoughts about <b>death</b> .                                |
| <input type="checkbox"/> I use drugs/alcohol to fit in with my <b>family</b> .  | <input type="checkbox"/> I use drugs/alcohol because of <b>habit</b> .   |
| <input type="checkbox"/> I use drugs/alcohol because I'll be <b>embarrassed</b> in front of others if I don't.                | <input type="checkbox"/> I use drugs/alcohol to help my physical <b>pain</b> .   |
| <input type="checkbox"/> I use drugs/alcohol to deal with stress related to my <b>spouse/girlfriend</b> or <b>boyfriend</b> . | <input type="checkbox"/> I use drugs/alcohol to help my <b>Back Pain</b> .   |
| <input type="checkbox"/> I use drugs/alcohol to deal with stress related to my <b>Children</b> .                              | <input type="checkbox"/> I use drugs/alcohol when I feel <b>angry</b> .  |
| <input type="checkbox"/> I use drugs/alcohol to deal with stress related to my <b>other family</b> members:                   | <input type="checkbox"/> I use drugs/alcohol when I am <b>alone</b> .  |
| _____   | <input type="checkbox"/> I use drugs/alcohol when I feeling <b>lonely</b> .  |
| <input type="checkbox"/> I use drugs/alcohol to deal with the stress related to <b>my current job</b> .                       | <input type="checkbox"/> I use drugs/alcohol when I feel <b>insecure</b> .   |
| <input type="checkbox"/> I use drugs/alcohol to deal with stress related to finding a <b>NEW job</b> .                        | <input type="checkbox"/> I use drugs/alcohol to lose <b>weight</b> .   |
|   | <input type="checkbox"/> I use drugs/alcohol because sometimes I just need to <b>relax</b> .                             |
|   | <input type="checkbox"/> Other _____   |
- 

### 6. Is there **someone else** that lives with you that uses any drugs or alcohol?

- Yes
- No