Appendices
ANNEXURE-I
INFORMATION SHEET

Registration No............................ Date ..................

Name :

Father’s/Mother’s Name :

Age : Yrs. Sex : Male/Female Religion :

Marital Status : Married/ Unmarried/Widow/ Widower/Divorce

Occupation : Monthly income :

Address :

Educational qualification :

Reason for discontinuing education (if applicable)

PERSONALITY FACT SHEET

Complaints : (1) Patient’s own words :

(2) From informant :

(3) Reliability of information :

DETAILS OF DRUGS/ ALCOHOL TAKING :

<table>
<thead>
<tr>
<th>Type of drugs</th>
<th>How taken</th>
<th>How often</th>
<th>How much</th>
<th>For how long</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NATURE OF PROBLEM

01. VISITORS FIRST APPEARANCE
   a. Anxiety    b. Relaxed    c. Mildly depressed    d. Depressed

02. DRESS

03. WHY HE/SHE TAKES DRUG?
   a. Family burden    b. Carry worry    c. Sudden change in rank
   d. Failure in academic performance    e. Peer group pressure    f. Lack of Money
   g. Excess of money    h. Availability of drugs    i. Pleasure    j. Other (please specify)

04. WHO INTRODUCED THE DRUGS FOR THE FIRST TIME?
   a. Himself due to curiosity    b. Friends
   c. Siblings    d. Other unknown person

05. INTERACTION WITH THE COUNSELLOR;
   a. Friendly    b. Unfriendly
   c. Aggressive    d. Co-operative

06. PRE-MORBID PERSONALITY

07. AGE WHEN YOU FIRST TOOK DRUGS?

08. HAVE YOU EVER SOUGHT HELP FOR DETOXIFICATION (FILL IN DETAILS)?

09. HAVE YOU EVER HAD EXPERIENCE OF NOT BEING ABLE TO REMEMBER EVERYTHING THAT HAPPENED IN THE NIGHT BEFORE USING DRUGS /ALCOHOL?

10. DID YOU EVER USE DRUGS /ALCOHOL TO REDUCE TENSION/ NEGATIVE FEELINGS/ PHYSICAL PROBLEMS?

11. PLEASE TELL ABOUT THE PHYSICAL PROBLEMS WHEN YOU DO NOT CONSUME DRUGS/ ALCOHOL
   a. Change in physical appearance    b. Loss of weight    c. headache    d. Loss of energy
   e. Anxiety, tension & nervousness    f. Sleeping difficulty    g. Disorder of appetite
   h. Digestive problems    i. Others (please specify)
12. DO YOUR PARENTS KNOW ABOUT YOUR DEPENDENCY OF DRUGS/ALCOHOL?
   a. Yes    b. No    c. I do not know

13. DO YOUR OTHER FAMILY MEMBERS KNOW ABOUT IT?
   a. Yes    b. No    c. I do not know

14. DID ANY ONE IN YOUR FAMILY USE ALCOHOL/DRUGS? PLEASE TELL IN DETAIL

15. WERE THERE ANY DEATHS IN YOUR FAMILY DUE TO HEAVY USE OF ALCOHOL/DRUGS?

16. MARITAL HISTORY:

17. WHAT WAS YOUR AGE AT MARRIAGE?  Yrs.

18. TYPE OF MARRIAGE
   a. Arranged/love/forced    b. Inter-caste/inter-relation

19. HOW IS YOUR RELATIONSHIP WITH SPOUSE
   a. Friendly & affectionate  b. Divorced  c. Poor & hostile  d. Warm

20. DETAIL REGARDING CHILDREN:

<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Occupation</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SEXUAL HISTORY
(Since adolescence – in a systematic manner)
LEGAL BACKGROUND:

20. DO YOU HAVE ANY LEGAL PROBLEM PENDING? Yes/No
21. HAVE YOU BEEN ARRESTED ANY TIME? Yes/No

Date
Place

Signature of patient
Signature of Counsellor

----------------------------------

MEDICAL FACT SHEET

1. GENERAL EXAMINATION [Please note all important findings]

2. SYSTEMIC EXAMINATION:
   a. Cardio vascular system –
   b. Respiratory system –
   c. Gastro intestinal system –
   d. Central nervous system –

3. PAST MEDICAL HISTORY:

4. HISTORY OF ANY PREVIOUS PSYCHIATRIC ILLNESS IN THE PATIENT/HIS FAMILY MEMBERS:

Signature of Medical Officer
Source:
Date: ............... MSHWARA
A drug Detoxification and Rehabilitation Centre run by NESPYM, Guwahati