HOPE HAVEN

ADMISSION APPLICATION

Name: ____

First Name Last Name Middle/Maiden Name

_________________ _____________________ _____________________

Date of Interview Date Admitted Referred By

__________________________________ ______________ ____________ ______ ______

Former Address City County State Zip

Zip Code of Last Permanent Address: ____________ SSN: ____________________________

Valid Driver's License: Yes No # _____________ Picture ID: Yes No

Transportation: Car Transit Homeless Verification Letter/Information: Yes No

SOCIAL HISTORY

____________ __________________ _____________ ____________________________

Age Race Date of Birth Place of Birth

_______________________________________ _____________________________________

Mother's Name (Married & Maiden) Father's Name

Prior Admissions to Hope Haven: ____________________ Date Last Discharged: _________________

Last School Grade Completed: ____________ Did you like school? Yes No Why or why not?

Are you presently enrolled in school? Yes No If so, where? _______________________

Are you currently on State or Federal probation? Yes No

For what charge(s)? __________________________ PO Name and Phone #: ________________________

Do we have your criminal background report? Yes No

RELIGIOUS AFFILIATION

Do you have any religious affiliation? Yes No If so, please list: ____________________

EMPLOYMENT HISTORY

Types and Skills

Occupation: ____ Last Employer: ________________________________

Is this your current employer? Yes No VR Involvement? Yes No

Did you serve in the military? Yes No Branch/dates: _________________________________

Did you like your stay in the military? Yes No Why/why not? ________________________________

What was your discharge status? ______________________ Discharge date: _______________________________

INCOME INFORMATION

Any source/type of income? Yes No Amount of Income: ____________________________

If yes, what type of income: Pension/Retirement SSI/SSDI TANF

Unemployment VA Benefits Other

Are you in the process of filing disability? Yes No

If so, what is your status? Awaiting Hearing Denied Income Pending

Do you receive Medicaid? Yes No Medicaid Number: _____________________________

Do you receive Medicare? Yes No Medicare Number: _____________________________

HISTORY OF ADDICTION/ALCOHOLISM

Blackouts DT's Epilepsy Neuritis Hallucinations

Date of Last Drink/Use: ___________________________ Age of First Drink/Use: __________________________

At what age did alcohol/drugs become a problem? ________________

Alcohol/drug related arrests? Yes No Other arrests? Yes No

If yes, explain: ____

Previous Treatments (List where and when):

Longest Clean Time: ______________________________ Sponsor? Yes No

Psychological History:

Have you ever been a patient in a mental hospital? Yes No

Have you ever had a mental health assessment/evaluation? Yes No

If yes, explain with dates:

Have you had any of the following in the last two months?

Financial burdens | Lack of Sexual Desire | Irritability | Family Problems | Weight Loss

Staring Spells | Problems with Job | Employment | Separation/Divorce

Family History:

Number of brothers, sisters, stepbrothers, stepsisters _________________

Number of children/stepchildren: _________________ Ages: ___________________

Are your child(ren)'s pediatric care (medical) needs being met? Yes No

If so, by whom? ____

Are your children receiving or need to have therapeutic interventions for any special needs? Yes No

If so, what type of therapeutic intervention and from whom? ____

Will your children need childcare? Yes No

Are they presently receiving childcare? Yes No If so, where? ______________________________

How well do family members get along? ____

Is there any family origin of abuse? Explain:____

Did any family members drink or use? If so, whom? ____

Marital/Significant Other History:

Marital status: Single Married Divorced Widowed Separated

If married, how long? ______________ Married before? Yes No How many times? ____________

Has there been abuse in your marriage or intimate relationships? Yes No

How well do/did you get along with your significant other/spouse? ____

How well did you get along with your children? ____

Living arrangements prior to treatment? ____ Number in Household: _________

Do you ever feel afraid of your partner? Yes No

In what ways? ____

Has there ever been any violence in your intimate relationships? (Example: pushing, pulling, slapping, punching or kicking) Yes No

How long ago did the most recent violence occur? ____

Has there ever been fighting in your intimate relationships that led to damage or destruction of personal belongings, property, or pets? Yes No

Have there ever been threats to use weapons such as a gun, knives by you or your partner? Yes No

Have you ever had a partner force you to have sex against your will? Yes No

Has physical abuse ever occurred while you were high? Yes No

Has physical abuse ever occurred while your partner was high? Yes No

Have you ever gotten high to cope with the violence in your relationships? Yes No

Have the police ever been called to your home due to fighting? Yes No

MEDICAL HISTORY

Family Doctor: ____

Address: ____ Phone: __________________________

Date of last physical examination? __________________ Date of last TB Test: _______________ Result: ______________

Do you have a history of: Diabetes Epilepsy High Blood Pressure

Cancer Nervous/mental disorder Other: ____________________

What over the counter medications have you taken in the last 6 months? ____

What medications are you allergic or sensitive to? ____

Are you currently on medications? Yes No

If yes, please give the names: ____

Prescribed by: ____

Do you presently have a disability that is covered under the Americans with Disabilities Act (ADA) that will require special accommodations or specific needs? Yes No

If yes, then what is that disability and what specific accommodations or specific need will need to be made?

Description: ____ Level of Functioning: _________________

Specific Needs: ____

Females Only

Are you pregnant now? Yes No # of times pregnant: __________________

Last menstrual period date: __________ Flow: Light Heavy Abnormal discharge

Last pap smear date: ____________ Results: ________________ Breast Exam: Pain Lump Discharge

EMERGENCY CONTACT INFORMATION

Name: ________________________________ Phone: ___________________________ Relationship: ________________

Complete address: ____

As a resident of Hope Haven, I understand and accept my written responsibilities. In consideration of your admitting me as a resident to Hope Haven, I, for myself, my heirs, assigns or personal representatives, do hereby release you and your staff from any liability for any personal injury or property damage that I may sustain at any time at Hope haven, or on its premises or while I am a passenger in any vehicle, and further agree to hold Hope Haven, Inc. free and harmless from any and all liability in connection therewith:

____

Staff Signature and Title Date

____

Resident Signature Date

HOPE HAVEN

DRUG HISTORY

Client Name: ____

Client No: ___________________________

Yes No

Used more drugs and/or alcohol than you intended?

Wanted to or tried to cut down or control your drug and/or alcohol use? # of Times ________________

Spent a lot of time trying to get drugs/alcohol, taking drugs/alcohol, and/or recovering from the effects of alcohol and/or drugs?

How much time do you spend thinking about using? ____________________

How much time do you spend under the influence? ____________________

What do you do to get drugs? ______________________________________

Have you been under the influence of drugs/alcohol while at work or school or put yourself and others in physically hazardous situation because you were under the influence (such as driving while intoxicated?)

Have you gone to work under the influence or operated machinery under the influence?

Have you given up or cut back on important social, occupational, or recreational activities because of your drug/alcohol abuse?

Have your friendships suffered because of your use?

Is your job at risk because of your use?

Has your spiritual life suffered because of your use?

Have you continued to use drugs and/or alcohol even though you know it's causing problems in your life and with those around you?

Have you gotten into legal trouble because of your use?

Have any medical professionals told you to stop using?

Have any family members expressed concern about your using?

Have you required more drugs/alcohol to achieve the same high?

Do you continue to use even when the drug isn't working?

Do you mix drugs to achieve the same effect?

Have you had a blackout?

Have you had withdrawal symptoms?

List symptoms____

Have you taken drugs/alcohol to relieve or avoid withdrawal symptoms?

Do you use drugs to "fix" a hangover?

Do you use drugs to relieve tension?

____ __________________________

Client’s Signature Date

HOPE HAVEN

DRUG HISTORY LIST

CLIENT NAME: ____

CLIENT NO: ____

Specify Name of Drug You Use/Used	Age When First Used	Age Regular Use Began	Route of Use	Amount You Use	How Often Do You Use	Date Last Used
Alcohol						
Amphetamines						
Barbiturates						
Caffeine						
Cocaine						
Hallucinogens						

Heroin						
Inhalants						
Marijuana/Hashish						
Narcotics/Opiates						
Over the Counter						
PCP						
Tranquilizers/Sedatives						
Other						

Primary drug ___________________________________ DSM IV-R Diagnosis _________________________________

Secondary drug _________________________________ Tertiary drug _______________________________________

Level of Severity Mild Moderate Severe Partial Remission Full Remission

____ __________________________

Client or Counselor's Signature Date