Application for Admission

Today's Date: __________

Motivating Factors for Seeking Recovery Based Services:
____
Preferred Date of Admission into Northwest Recovery Center:_______________________________
Participant's First Name: ___________________________ MI: _____ Last Name: _______________
Participant prefers to be called: ____________________
DOB: ____________ Age: _____ Gender: ☐Male ☐Female
Name of person completing this form: ________________ Relationship to Applicant: ____________
Participant's Primary Address:
____
How long have you lived at this address? ________________
Participant's Phone Numbers: (Check YES or NO if I can call and identify myself or leave messages on each phone)

Home: ______________________		Cell: ______________________	
Call and identify:	☐YES ☐NO	Call and identify:	☐YES ☐NO
Text Reminders:	☐YES ☐NO	Text Reminders:	☐YES ☐NO
Leave message:	☐YES ☐NO	Leave message:	☐YES ☐NO
Leave message:	☐YES ☐NO	Leave message:	☐YES ☐NO

Work: ______________________

Highest Education Completed

☐ Grade ______________
☐ Associate Degree
☐ Certificate Program (e.g. Trade school certificate)
☐ Bachelors Degree
☐ Masters Degree
☐ Professional Degree (JD, MD) ☐PhD

Current Marital Status:

☐ Single – Never Married
☐ Married
☐ Separated
☐ Living together, but not legally married
☐ Divorced
☐ Widowed
☐ Minor Child
Number of Marriages: ___________

Northwest Recovery Center

Military History

Are you a military veteran? ☐ Yes ☐ No

If you have military history, what branch? _____________ Have you ever been deployed? ☐ Yes ☐ No

If Yes, Please Specify:

____

Are you currently on active duty in the military? ☐ Yes ☐ No

Legal

Have you ever been arrested? ☐Yes ☐No If yes, what charges?

____

Have you ever been convicted? ☐Yes ☐No If yes, what charges?

____

Do you have any current or pending legal concerns?

____

Are You A Registered Violent or Sexual Offender: ☐Yes ☐No

Pending Legal Concerns: ☐Yes ☐No

If Yes, Please Specify:

____

Current level of employment:

☐ Part-time: Paid work less than 30 hrs/wk

☐ Day laborer: No consistent work

☐ Full-time student

☐ Full-time: Paid work more than 30 hrs/wk

☐ Retired from active employment

☐ Disabled and unable to work

☐ Unemployed

☐ Homemaker

☐ Other (please indicate):

____

How long have you been at your current job? _______________

Do you have any employment concerns?

____

Do you have financial concerns?

____

Who lives with you?

Name: ___________________________________ Relationship: ___________________ Age: _________

Name: ___________________________________ Relationship: ___________________ Age: _________

Name: ___________________________________ Relationship: ___________________ Age: _________

Name: ___________________________________ Relationship: ___________________ Age: _________

Name: ___________________________________ Relationship: ___________________ Age: _________

Name: ___________________________________ Relationship: ___________________ Age: _________

How would you describe your relationships with the people you live with? Who do you get along with the best and who do you have the most conflict with?

____
____
____
____

Do you have any other immediate family who does not live with you? (If yes, list below)

Name: ______________________________ Relationship: _________________ Age: ________
Name: ______________________________ Relationship: _________________ Age: ________
Name: ______________________________ Relationship: _________________ Age: ________
Name: ______________________________ Relationship: _________________ Age: ________

Are you adopted? ☐Yes ☐No

Where were you raised and with whom?

____

Do any of your family members have any diagnosed mental health concerns? (Relationship and diagnosis)

____
____
____
____

Who referred you to Northwest Recovery Center, Inc.?

☐ Self
☐ Family/Friend
☐ Clergy
☐ Inpatient Facility
☐ Doctor/Medical Professional
☐ Another counselor
☐ Hospital
☐ School
☐ Employer
☐ EAP
☐ Police/Law Enforcement
☐ Court/Judge
☐ Probation Officer
☐ Attorney
☐ Other ______________________

Medical

Current Medical Conditions:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Seizures ☐ Tuberculosis ☐ Activity Restrictions
☐ Dietary Restrictions ☐ Allergies______________________________ ☐ Infectious Diseases
______________________________ ☐ Other ______________________________

Past Health Problems:
____

Date of Last Physician Visit:
____

Name of Current Physician or Primary Care Provider:
____

List Current Medications (Prescription and Over The Counter):

Medication: ___________________________Dose: __________________Frequency: ________________
Medication: ___________________________Dose: __________________Frequency: ________________
Medication: ___________________________Dose: __________________Frequency: ________________
Medication: ___________________________Dose: __________________Frequency: ________________
Medication: ___________________________Dose: __________________Frequency: ________________
Medication: ___________________________Dose: __________________Frequency: ________________

Detox history: ☐Yes ☐No **Prior Treatment:** ☐Yes ☐No
Suboxone use: ☐Yes ☐No
If Yes, Use History: ____ **How Long:** __________________
History of IV use: ☐Yes ☐No
If Yes, Use History: ____ **How Long:** __________________
Suicidal Ideation: ☐Yes ☐No **If Yes, Please Specify Suicidal History (Last Attempt):**
____

History of Cutting: ☐Yes ☐No **If Yes, Last Cutting Occurrence**:
____

Open Wounds/History of MRSA: ☐Yes ☐No **Ambulation/Disabilities:** ☐Yes ☐No

SUBSTANCE ABUSE SCREENING SELF-REPORT

Have you used or are you currently using: Please check if current

☐ Alcohol Frequency/Amount: ______________________________________
☐ Marijuana Frequency/Amount: ______________________________________
☐ Cocaine Frequency/Amount: ______________________________________
☐ Meth Frequency/Amount: ______________________________________
☐ Fentanyl Frequency/Amount: ______________________________________
☐ Pain Pills Frequency/Amount: ______________________________________
☐ Heroin Frequency/Amount: ______________________________________
☐ Sleeping Pills Frequency/Amount: ______________________________________
☐ Tranquilizers Frequency/Amount: ______________________________________
☐ Nicotine Frequency/Amount: ______________________________________

☐ Diet Pills Frequency/Amount: ______________________________________
☐ Spice Frequency/Amount: ______________________________________
☐ Bath Salts Frequency/Amount: ______________________________________
☐ LSD/PCP Frequency/Amount: ______________________________________
☐ Ecstasy/Molly Frequency/Amount: ______________________________________
☐ Other Frequency/Amount: ______________________________________
☐ Other Frequency/Amount: ______________________________________

If you checked yes to any of the previous answer the following:

1. Have other people said you have a problem with drugs/alcohol? ☐Yes ☐No
2. Has your use of drugs/alcohol interfered with school, work or social functioning? ☐Yes ☐No
3. Have you ever been arrested for behavior that occurred under the influence of drugs/alcohol? (e.g. disorderly conduct, DUI, MIP, other crimes?) ☐Yes ☐No
4. Have you ever tried to stop or limit your use of drugs/alcohol unsuccessfully? ☐Yes ☐No
5. Have you noticed that it takes more of your drug or alcohol to have the same effect? ☐Yes ☐No
6. When you stop using your drugs/alcohol do you have any side effects? ☐Yes ☐No (e.g. shakes, tremors, seizures, sweats, diarrhea, constipation, vomiting, headaches, etc.)
7. Do you spend a lot of time on getting, using and recovering from drugs/alcohol? ☐Yes ☐No
8. Are you preoccupied with thoughts of your next use or obtaining the drugs/alcohol? ☐Yes ☐No
9. Have you stopped doing activities because you were using drugs/alcohol? ☐Yes ☐No
10. Have you experience any physical or emotions problems due to your use? ☐Yes ☐No

Previous Treatment (when, where, outcomes):
____
____
____
____
____