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Phases Transitional Housing Program Application  
*Offered through Wilkes Recovery Revolution, Inc.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Birth place \_\_\_\_\_ county \_\_\_\_\_

Do you maintain a primary residence? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you homeless? \_\_\_\_\_ Yes \_\_\_\_\_ No if yes, for how long? \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Mobile \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Race \_\_\_\_\_

Marital status: \_\_\_\_\_ Maiden name: \_\_\_\_\_

(if married give spouse name) spouse: \_\_\_\_\_

highest level of education completed: \_\_\_\_\_

SSN: \_\_\_\_\_

**REFERRAL INFORMATION**

Referring agency \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ FAX: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Are you currently employed? \_\_\_\_ Yes \_\_\_\_ No

Employer's name \_\_\_\_\_

Previous employer's name/ dates employed \_\_\_\_\_

Reason no longer there \_\_\_\_\_

Are you a U.S. veteran? \_\_\_\_ Yes \_\_\_\_ No

If yes, what branch \_\_\_\_\_

Honorable discharge: \_\_\_\_\_ dishonorable discharge: \_\_\_\_\_

Do you have any work restrictions? \_\_\_\_\_

Describe prior work experience or assets:

\_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL INFORMATION**

Do you own property? \_\_\_\_ Yes \_\_\_\_ No if yes describe: \_\_\_\_\_

\_\_\_\_\_

Do you own an automobile? \_\_\_\_ Yes \_\_\_\_ No If yes describe: \_\_\_\_\_

\_\_\_\_\_

Are you ordered to pay child support? \_\_\_\_ Yes \_\_\_\_ No

Are you behind? \_\_\_\_ Yes \_\_\_\_ No If so, how much? \_\_\_\_\_

Do you receive any ongoing financial reimbursement for any reason? (disability, trust funds, etc.) \_\_\_\_

Yes \_\_\_\_ No if yes explain: \_\_\_\_\_

\_\_\_\_\_

Are you currently applying for disability (ssi, ssdi)? \_\_\_\_ Yes \_\_\_\_ No

If yes for what reason? \_\_\_\_\_

**FAMILY HISTORY**

Does anyone in your family have a history of alcohol and/or drug abuse? \_\_\_ Yes \_\_\_ No

If yes, please check all that applies. \_\_\_ father \_\_\_ mother \_\_\_ grandparent(s)  
\_\_\_ siblings \_\_\_ stepparent (live in) \_\_\_ uncles/aunts \_\_\_ spouse or significant other  
\_\_\_ children \_\_\_ caretaker

Please describe your current circumstances with your immediate family: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your parent's current marital status?

\_\_\_ married to each other  
\_\_\_ separated for \_\_\_ years  
\_\_\_ divorced for \_\_\_ years  
\_\_\_ mother remarried \_\_\_ times  
\_\_\_ father remarried \_\_\_ times  
\_\_\_ mother involved with someone  
\_\_\_ father involved with someone  
\_\_\_ mother deceased for \_\_\_ years, your age at mother's death \_\_\_  
\_\_\_ father deceased for \_\_\_ years, your age at father's death \_\_\_

Describe your childhood family experience:

\_\_\_ outstanding home environment \_\_\_ normal home environment  
\_\_\_ chaotic home environment  
\_\_\_ witnessed physical/verbal/sexual abuse toward others  
\_\_\_ experienced physical/verbal/sexual abuse from others

**CHILDREN INFORMATION:**

NAME OF CHILDREN

AGE OF CHILD

_____	_____
_____	_____
_____	_____
_____	_____

Who currently has custody of children:

\_\_\_\_\_

is child currently enrolled in school? \_\_\_ Yes \_\_\_ No

other agencies involved:  dss  juvenile court  gal  other

If dss is involved, what is your social worker's name: \_\_\_\_\_

Address: \_\_\_\_\_

phone: \_\_\_\_\_ fax: \_\_\_\_\_

**SUBSTANCE ABUSE HISTORY**

Please list in order of preference all drugs used past to present. This must be completed.

Drug	Amount used at peak	Age at first use	Method of use	Date of last use

Consequences of substance abuse (check all that apply):  
 Hangover    Withdrawal symptoms    Sleep Disturbance    Binges    Suicidal Impulse  
 Seizures    Medical Conditions    Assaults    Job Loss    Blackouts    Tolerance Change  
 Arrests    Overdose    Loss of control amount used    Relationship Conflicts  
 Other \_\_\_\_\_

On a scale of 1 to 10:  
(no problem) 1 2 3 4 5 6 7 8 9 10 (very serious problem)

How serious of a problem do you think you have with drugs/alcohol? \_\_\_\_\_

How motivated are you to make changes in your life currently? \_\_\_\_\_

Have you ever been in a recovery house?  Yes  No

If yes..... Name: \_\_\_\_\_  
Where? \_\_\_\_\_  
When? \_\_\_\_\_  
How long? \_\_\_\_\_  
Why did you leave? \_\_\_\_\_

Have you ever been in an outpatient treatment program?  Yes  No

If yes.... Name: \_\_\_\_\_  
Where? \_\_\_\_\_  
When? \_\_\_\_\_

How long? \_\_\_\_\_

Did you complete? \_\_\_\_ Yes \_\_\_\_ No

If no, why did you leave?

Have you ever been in an inpatient treatment program? \_\_\_\_ Yes \_\_\_\_ No

If yes... Name: \_\_\_\_\_

Where? \_\_\_\_\_

When? \_\_\_\_\_

How Long? \_\_\_\_\_

Did you complete it? \_\_\_\_ Yes \_\_\_\_ No

If no, why did you leave? \_\_\_\_\_

How many times have you completed detox? \_\_\_\_\_

Do you consider yourself an alcoholic / addict? \_\_\_\_ Yes \_\_\_\_ No

Do you currently have a sponsor? \_\_\_\_ Yes \_\_\_\_ No

Are you working or willing to work the 12 steps? \_\_\_\_ Yes \_\_\_\_ No

Are you currently attending AA/NA meetings? \_\_\_\_ Yes \_\_\_\_ No

If yes, how many per week? \_\_\_\_\_

Have you ever overdosed? \_\_\_\_ Yes \_\_\_\_ No If yes answer the following questions.

How many times? \_\_\_\_\_

What were the circumstances surrounding the overdose? (when, where,  
why, etc.) \_\_\_\_\_

Where you revived by naloxone? \_\_\_\_ Yes \_\_\_\_ No

**MEDICAL HISTORY:**

Are you currently under the care of a physician?  Yes  No

If yes, Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason: \_\_\_\_\_

Do you suffer from or have experienced any of the following?

Diabetes:  Yes  No: (if yes, please explain)

\_\_\_\_\_

high blood pressure:  Yes  No : (if yes, please explain)

\_\_\_\_\_

Heart disease:  Yes  No : (if yes, please explain)

\_\_\_\_\_

stroke:  Yes  No : (if yes, please explain)

\_\_\_\_\_

Seizures:  Yes  No : (if yes, please explain)

\_\_\_\_\_

liver or kidney disease:  Yes  No : (if yes, please explain)

\_\_\_\_\_

Thyroid or hormonal:  Yes  No : (if yes, please explain)

\_\_\_\_\_

Cancer:  Yes  No : (if yes, please explain)

\_\_\_\_\_

have you ever been tested for aids/ hiv, stds, hep a b c d?  Yes  No

If yes test date and result: \_\_\_\_\_

\_\_\_\_\_

Are you pregnant?  Yes  No: (if yes, due date.)

\_\_\_\_\_

list prescribed and over-the-counter medications not list above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies to environment, food, or medication?  Yes  No

If yes, please explain: \_\_\_\_\_

**MENTAL HEALTH HISTORY:**

Have you ever been hospitalized and/or treated for any mental health issues?

Yes  No

if yes please answer the following questions:

was it voluntary or involuntary? \_\_\_\_\_

Are you currently taking any mental health medications:  Yes  No if so, name and dosage:

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Do you have a family history of mental health problems?  Yes  No

If yes, in what way? \_\_\_\_\_

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Have you ever been sexually assaulted?  Yes  No

If so, have you received counseling for this?  Yes  No

Are you currently suicidal?  Yes  No

Have you ever tried to commit suicide?  Yes  No If yes, date \_\_\_\_\_

Have you ever had cutting or bulimic behaviors?  Yes  No

Have you ever been the victim of a violent crime?  Yes  No

Do you currently have a health care provider?  Yes  No if yes please list your current provider. \_\_\_\_\_

How did substance use affect your mental health? \_\_\_\_\_

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**CRIMINAL JUSTICE INFORMATION**

Have you ever been convicted of a crime? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please give nature of charge and date of convictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did any of these convictions lead to incarceration? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please list institution and year of confinement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently incarcerated? \_\_\_ Yes \_\_\_ No if yes which facility? \_\_\_\_\_

\_\_\_\_\_

Expected release date? \_\_\_\_\_

Have you ever been convicted of a sexual offense? \_\_\_ Yes \_\_\_ No

If so, please list where \_\_\_\_\_  
opus number: \_\_\_\_\_

**PAROLE OR PROBATION OFFICER**

Officer's name: \_\_\_\_\_

address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Do you have any pending legal actions or outstanding warrants? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes list them by name and date: \_\_\_\_\_

\_\_\_\_\_

when is your next court date? \_\_\_\_\_

Where is your court date? (city, state, county) \_\_\_\_\_

What is your attorney's name? \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_



**MISCELLANEOUS:**

Will you have your admissions fee? \_\_\_\_\_ Yes \_\_\_\_\_ No

How much will you bring with you? \_\_\_\_\_

Do you have a valid NC driver's license that you will bring with you? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what is your license number? \_\_\_\_\_

Do you have a vehicle? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have a photo ID that you will bring with you? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what is your ID number? \_\_\_\_\_

Do you have any future appointments (i.e. DOCTOR'S, DENTIST, SOCIAL SERVICES)? If yes, please explain.

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**NOTIFY IN CASE OF EMERGENCY:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Mobile number: \_\_\_\_\_

Work number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**AFFIRMATION**

I affirm that my answers and information provided by me in this application are true and accurate. I understand that if I am accepted in the program, any misinformation and/or dishonest answer may be grounds for my dismissal from the Phases Program. I also understand that should any other information concerning me arise while I am in Phases that renders me ineligible to continue, I will be discharged.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**MENTAL STATUS:** (To be filled out by counselor or caregiver) (CHECK AND DESCRIBE)

**DANGER TO SELF:**

- NONE
- THREATS OF SUICIDE
- PLAN FOR SUICIDE
- PREOCCUPATION WITH DEATH
- SUICIDE ATTEMPTS
- INABILITY TO CARE FOR SELF

**DANGER TO OTHERS:**

- NONE
- THREATS TO HARM OTHERS
- PLAN TO HARM OTHERS
- ATTEMPTS TO HARM OTHERS

**ATTITUDE:**

- COOPERATIVE
- UNCOOPERATIVE
- RESERVED
- SARCASTIC
- SUSPICIOUS
- GUARDED
- HOSTILE
- PRESERVATION

**EMOTIONAL STATE:**

- GOOD
- SAD/DEPRESSED
- EUPHORIC
- HOSTILE

**THOUGHT FORM:**

- NORMAL
- TANGENTIAL THINKING
- LOOSE ASSOCIATIONS
- SLOWNESS IN THOUGHT
- INCOHERENT
- CONFUSED
- FLIGHT OF IDEAS
- OTHER

**INSIGHT:**

- GOOD
- FAIR
- POOR

**THOUGHT CONTENT:**

- NORMAL
- UNABLE TO ACCESS
- IDEAS OF REFERENCE
- SUSPICIOUS
- DELUSION
- HALLUCINATIONS
- FEELING HOPELESS/HELPLESS

DESCRIPTIONS: (To be filled out by counselor or caregiver)

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