



Out of the Darkness, Inc.
 P.O. Box 60824
 Rochester, New York 14606

Phone: (585) 232-3777 or (585) 278-3613
Fax: (585) 287-5558
Email: contact@outofthedarknessroc.org
Web: www.outofthedarknessroc.org

Out of the Darkness, Inc. Client Application

Thank you for your interest in applying for a place to stay with **Out of the Darkness, Inc.!** We invite you to complete this **confidential Client Application** that will be used only by our intake team members during the review process.

Directions: Please complete each section in the **Client Application** by selecting or typing your responses. When finished, please submit your application to us via email contact@outofthedarknessroc.org or fax **(585) 287-5558**.

General Information

Reason for applying for admission to Out of the Darkness, Inc.			
How are you applying?		Which agency?	
Out of the Darkness, Inc. is not a shelter, we are a recovery facility. Are you in need of recovery?			
Client Name		DSS Case #	
Gender		Date of Birth	
		Age	
Race/Ethnicity		County of Residence	
Home Phone # (if applicable)		Cell Phone #	
Permanent Address			
Emergency Contact		Phone #	
Address		Relationship	
Case Manager		Phone #	
Agency Name		Phone #	

General Information (Continued)

Attorney Name Phone #

Legal Status Referral Source

Stated Problem: If "Other", please explain

Educational & Occupational History

Highest Level of Education Location

Previous Employer Current Income

Other Sources of Income

Family & Social Information

Marital Status How many children do you have?

Motivation to Stay Sober

Interests/Hobbies

Food Allergies

Do you have... Diabetes

Other

Recovery History

No. Of Detoxes 1 2 3 4 5 or more

Last Detox

Where When

Completed? Outcome Time Clean

Recovery History (Continued)

Detox #2

Where	<input type="text"/>	When	<input type="text"/>
Completed?	<input type="text"/>	Outcome	<input type="text"/>
		Time Clean	<input type="text"/>

Detox #3

Where	<input type="text"/>	When	<input type="text"/>
Completed?	<input type="text"/>	Outcome	<input type="text"/>
		Time Clean	<input type="text"/>

Detox #4

Where	<input type="text"/>	When	<input type="text"/>
Completed?	<input type="text"/>	Outcome	<input type="text"/>
		Time Clean	<input type="text"/>

Detox #5

Where	<input type="text"/>	When	<input type="text"/>
Completed?	<input type="text"/>	Outcome	<input type="text"/>
		Time Clean	<input type="text"/>

Support System

Group Meetings:
(Examples: AA or NA)

Friends

Community Interests/Involvement

Religious/Spiritual Involvement

Legal System Involvement

Do you have pending charges? If yes, please explain.

Do you have court involvement? If yes, please explain.

Do you have current warrants? If yes, please explain.

Legal System Involvement (Continued)

Other?

If yes, please explain.

Mental Health Status Examination

Have you ever attempted suicide?

Date(s)

If yes, how?

Do you feel suicidal?

Do you engage in self-harm behaviors (ex. self-cutting)?

Do you suffer from anxiety, depression, etc.?

List of Medications Taken:

1.

2.

3.

4.

5.

6.

7.

Current Medical Problems

Victimization History

(Please note if abuse happened during childhood, adulthood, or both.)

Abuse

Physical

Sexual

Mental

Neglect

Domestic Violence

Other

Potentially Abusive Behavior (Chemical Dependence/Substance Abuse)

Please use the following format when entering specific dates: 01/01/2021 or Month/Day/Year

<u>Substance</u>	<u>First Use</u>	<u>Current</u>	<u>Highest</u>	<u>Most Recent Use</u>
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amphetamines	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Caffeine	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cannabis/Marijuana	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cocaine	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Depressants	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-Cigarettes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hallucinogens (PCP)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hypnotics or Sedatives	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inhalants	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
K2, Bath salts, Spice	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nicotine/Tobacco	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Opiates or Opioids	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I give consent to the ***Out of the Darkness, Inc.*** intake team to review my ***Client Application*** for a place to stay in the ***Sober Recovery House***.

I give consent **Signature** **Date**