Demi's Way

DEMI'S WAY WOMEN'S RECOVERY
Application

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ DOB: _____ Age: _____ Sex: _____

Emergency Contact (Name / relationship): _____

Emergency phone #: _____

Primary Care Physician: _____

Physician Location/Address: _____

Psychiatrist (if applicable): _____

Current Medications (both prescribed and OTC): _____

Last TB Test Date: _____ Location/Physician: _____

Special Needs / Accommodations: _____

Any medical conditions / allergies / chronic pain: _____

Source of Income: ☐ Wages/Salary ☐Public Assistance ☐Retirement/Pension ☐Disability

☐None If yes, how much do you earn or receive per month? _____

If none, who provides your financial support? _____

Do you have registered/insured vehicle you intend to bring? ☐Yes ☐No

Referral Source/contact #_____

Are you currently in Substance Abuse treatment? ☐Yes ☐No If yes: Location/Type

(Inpatient/IOP): _____

Admission date to current treatment: _____ Estimated discharge date: _____

If no: When and where did you last receive treatment? _____