The Villages of Armenia

Phone: 772-766-6510

Email: admin@villagesofarmenia.com

Preferred Date of Admission: _____

Name of Individual / Agency referring Client:_____

Phone Number and Best Time to Call Back: (_____)_____

Client's Name: _____D.O.B_____

Client's Phone Number: (_____)_____Email:_____

Address: _____

City: _____ State: _____ Zip: _____

Prior Treatment: (please cross out those that DO NOT apply) Intensive Outpatient, Inpatient, Medications, Psychologist, Group Therapy, 12 Step Program, Exercise Therapy, Nutrition Therapy, Light Therapy, Equine Therapy, Mindfulness Therapy, Yoga Therapy, Faith Based Therapy, Wilderness Therapy, Acupuncture Therapy, Missionary Therapy

Motivating Factors for Seeking Treatment: (please use back of application if more space is needed.)

_____

_____

Medical Conditions

Conditions:_____

Allergies: _____

Medications:_____

Seizures: YES / NO If Yes, Last Occurrence: _____Seizures due to Substance Use: YES/NO

If Medical, Do Seizures Occur While Taking Medications: YES / NO Are you Taking Prescribed Meds Daily: YES / NO

Mental Health History: (please use back of application if more space is needed.)

_____

Suicidal Ideation: YES / NO If Yes, Specify Suicidal History: (please use back of application if more space is needed.)

_____

Are You A Registered Violent or Sexual Offender: YES / NO

Pending Legal Concerns: YES / NO

If Yes, Please Specify: (please use back of application if more space is needed.)

_____

Open Wounds / History of MRSA: YES / NO Disabilities: YES / NO Stairs OK: YES / NO