Glynn's Place
Men's Recovery Residence

Glynn's Place
(478)274-8986 office
(478)254-9709 fax

Pre-Entry Screen

Staff Member:_____Date of Screen: _____

Name: _____Age: _____Gender: M F T

Referral Source:_____Entry Date:_____

Co-occurring Diagnosis_____

Prior Treatment(s):_____

Recovery Residence History_____

Drug(s) of Choice:_____Any IV Opiate Use: Y N _____

Recovery Time:_____

Medications:_____

History of Self-Harm:_____

Recent Suicidal ideation Homicidal ideation: _____

Relationship Status:_____Children:_____Sexual Orientation:_____

Work Experience/Plan: _____

Parent/Family Support:_____Location:_____

TB Test Y N (Must bring or have copy of results) Fees Discussed: Y N $_____/mo.

Ever been arrested, convicted, or questioned for any violent or sexual crimes: Y N

Any outstanding warrants: Y N _____

Legal Issues:_____

Are you legally mandated to be here? Y N Legal Charge? _____

Vehicle: Y N Valid License: Y N Drug Screens Discussed: Y N

Location Preference:_____Interview D/T/C:_____

PLEASE WRITE ANY ADDITIONAL NOTES ON THE BACK OF THIS FORM.