



Bloom Recovery Residences LLC  
info@bloomrecoveryresidences.com  
615-802-0500  
2411 Anchor Street, Murfreesboro, TN, 37130  
www.bloomrecoveryresidences.com

Name: \_\_\_\_\_ Potential Intake Date: \_\_\_\_\_

**Resident Information:**

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your plan to return to this address following your completion here? Y N

If you go on overnight passes while you are here is this where you plan on staying? Y N

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status S M D W P Children Y N

Spouses/Partner Name \_\_\_\_\_ Supportive? Y N

Children (names/ages) \_\_\_\_\_

Are you currently employed? Employed part time Employed full time Unemployed and looking for work

Unemployed and not looking for work (retired, disabled, enrolled in school, etc) Other \_\_\_\_\_

Are you currently enrolled in school or a job training program? Y N If yes, explain \_\_\_\_\_

**Emergency Contact Information:**

Contact Name \_\_\_\_\_ Release Y N

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Legal Information:**

Are you facing any legal charges? Y N Probation/parole? Y N Warrants? Y N

If yes, explain \_\_\_\_\_

Have you ever been arrested?

If yes, explain \_\_\_\_\_

Supervising Officer Name \_\_\_\_\_ Release Y N

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Addiction History:**

Current recovery date \_\_\_\_\_

Drug of Choice Alcohol Amphetamines Benzoids Cocaine Hallucinogen Marijuana Opiates Other

Age of first use \_\_\_\_\_ IV Drug Use? Y N Have you ever relapsed? Y N

Have you ever been in treatment? Y N How many times? \_\_\_\_\_

Last Treatment Center Name \_\_\_\_\_ Date Released \_\_\_\_\_

Case Manger \_\_\_\_\_ Release? Y N

Have you ever been in a halfway house? Y N

Have you ever attended 12 step meetings? Y N Type preferred \_\_\_\_\_

Do you plan on participating in IOP or therapy? Y N If yes, where? \_\_\_\_\_

History of self harm? Y N History of Eating disorder? Y N History of suicidal/homicidal ideation? Y N

If yes to any above, explain \_\_\_\_\_

Previous Diagnosis \_\_\_\_\_

Medication(s) Y N If yes, explain \_\_\_\_\_

Are there any health problems we should be aware of? Y N If yes, explain \_\_\_\_\_

Do you currently have a primary care doctor? Y N

Physicians Name \_\_\_\_\_ Release? Y N

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



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Who suggested that you come to Bloom Recovery Residences?

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What would you like to accomplish during your stay here?

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What potential challenges do you see in improving your recovery?

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What else would be helpful for us to know about you?

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