"Transitional Living for Recovering Men"

Admission Application

Name____Date:____________________

Residence: _________________________________Phone:___________________________

In Case of Emergency, Notify: _______________________Phone:______________________

Age: ______ Race: __________ Marital Status: __________ Birth Date: ______________

Social Security #_____-____-_____Have You Been Here Before? Yes or No

Referred by (Name)__________________________ (Agency)___________________________
Education Completed:_______________
Why Have You Chosen our Facility ____

Medical/Psychiatric History
Where: ______________________________ When: __________________________
Reason for Admission: ____
Current Medical Conditions: ____
Current Emotional Status: ____
List All Current Medications: ____

Alcohol/Drug Treatment Programs

Where: ____________________ When: __________ Length: ______________
Detox Programs: ____________ When: __________ Length: ______________

Alcohol/Drug History

Are You an Alcoholic? Yes No Are You an Addict? Yes No
Last Date Used: _____________________________
Seizures Yes No If yes Date of last Seizure ___________________
History of DT's Yes No Blackouts Yes No
Marijuana Yes No Hallucinations Yes No
Cocaine Yes No

List all other drugs and date last used ____

Have you ever attempted Suicide? ____

Longest period of previous sobriety? ____

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