Application for Admission
Female Only Recovery Home

CLIENT INFORMATION:

First Name: _____ **Middle Name:** _____
Last Name: _____ **Last Name at Birth:** _____

Alias/Other Names:_____

Date of Birth:___/___/_____ **Age:** ____

Primary Residence:

Street Address: _____

City: _____ **County:** _____ **State:** ____ **Zip:** _____

Mailing Address: _____

City: _____ **County:** _____**State:** _____ **Zip:** _____

Current Location: _____

Phone Numbers: (____)_____-_____ **Primary:** _____

Phone Numbers: (____)_____-_____ **Secondary:** _____

Email Address:

Emergency Contact Person: _____**Relation:** _____

Street Address: _____

City: _____ **County:** _____ **State:** ____ **Zip:** _____

Phone Numbers: (____)_____-_____ **Primary:** _____

Phone Numbers: (____)_____-_____ **Secondary:** _____

Referral Information:

Referral Date: ____/____/_____ **Referral Agency/Source:** _____

Contact Person: _____ **Phone Number:** (____)_____-_____

Substance Use:

What Substance Use is the primary reason to seek our program: _____

How often was this use: _____times within day/week/month.

How much use: _____

Please rank in order the severity of each drug used and how often:

- ***None***
- ***Alcohol _____days/week/month***
- ***Marijuana/Hashish _____days/week/month***
- ***Hallucinogens/LSD/PCP/Psychedelics/Mushrooms _____days/week/month***
- ***Inhalants _____days/week/month***
- ***Crack/Freebase _____days/week/month***
- ***Heroin and Cocaine (mixed together as Speedball) _____days/week/month***
- ***Cocaine (by itself) _____days/week/month***
- ***Heroin (by itself) _____days/week/month***
- ***Street Methadone (non-prescription) _____days/week/month***
- ***Other Opiates/Opium/Morphine/Demerol _____days/week/month***
- ***Methamphetamines _____days/week/month***
- ***Amphetamines (other uppers) _____days/week/month***
- ***Tranquilizers/Barbiturates/Sedatives (downers) _____days/week/month***

What is the date of last use: ____/_____/_____

Are you presenting symptoms of withdrawal: Y / N

Currently enrolled in any Medication Assisted Treatment: Y / N

Methadone:_____ Suboxone: _____ Other:_____

Have you attended any other inpatient treatment: Y / N Dates: ____/____/_____

What Facility/Where: _____

Currently attending any Outpatient/IOP/12-Step Meetings: Y / N

What program and how often: _____

Social History:

Marital Status: _____ **Children:** _____

Education:

GED: Y / N **Diploma: Y / N** **Last Grade Completed:** _____

Degrees/Trade/Vocation: _____

Current Employment: _____

Prior Employment: _____

Medical:

Chronic Medical Problems: _____ **Pregnant: Y / N**

Health Conditions/Allergies: _____

Any Transmittable illness/disease: Y / N **Type:** _____

Current Medications: _____

Mental Health Diagnosis: _____

Mental Health Counseling and Medications: _____

Impairment/Other health concerns: _____

Activity Limitations: _____

Legal Issues:

Is treatment required or mandated by any legal authority: Y / N

Please provide information of order: _____

Probation Status: Y / N **Offense:** _____**County:** _____

Pending Charges: _____

Prior Offenses/Convictions: _____

Required to register as a Sex Offender in any State: Y / N **Where:** _____

Registry Offense: _____

Faith and Recovery:

Home Church: _____ Denomination: _____

If you do not have a home church and/or accepted Christ—are you willing to be open and accepting of a Faith Based Recovery Program: Y / N

Why do you seek recovery and want to attend our program?:

_____

_____

_____

_____

_____

_____

_____

_____

(use back of page or separate paper if needed)

Recovery Road Ministries Recovery Program is a Christian Faith Based Recovery Program that is a 10 month commitment. It is a Christian Rehabilitation Home with an in-house recovery program. We are not a medical facility nor a homeless shelter.

By signing this application you are acknowledging that upon being accepted, you are committing to attending a 10 month, in-house recovery program and agree to follow the recovery program, house rules, and directives of the Executive Director and Staff. Violations of the rules and directives will lead to dismissal from the program.

Signed this _____Day of _____, 20_____

_____ _____

Printed name of Applicant **Signed name of Applicant**

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-recovery.rd.ministries@gmail.com- -www.recoveryroadministries.org-