



# Application for Admission

## CLIENT INFORMATION:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ Last Name at Birth: \_\_\_\_\_

Alias/Other Names: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: M\_\_F\_\_

## 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:

- Alcohol \_\_\_\_\_ days/week/month
- Marijuana/Hash/Delta8 \_\_\_\_\_ days/week/month
- Hallucinogens/LSD/PCP/Psychedelics/Mushrooms \_\_\_\_\_ days/week/month
- Inhalants \_\_\_\_\_ days/week/month
- Crack \_\_\_\_\_ days/week/month
- Fentanyl \_\_\_\_\_ days/week/month
- Cocaine (by itself) \_\_\_\_\_ days/week/month
- Heroin (by itself) \_\_\_\_\_ days/week/month
- Street Methadone (non-prescription) \_\_\_\_\_ days/week/month
- Opiates/Opium/Morphine/Demerol/Oxy \_\_\_\_\_ 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:** \_\_\_\_\_

**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?:**

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(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**

Recovery Road Ministries recognizes the rights of all individual's privacy and holds each person's confidentiality in the highest regard. Any information disclosed will done with consent of the client prior to discussing confidential information and used solely for Recovery Road Ministries purposes. Upon acceptance into Recovery Road Ministries, each client is given the opportunity to complete all necessary releases of information to provide the ability of staff to discuss important information with those that the important or necessary for continuity of care. No information will be disclosed to any party without the written, documented consent of the client.

**-Women's Home: 80 Canal Street, Graniteville SC 29829- 803-507-2065-**

**-Men's Home: 1774 Edgefield Highway, Aiken SC 29801 — 803-640-4960-**