SEEDS OF HOPE, INC
ADMISSION APPLICATION AND ASSESSMENT FORM
MAT-Vivitrol Only Facility

Name: _____
Date: _____
Address: _____
Phone Number: _____
City: _____
State: _____
Zip Code: _____
Date of Birth: _____
Age: _____
Race: _____
Social Security Number: _____
Are you living with family? _____
Are you living with friends? _____
Are you incarcerated? _____
If you are incarcerated give release date? _____
Is your release date being determined upon acceptance into a program? Yes_____ No_____
Are you coming from Detox? _____
Give name and number: _____
Are coming from rehab? _____
Give name and number: _____

Are you coming from another transitional home? Yes_____ No_____
Give name and number: _____
Are you homeless? _____
Were you born a female? _____
Have you ever been a resident at Seeds of Hope? _____

LEGAL HISTORY
Have you engaged in illegal activities in order to obtain alcohol or drugs? Yes_____ No_____
Have you been arrested for possession of illegal drugs? Yes_____ No_____
Have you been arrested for DUI? Yes_____ No_____
Have you been arrested for Public Intoxication? Yes_____ No_____
Do you have any cases pending? Yes_____ No_____
Is there a warrant out for your arrest? Yes_____ No_____
Is there a possibility a warrant could be out for your arrest? Yes_____ No_____

<u>List charges for your incarceration and/or all pending charges</u>
Arrest Date: _____
Charge/County: _____
Comments: _____

List prior charges you have received which are not mentioned above

Date: _____
Charges: _____
Convictions/Outcome: _____

Are you currently on probation/parole? Yes_____ No_____
Name of probation/parole officer: _____
Phone Number: _____
Next court date and/or probation/parole appointment: _____
Amount owed deemed by the court: _____

EMERGENCY CONTACT: List two
Name: _____
Phone Number: _____
Address: _____
City: _____
State: _____
Relationship: _____
How often are you in contact with this person? _____

Name: _____
Phone Number: _____
Address: _____
City: _____
State: _____
Relationship: _____
How often are you in contact with this person? _____

FAMILY/MARITAL STATUS Circle the proper answer: SINGLE, MARRIED, DIVORCED, WIDOWED

Has your drinking or using drugs created problems between you and your family members?

Yes_____ No_____

Have you lost friends because of your drinking and use of drugs? Yes_____ No_____

Has any one ever told you that you have a problem with drinking or using drugs? Yes_____ No_____

Do most of the people you associate with drink or use drugs? Yes_____ No_____

Have you neglected your family because of your drinking and use of drugs? Yes_____ No_____
Are you currently married? _____
Name of spouse: _____

Are you currently in a relationship? Yes_____ No_____

Does the person you are currently in a relationship with use any type drugs (alcohol is a drug) Yes_____ No_____
Your Sexual Preference: _____
Name of the person you are in a relationship with: _____

Do you have children? Yes_____ No_____
(if yes please list below)

Name: _____
Age: _____
Sex: _____
Lives with: _____
Is a county involved with the welfare of your children? _____
Name of county: _____
Case Manager Name _____
Phone number _____
What is your current visitation schedule? _____

ALCOHOL/DRUUG PROBLEMS
What is your drug of choice? _____
Give last date of using any type of alcohol and/or drugs_____
How old were you when first used any type of alcohol and/or drug? _____
How much do/did you use in a day? _____
If you are not working give a brief detail on how you obtain your drugs. _____
Check all you have used in your life time:
Alcohol_____
Barbiturates_____
Crack_____
Marijuana_____
Opiates (Vicodin, Heroin, Morphine, Oxycontin) _____
Cocaine_____
Zanax/Valium_____
Benzodiazepines (Date Rape Drugs) _____
Amphetamine/Diet Pills_____
Hallucinogens_____

List any drugs not mentioned above which you have used: _____

Have you abused prescription drugs? Yes_____ No_____
Do you abuse more than one drug at a time? Yes_____ No_____
Do you use drink or use drugs more than once a week? Yes_____ No_____
Have you tried to stop drinking or using drugs and were not able to do so? Yes_____ No_____
Have you had blackouts or flashbacks as a result of drinking or using drugs? Yes_____ No_____
Do you ever have feelings of guilt or shame about your drinking and using drugs? Yes_____ No_____
Do others complain about your involvement with drinking and using drugs? Yes_____ No_____
Is there a certain time of the day you crave a drink or to use drugs? Yes_____ No_____
Have you had financial difficulties as a result of drinking or using drugs? Yes_____ No_____
Has your efficiency decreased since you began drinking or using drugs? Yes_____ No_____
Has your ambition decreased since drinking or using drugs? Yes_____ No_____
Do you turn to inferior companions and environments when drinking or using drugs? Yes_____ No_____
Do you drink or use drugs alone? Yes_____ No_____
Do you drink and use to enhance having a good time? Yes_____ No_____
Have you been involved in a treatment program related to substance use? Yes_____ No_____

List programs you have been involved within the past 10 years for: _____
Detox/Substance: _____
Abuse Treatment/Transitional Living: _____
Date: _____

Facility/location: _____
Reason for leaving & length of stay: _____
Longest period of abstinence from all alcohol and/or drugs: _____
When? _____

Give a brief detail on why you feel you were not able to remain substance free. _____

MENTAL HEALTH

Have you been diagnosed Schizophrenia? Yes_____ No_____

Have you been diagnosed Manic Depressive? Yes_____ No_____

Have you been diagnosed Bi-Polar? Yes_____ No_____

Have you been diagnosed with PTSD? Yes_____ No_____

Have you been diagnosed with a Personality Disorder? Yes_____ No_____

List other diagnosis you have been given that are not mentioned:

Was your diagnosis after 1 year of being free from drinking or using drugs? Yes_____ No_____

Are you currently on any medication? Yes_____ No_____

Was your diagnosis before you started drinking or using drugs? Yes_____ No_____

Was your diagnosis before you started drinking or using drugs? Yes_____ No_____

Have you ever been hospitalized for any mental illness? Yes_____ No_____

If yes list:

Date: _____
Facility/location: _____

Have you ever attempted suicide? Yes_____ No_____

Do you have a history of self mutilating? Yes_____ No_____

Date you last attempted suicide: _____

Please give details of your last attempt: _____

Date you last self mutilated? _____

Do you have any history of an eating disorder? Yes_____ No_____

Elaborate_____

MEDICAL HISTORY

Do you have any physical illness requiring regular medical care? Yes_____ No_____

Elaborate: _____

Do you have a history with seizures? Yes_____ No_____
Give date you had your last seizure: _____

Do you have asthma? Yes_____ No_____
Do you have emphysema? Yes_____ No_____
Do you have Hepatitis? Yes_____ No_____
If so: What type? _____

Do you have HIV/AIDS? Yes_____ No_____
Do you have high blood pressure? Yes_____ No_____
Do you have any type of blood disease? Yes_____ No_____
Is there a possibility you have a sexually transmitted disease? Yes_____ No_____
Are you pregnant or is there a chance you could be? Yes_____ No_____
What type of birth control if any are you using? _____

When was your last menstrual period? _____

Do you have a hearing problem? Yes_____ No_____
Do you have any unusual bruising or bleeding? Yes_____ No_____
Do you have any type of heart problems? Yes_____ No_____
Do you have irregular heart beat? Yes_____ No_____
Have you ever been diagnosed with cancer? Yes_____ No_____
If so what type of treatment did you receive? _____

Do you have nausea, vomiting, diarrhea, or constipation? Yes_____ No_____
Do you take any type of over the counter medication? Yes_____ No_____
List over the counter medications: _____

Do you have diabetes? Yes_____ No_____
If so how is it controlled: _____

Are you currently in pain? Yes_____ No_____
If you are in pain where is the pain? _____
On a scale of 1-10 rate your pain_____
1 being very mild, 10 being unbearable
1 2 3 4 5 6 7 8 9 10

Do you take medication for pain? Yes_____ No_____
LIST MEDICATION YOU TAKE FOR PAIN: _____

Have you had a physical within the past 12 months? Yes_____ No_____
Have you had a TB test within the past 12 months? Yes_____ No_____
Have you been seen by a doctor in the past 12 months? Yes_____ No_____

If you have been seen by doctors indicate why? _____

Have you ever tested positive for covid? Yes_____ No_____ When_____

Have you been vaccinated for COVID-19? Yes_____ No_____ Date(s) 1st dose _____ 2nd dose _____

Are you willing to be vaccinated? Yes_____ No_____

EMPLOYMENT HISTORY

Are you currently employed?

Yes_____ No_____

Days and time you are scheduled to work_____

Present Employer information:

Name: _____

Phone Number: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Supervisor: _____

Phone Number: _____

Pay Rate: _____

Net income: _____

Pay date: _____

Wkly: Yes_____ No_____

Bi Wkly: Yes_____ No_____

Monthly: Yes_____ No_____

If you are not working when is the last time you held a job: _____

Are you currently on disability? Yes_____ No_____

Have you applied for disability? Yes_____ No_____

Are you able to be employed 32 hours a week? Yes_____ No_____

If on disability: Date you receive your disability check: _____

Total amount of check: _____

If you are not able to be employed 32 hours a week, please explain. _____

Have you ever been in trouble at work because of your use of alcohol and/or drugs? Yes_____ No_____

Have you lost a job because of alcohol and/or drug use? Yes_____ No_____

Are you trained in a specific field? Yes_____ No_____

If you are trained in a specific field state the field: _____

What is the highest-level education you completed? _____

Do you have a state ID? Yes_____ No_____

Do you have a social security card? Yes_____ No_____

Do you have a birth certificate? Yes_____ No_____

Do you have a driver's license? Yes_____ No_____

Do you have a vehicle? Yes_____ No_____

Is your vehicle properly registered? Yes_____ No_____

Is your vehicle insured? Yes_____ No_____

FINANCIAL

Do you receive food stamps? Yes_____ No_____
If yes state how much: _____
Do you have a checking account or savings account? Yes_____ No_____
If yes give name of bank and dollar amount in account: _____
Do you receive a support? Yes_____ No_____
If yes how much: _____

If yes give the name of the bank and submit your last bank statement? _____
List all debtors (include court, and probation fees, child support/care) amount owed, payment arrangements:
_____

Name: _____
Total owed: _____
Arrangements made/How often and amount: _____

RECOVERY

Have you ever attended a 12 step meeting (AA/CA/NA)? Yes_____ No_____
Do you have a sponsor within a 12 step program (AA/CA/NA)? Yes_____ No_____
If you have a sponsor please give name and number: _____
How do you feel Seeds of Hope can help you? _____
What do you feel will be your biggest problem(s) maintaining abstinence from alcohol and drugs:
_____

I acknowledge that this information is true and, if I have knowingly falsified anything, I could automatically become ineligible for acceptance and/or admission into Seeds of Hope.

Applicant's Signature: _____

Date: _____

SEEDS OF HOPE