SEEDS OF HOPE, INC

ADMISSION APPLICATION AND ASSESSMENT FORM

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 a 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 you coming from rehab? _____ **Give name and number** _____

Are you coming from another transitional home? _____ **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**

List charges for your incarceration and/or all pending charges

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?** _____

Do you have insurance?**Yes or No**

Provider name of insurance _____

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 anyone 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? _____

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? _____ If so 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/DRUG PROBLEMS

What is your drug of choice? _____

Give last date of using any type of alcohol and/or drugs _____

How old were you when you 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 lifetime

Alcohol	_____	Barbiturates	_____	Benzodiazepines Xanax, Valium	_____	Marijuana	_____
Opiates (Vicodin, Heroin, Morphine Oxycontin	_____	Cocaine	_____	Crack	_____	Date Rape Drugs	_____
Amphetamine/Diet Pills	_____	Hallucinogens Psychedelics	_____	Inhalants	_____	Methamphetamine	_____

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 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 it 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 with Schizophrenia? **Yes** **No**
Have you been diagnosed with 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 before you started drinking or using drugs? **Yes** **No**
Was your diagnosis after 1 year of being free from drinking or using drugs? **Yes** **No**
Are you currently on any medication? **Yes** **No**

LIST MEDICATION TYPE, MILLIGRAM, AND WHY

_____ _____
_____ _____
_____ _____
_____ _____

Do you have a history of taking any type of medication that you are not currently taking? **Yes** **No**

LIST MEDICATION YOU NORMALLY TAKE WHICH YOU CURRENTLY ARE NOT TAKING & WHY.

_____ _____
_____ _____
_____ _____

Have you ever been hospitalized for any mental illness? If yes list **Yes** **No**

Date	Facility/location	Diagnosis and Treatment plan

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 _____

Can you climb up and down stairs? **Yes** **No**

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 an 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 Circle

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, why? _____

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 _____

Weekly _____ Bi Weekly _____ Monthly _____

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 child 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