

Wirt County Recovery - Application

Section 1: Basic Information

Name of Applicant: _____ Date: ____/____/____

Person making the Referral (if self-please specify) _____

Applicant: Age _____ Date of Birth _____ S.S.N. ____-____-____

Military Status: Not Applicable Active Veteran

Two Phone Numbers to reach (please specify who the phone belongs to) _____

Email Address: _____ County Residing: _____

Where are you currently residing? _____

Present address: _____

Emergency Contact Person and Phone Number: _____

Marital/Relationship Status: Single Married Divorced Widowed

Ethnicity: ___ Not Hispanic or Latino ___ Hispanic or Latino ___ Unknown

Race: ___ White ___ Black/African American ___ Native Hawaiian/Pacific Islander

___ American Indian/Alaskan Native ___ Asian ___ Unknown

Highest level of education completed: _____ Source and Amount of income: _____

Type of Insurance (circle all that apply:) Medicaid Medicare Private Insurance Self Pay

Do you receive any other government assistance (i.e. food stamps, HUD, WIC, SSI, etc.)? Yes No

If yes, please explain: _____

Do you need help getting any of the following: (check all that apply)

___ Insurance ___ Food Stamps ___ HUD ___ WIC ___ Food Pantry ___ Other (Explain): _____

Please check all that apply:

___ Pregnant, due date: _____

___ Past IV use, last date used: _____

___ Parenting Woman

___ Homeless

_____ None of the Above

If you have children, is CPS involved? Yes No N/A

Number of Dependent Children: _____

Are your children currently residing with you? Yes No

If applicable, list the name(s), age(s), and gender of dependent children: _____

It has been our experience that unhealthy relationships early in recovery sabotage the treatment process. If it came down to you being successful in recovery, would you be willing to break some unhealthy relationship ties? Yes No
Explain:

Section 2: Medical/Treatment Information

Date of last menstrual period: _____

List any medical conditions and/or complaints; please include both physical and mental diagnosis (please include physical, mental, dental, and eyesight issues/conditions):

CURRENT MEDICATIONS (List all medications including vitamins, birth control, OTC's, and prescribed medications):

Medication	Dosage	Frequency

How many times have you been to the E.R., clinic, or Doctor's office in the last six months and why?

Describe all past treatment attempts (please include outpatient services, 28 day treatment, detox, CSU's, individual therapy, etc.):

Where?	When? (Dates/Years)	Length of Stay/Amount of Time Seen	If applicable, did you graduate?

Are you currently or have you ever had homicidal thoughts or ever made any attempts? Yes No

If yes, please explain: _____

Are you currently or have you ever had suicidal thoughts or ever attempted suicide? Yes No If yes, please explain: _____

Have you ever experienced self-destructive behavior (i.e. cut yourself, burn yourself, practiced an eating disorder etc.)? Yes No If yes, please explain: _____

Have you ever been physically, emotionally, or sexually abused? Yes If yes, please explain: _____

Section 3: Legal

Are you currently incarcerated? ___ Y ___ N If yes:

Where?	Counselor:	Contact Number:	Current Length of Stay:

Also, if so, are you going to need to Parole or Probation? _____

Do you have a Parole or Probation Officer? Yes No Not assigned yet

If yes, please provide name of officer and phone number: _____

Are you a registered sex offender or have you ever been charged with sex related crime? Yes No

List all current and past charge(s)/conviction(s) or pending charge(s) (include misdemeanors and felonies,) crime convicted of, sentence, and present status:

Are you convicted of a drug felony? Yes No Are you a Domestic Violence Victim? Yes No
Are you currently fleeing a violent situation? Yes No Protective Order? Yes No Active
warrant? Yes No Are you Out on Bond? Yes No

Are you required by the courts or any other legal entity to enter this program? _____

If so, what County? _____ Who is the Judge? _____

Court in the next week? Yes No Upcoming Court Dates: _____

Your lawyer's name _____ Phone _____

Section 4: Alcohol/Drug Use

Do you believe you have a problem with drugs? Yes No

Do you believe you have a problem with alcohol? Yes No

Have you ever attended a 12 step program (AA/NA) Yes No

Willing to attend 12 step programs, counseling, therapy and/or groups? Yes No

Have you applied to long term program? Yes No Where: _____

Please explain the answers to questions: _____

What is your drug(s) of choice? _____

As of today, when was your last date of drink/use? _____

Please fill in the chart below:

CHEMICAL	EVER USED?	AGE FIRST USED	LAST USE/AMOUNT
Alcohol			
THC (Marijuana)			
Cocaine/Crack			
Hallucinogens			
Speed, Uppers, Diet Pills			
Barbiturates (downers)			
Tranquilizers (Valium, Xanax, etc)			
Narcotics (Opiates)			
Heroin			
Inhalants			
Meth			

Why do you want to enter our program? _____

What are some goals you hope to achieve by getting clean?

1. _____
2. _____
3. _____

Signature Date