P.A.I.N. SOBER LIVING APPLICATION

This form is subject to the Privacy Act of 1974. This form is designed to help your provider develop a treatment plan that best meets your needs and the reasons for your appointment.

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| **Patient Information** |
| Client First Name (please print):  | Last |
| Client Date of Birth:  | Gender: Male Female  |
| Street Address or PO Box:  |
| City:  | State: Zip: |
| PhoneHome: Cell:  |
| Email Address:  |
| Emergency Contact Name: Phone:  |
| How did you hear about P.A.I.N?  |

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| **Parent / Guardian / Spouse Information**  |
| Parent / Guardian / Spouse Name (please print):  | Last Name:  |
| Date of Birth:  | Gender: Male Female  |
| Street Address or PO Box:  |
| City:  | State: Zip:  |
| PhoneCell: Email:  |

Patient Information:

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| **Reasons for Residing at PAIN Sober Living:** |
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| Sobriety Date: |
| Primary Drug of Choice:  | Secondary Drug(s) of Choice:  |

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| **Mental Health History** |
| Have you had any previous counseling, mental health treatment treatment, or substance abuse treatment?If yes, please specify:  | Yes No  |
| Have you ever taken medication for a mental health or substance abuse problem?  | Yes No |
| If so, how long? |
| **Health Information** |
| Allergic to anything? |
| Please circle the best description of your present overall health: Excellent Good Fair PoorExplain: |
| Name and Facility of Primary Care Provider: Address: Phone:**MEDICATION** |

|  |  |
| --- | --- |
| Name of Medication Currently Used  | Reasons for Medication  |
| 1. |  |
| 2. |  |
| 3. |  |
| 4.  |  |
| List any significant current and past medical problems, including hospitalizations, surgeries and traumatic injuries:

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| --- | --- |
| 1. | Currently treated: Yes No  |
| 2. | Currently treated: Yes No  |
| 3. | Currently treated: Yes No  |

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| **Social Support / Spirituality (Optional)**  |
| How important is the spiritual dimension of your life? Not Important 0 - 1 - 2 - 3 -4 Very Important (please circle one) |
| How much is your spiritual community a source of support for you? Not Important 1 -2 -3 -4 Very Important (please circle one)If so, what faith community are you a part of?

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| Does your spiritual life help you cope with your struggles? Yes / No  |

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| **Legal**

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| Do you have any recent or current legal problems?Describe |

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| Attorney Name:  |

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| --- |
| Phone:**Occupation** |

Are you currently employed?If so, where?How long have you been employed there?Job Contact Person: Phone:What is your Schedule: |

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TREATMENT VERIFICATION

Treatment Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_