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: |
| Phone  Home: Cell: | |
| Email Address: | |
| Emergency Contact Name: Phone: | |
| How did you hear about P.A.I.N? | |

|  |  |
| --- | --- |
| **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: |
| Phone  Cell: Email: | |

Patient Information:

|  |  |
| --- | --- |
| **Reasons for Residing at PAIN Sober Living:** | |
|  | |
| 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 Poor  Explain: | |
| 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:   |  |  | | --- | --- | | 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?   |  | | --- | | Does your spiritual life help you cope with your struggles? Yes / No | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Legal**   |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | Do you have any recent or current legal problems?  Describe |  |  | | --- | | Attorney Name: |  |  | | --- | | Phone:  **Occupation** |   Are you currently employed?  If so, where?  How long have you been employed there?  Job Contact Person: Phone:  What is your Schedule: | |

TREATMENT VERIFICATION

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

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

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

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

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

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

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

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