HOPE HAVEN INC.
ADMISSION APPLICATION

NAME: _____
First Last Middle/Maiden

_____ _____ _____
Date of Interview Date Admitted Referred By

_____ _____ _____ _____ _____
Former Address City County State Zip

Zip Code of Last Permanent Address _____

Valid Drivers License Y/N #_____ Picture ID: Y/N - Transportation: Car Transit

Social Security Card: #_____ Homeless Verification Letter/Information_____

SOCIAL HISTORY

_____ _____ _____ _____
Age Race Date of Birth Place of Birth

_____ _____
Mother's Name (married & maiden) Father's Name

Prior Admits to Hope Haven _____Last Date Discharged_____

Last School Grade Completed_____ Did you like school? Y/N Why or why not?
_____

Are you presently enrolled in school? Y/N if so, where? _____

Are you presently on State or Federal Probation? Y/N For what charge(s)_____
P.O. Name and phone #_____
Do we have your criminal background report Yes / No

EMPLOYMENT HISTORY (Types and Skills)
_____
_____

Occupation _____ Last Employer _____
Is this your current employer? Yes / No VR Involvement Yes____No___
Did you serve in the military? Y/N If yes, branch and dates served_____
Did you like your stay in the military? Yes / No Why or why not? _____
What was your discharge status?_____ What was your discharge date?_____

INCOME INFORMATION

Any source/type of income? Yes ____No____

If yes; what type of income PENSION/RETIREMENT____SSI/SSDI____TANF____
UNEMPLOYMENT_____VA BENEFITS____ OTHER____

What amount of income? _____

Are you in the process of filing disability? Yes ____No____

If yes; what is your status Awaiting Hearing ____ Denied ____ Income Pending ____

Do you receive Medicaid? Yes____ No____ Medicaid Number _____

Do you receive Medicare? Yes ____ No ___ Medicare Number_____

HISTORY OF ADDICTION/ALCOHOLISM:

Blackouts ____ DT's_____ Epilepsy____ Neuritis_____Hallucinations_____ Date of Last Drink/Use _____ Age of First Drink/Use_____

At what age did alcohol/drugs become a problem? _____

Alcohol/Drug Related Arrests: _____Other Arrests:_____

If yes, explain_____

Previous Treatments (List where and when)

_____

_____

_____

_____

_____

Longest Clean Time_____

Sponsor Y/N

Psychological History:

Have you ever been a patient in a mental hospital? Yes / No
Have you ever had a mental health assessment / evaluation? Yes / No
If Yes, Explain with dates:

_____
_____

Have you had any of the following in the last two months?
Financial burdens__ Lack of Sexual desire__ Irritability__ Family Problems__ Weight Loss___
Staring Spells____ Problems with job___ Employment___ Separation or divorce_____

Family History:
Number of Brothers, sisters, stepbrothers, stepsisters_____

Number of children, stepchildren_____ Ages: _____

Are your child (ren)'s pediatric care (medical) needs being met? Y/N If so, by whom_____

Are your children receiving /or need to have therapeutic interventions for any special needs? Y/N

If so, what type of therapeutic intervention and from whom? _____
(Developmental needs, Child Mental Health, Substance Abuse Issues)

Will your children need childcare? Yes / No Are they presently receiving childcare? Yes / No
If so where? _____

How well do family members get along? _____

Is there any family of origin abuse? Explain: _____

Did any family members drink or use? If so whom? _____

MARITAL/SIGNIFICANT OTHER HISTORY

Marital Status: Single___ Married___ Divorced___ Widowed___ Separated___
If married, how long? _____ Married Before? Yes / No How many times? _____

Has there been abuse in your marriage or intimate relationships? Yes / No

How well do /did you get along with your significant other/spouse? _____

How well did you get along with your children? _____

Living arrangements prior to treatment? _____
Number in the household? _____
Do you ever feel afraid of your partner? _____ In what ways? _____
_____

Has there ever been any violence in your intimate relationships? (Example: pushing, pulling, slapping, punching or kicking) Y/N _____
How long ago did the most recent violence occur? _____
Has there ever been fighting in your intimate relationships that led to damage or destruction of personal belongings, property or pets? Y/N _____
Have there ever been threats to use weapons such as a gun, knives by you or your partner? Y/N _

Have ever had a partner force you to have sex against your will? Y/N_____
Has physical abuse ever occurred while you were high? Y/N _____
Has physical abuse ever occurred while your partner was high? Y/N_____
Have you ever gotten high to cope with the violence in your relationships? Y/N_____
Have the police ever been called to your home due to fighting? Y/N _____

MEDICAL HISTORY

Family Doctor: _____
Address: _____Phone: _____
Date of last physical examination? _____
When was your last TB test? _____ Results_____
Do you have a history of: Diabetes_____ Epilepsy____ High blood pressure _____
Cancer_____ Nervous or mental disorder _____ Other _____

What over the counter medications have you taken in the last six months? _____
_____
What medications are you ALLERGIC OR SENSITIVE TO:
_____

Are you currently on medications? Yes / No If yes, please give the names: _____
_____

_____

Prescribed by: _____

Females Only: Are you pregnant now? Yes / No # of times pregnant_____
Last menstrual period_____ Flow: Light Heavy Abnormal Discharge
Last Pap smear: _____ Results: _____ Breast Exam: C/o pain___ Lump_____ Discharge___

_____
Do you presently have a Disability that is covered under the Americans with Disabilities Act (ADA) that will require special accommodations or specific needs? Yes____ No____
If yes, then what is that disability and what specific accommodation or specific need will need to be made?
Please describe_____
Level of Functioning_____ Specific Needs _____

EMERGENCY CONTACT INFORMATION:

_____

Name Phone Relationship

Complete address: _____

As a resident of Hope Haven, I understand and accept my written responsibilities. In consideration of your admitting me as a resident to Hope Haven, I, for myself, my heirs, assigns or personal representatives, do hereby release you and your staff from any liability for any personal injury or property damage that I may sustain at any time at Hope haven, or on its premises or while I am a passenger in any vehicle, and further agree to hold Hope Haven, Inc. free and harmless from any and all liability in connection therewith:

_____

STAFF SIGNATURE AND TITLE Date

_____

RESIDENT SIGNATURE Date

Hope Haven, Inc.
3815 N. Tryon St.
Charlotte, NC 28206

DRUG HISTORY

Client Name: _____

Client No: _____

Yes	No	
___	___	Used more drugs and/or alcohol than you intended?
___	___	Wanted to or tried to cut down or control your drug and/or alcohol use?
		How many times? _____
___	___	Spent a lot of time trying to get drugs/alcohol, taking drugs/alcohol, and/or recovering from the effects of alcohol and/or drugs?
		How much time do you spend thinking about using? _____
		How much time do you spend under the influence? _____
		What do you do to get drugs? _____
___	___	Have you been under the influence of drugs/alcohol while at work or school or put yourself and others in physically hazardous situation because you were under the influence (such as driving while intoxicated?)
___	___	Have you gone to work under the influence or operated machinery under the influence?
___	___	Have you given up or cut back on important social, occupational, or recreational activities because of your drug/alcohol abuse?
___	___	Have your friendships suffered because of your use?
___	___	Is your job at risk because of your use?
___	___	Has your spiritual life suffered because of your use?
___	___	Have you continued to use drugs and/or alcohol even though you know it's causing problems in your life and with those around you?
___	___	Have you gotten into legal trouble because of your use?
___	___	Have any medical professionals told you to stop using?
___	___	Have any family members expressed concern about your using?
___	___	Have you required more drugs/alcohol to achieve the same high?
___	___	Do you continue to use even when the drug isn't working?
___	___	Do you mix drugs to achieve the same effect?
___	___	Have you had a blackout?
___	___	Have you had withdrawal symptoms?
		List symptoms_____
		_____
___	___	Have you taken drugs/alcohol to relieve or avoid withdrawal symptoms?
___	___	Do you use drugs to "fix" a hangover?
___	___	Do you use drugs to relieve tension?

_____ _____

Client's Signature Date

Hope Haven, Inc.
3815 N. Tryon St.
Charlotte, NC 28206

DRUG HISTORY LIST

CLIENT NAME: _____

CLIENT NO: _____

Drug/Specify Name of Drug You Use/Used	Age When First Used	Age Regular Use Began	Route of Use	Amount You Use	How Often Do you Use	Date Last Used
Alcohol						
Amphetamines						
Barbiturates						
Caffeine						
Cocaine						
Hallucinogens						
Heroin						
Inhalents						
Marijuana/Hashish						
Narcotics/Opiates						
Over The Counter						
PCP						
Tranquilzers/Sedatives						
Other						

Primary drug _____ DSM IV-R Diagnosis _____

Secondary drug _____ _____

Tertiary drug _____ _____

Level of Severity _____

Mild _____ Moderate _____ Severe _____ Partial Remission _____ Full Remission _____

_____ _____

Client or Counselor's Signature Date

Form # 1-10-85
Revised 11/17/15 t.m.s.