The Women's Home, Inc.

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APPLICATION FOR ADMISSION

Name: _____

SSN: _____ Birth Date: _____

Last Address: _____

Permanent Address: _____

Phone Number: _____ E-mail: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health Insurance Carrier: _____ Policy Number _____

In case of emergency, notify (prefer nearest relative):

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

In your opinion, what are your problems (alcohol, drugs, personal, family, other)? Please explain:

_____

_____

_____

What do you hope to accomplish by living in The Women's Home?

_____

_____

_____

ALCOHOL & DRUG ABUSE HISTORY

When was your last drink or other drug use? _____
What drink/drug did you use and how much? _____

Did it take more or less to get drunk/high than it had before? ☐ More ☐ Less

What is your drug of choice? _____

List, beginning with primary drug or alcohol. Include all prescribed and over-the-counter medications taken in excess of prescribed amounts or to achieve a mood altering affect:

Name of Drug	Age First Used	Frequency	Quantity	Method

Have you ever overdosed on alcohol or drugs? ☐ Yes ☐ No Please explain.

Have you ever experienced any of the following when you stopped using alcohol or other drugs?

- ☐ Loss of memory
- ☐ Hallucinations
- ☐ Extreme fatigue
- ☐ DT's
- ☐ Flashbacks
- ☐ The "shakes"
- ☐ Seizures
- ☐ Blackouts
- ☐ Insomnia

If you have ever had a loss of memory while/after drinking, for how long? _____

Have you at any time, prior to now, discontinued your drinking or drug use for any reason? If yes, please explain:

What was your longest period of abstinence? When? _____

Treatment places and dates:

Are you physically or psychologically dependent on any mood altering substance? ☐ Yes ☐ No

If yes, which? _____

How has alcohol/drug use caused life problems for you?

Do you desire to stop using alcohol and mood-altering drugs? ☐ Yes ☐ No Please explain.

MEDICAL HISTORY

Medications

Please list all **current** medications (prescribed and over the counter)

Medication	Dosage	Frequency	Why Taken	Physician/Phone Number

Please list all medications (prescribed and over the counter) taken in the past five years:

Medication	Dosage	Frequency	Why Taken	Physician/Phone Number	When/Dates

List any prescribed or non-prescribed medications that were ineffective

Have you taken yourself off any medications? ☐ Yes ☐ No If yes, please explain

Are you allergic to any medication? ☐ Yes ☐ No If yes, please explain.

Medical Problems

Do you have any medical problems for which you are receiving treatment or which require monitoring?
☐ Yes ☐ No If yes, please identify the disorder, the prescribed treatment or monitoring and follow up.

Do you have or have you had any contagious diseases? ☐ Yes ☐ No If yes, please explain.

Have you been hospitalized during the past five years? ☐ Yes ☐ No

How many times? _____ Reason: _____

Any difficulties with: ☐ Hearing ☐ Vision ☐ Reading ☐ Writing ☐ Other.

If yes, please explain._____

Date and place of last complete physical exam: _____

Mental Health

Have you ever seen a mental health professional? ☐ Yes ☐ No If yes, why_____

Are you currently seeing one? ☐ Yes ☐ No If yes, why_____

Name: _____ Phone: _____

Do you think you need to see one at this time? ☐ Yes ☐ No If yes, why_____

Eating Patterns

Do you now have, or have you had in the past, an eating disorder (anorexia, bulimia, compulsive overeating?). ☐ Yes ☐ No If yes, please explain _____

Do you eat three meals a day? ☐ Yes ☐ No

Would you describe your daily eating as nutritionally balanced? ☐ Yes ☐ No Please explain.

Sexual and Reproductive Health History

Do you have now, or have you had in the past any sexual diseases, infections, or conditions or reproductive health conditions or disorders? ☐ Yes ☐ No If yes, please explain.

Do you think you could be pregnant now? ☐ Yes ☐ No

Suicide

Have you ever thought about attempting suicide? ☐ Yes ☐ No
Have you ever planned your suicide? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No

If yes to any of these questions please explain, including dates:

LEGAL HISTORY

Current Charges? ☐ Yes ☐ No If yes, with what are you charged?

When and where is your court date?

Name of your attorney: Phone:

Name of probation officer: Phone:

List legal history:

Date	Charge	Disposition

Have you served time in jail or prison? ☐ Yes ☐ No If yes, when, where,for what and for how long?

PERSONAL

Car: (make, model, year)
Car Insurance Carrier:
Policy # & Expiration Date:

Valid Driver's License: ID # State Expiration Date

Marital Status

☐ Single
☐ 1st marriage
☐ 2nd marriage
☐ Separated
☐ Divorced
☐ Widowed

Describe your present relationship with your spouse or partner.

Have you or your spouse or partner ever sought counseling? If yes, please explain:

Children

Name Age Reside with you?

Describe your present relationship with your child/children.

What are your interests and hobbies?

Have you lost interest in hobbies, or other recreational activities because of your chemical use? _____

EMPLOYMENT HISTORY

Name of Current Employer/Organization:

Address:

Date you started with company: Hours/Week:

Job title and description of work you do:

Do you plan to continue in your current employment? ☐ Yes ☐ No If no, please explain.

Describe your attitude toward your current job.

Past Employment History

Position Dates Employed Skills Used

How has chemical dependency affected your job performance?

How has chemical dependency affect your financial situation?

Were you in the military? ☐ Yes ☐ No Branch:

Dates of Service: Type of Discharge

EDUCATIONAL HISTORY

High School graduate? ☐ Yes ☐ No Month/Year_____

Did you get a GED Equivalency certificate? ☐ Yes ☐ No

What is the highest grade completed?

List high schools, colleges, and universities you have attended either full or part time beginning with the most recent:

School/ College	Location	From (mo/yr)	To (mo/yr)	Diploma/ Degree

Major field of study in college work: _____

FAMILY HISTORY

Marital status of parents

☐ Married ☐ Separated/Date _____ ☐ Divorced/Date _____ ☐ Never married

Deceased: Mother/date: _____Father/date:_____

If parents are separated or divorced, what do you think was the major cause?

_____

How do/did your parents get along with each other?

_____

Which parent did you get along with better? Why?

_____

Describe your parents' drinking and/or drug use patterns.

_____

Describe the drinking/drug use of significant close relatives.

_____

What problems have been created in your family as a result of your addiction?

☐ Social ☐ Physical Abuse
☐ Financial ☐ Communication
☐ Sexual ☐ Alcohol/drug use
☐ Legal ☐ Emotional ☐ Spiritual

When did you first notice you had a problem with your use and what was happening to your family at that time?_____

_____

Who are you closest to in your family? Why?

Who do you have the most problems with in your family? Why?

What are the strongest feelings you can remember as a child? Why?

Describe a significant childhood experience.

What do you see as the major problems and/or stress in your family at this time?

Do you think that your family has assets/strengths? If so, what are they?

How would you describe your relationship with your parents?

- ☐ Close and warm
- ☐ Conflicted
- ☐ Physically abusive
- ☐ Emotionally cold/abuse
- ☐ Sexually abusive
- ☐ Distant
- ☐ Other. Please explain.

How did your family deal with anger?

What would you like to see change in your family relationships after treatment?

What type of area were you raised in? ☐ Rural ☐ City ☐ Other:_____

Did your family move while you were at home? ☐ Yes ☐ No If yes, how many times?_____

List any chronic physical complaints or serious illnesses of your parents or siblings.

THE WOMEN'S HOME
P.O. BOX 7412, ARLINGTON, VA 22207 (703) 237-2822

CONFIDENTIAL INFORMATION CONSENT

I,_____, DO HEREBY CONSENT AND AUTHORIZE THE WOMEN'S HOME, INC. TO OBTAIN FROM AND RELEASE TO MY CURRENT AND PREVIOUS PHYSICIANS, COUNSELORS, TREATMENT FACILITIES/ STAFF, FAMILY, ATTORNEYS, JUDGES, PAROLE AND PROBATION OFFICERS, AND SOCIAL WORKERS, INCLUDING, BUT NOT LIMITED TO:

(NAME OF PERSON/ TITLE/ ORGANIZATION, ADDRESS/ CITY/STATE/ TELEPHONE)

_____

_____

_____

_____

THE FOLLOWING INFORMATION PERTAINING TO MYSELF:

OBTAIN	RELEASE	
( )	( )	PRESENCE IN TREATMENT (ADMIT/DISCHARGE DATES, ETC.)
( )	( )	MEDICAL HISTORY AND PHYSICAL EXAMINATION
( )	( )	DIAGNOSIS, BRIEF DESCRIPTION, PROGRAM/PROGNOSIS
( )	( )	DISCHARGE SUMMARY/CONTINUING CARE PLAN
( )	( )	EDUCATIONAL RECORDS/ACHIEVEMENTS/ASSESSMENTS
( )	( )	PSYCHOLOGICAL TESTS/PROJECTIVE ASSESSMENTS
( )	( )	BIOPSYCHOSOCIAL/DIAGNOSTIC SUMMARY
( )	( )	HEALTH RECORDS
( )	( )	TREATMENT PLAN
( )	( )	SOCIAL WORK RECORDS
( )	( )	IMMUNIZATION RECORDS
( )	( )	LEGAL RECORDS/FILINGS/CASE FILES
( )	( )	OTHER:_____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES:

( ) TO DETERMINE APPROPRIATENESS FOR ADMISSION
( ) TO PROVIDE ONGOING TREATMENT/CONTINUING CARE
( ) TO ENABLE JUDGES, ATTORNEYS, PROBATION/PAROLE OFFICERS TO SUPPORT TREATMENT GOALS OR MAKE LEGAL DECISIONS ON MY BEHALF
( ) TO COORDINATE TREATMENT WITH MY FAMILY/CONCERNED PERSONS
( ) OTHER:_____

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL AND STATE CONFIDENTIALITY LAWS AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT. THIS AUTHORIZATION IS IN FORCE UNTIL_____. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY NOTIFYING THE DIRECTOR IN WRITING EXCEPT THAT SUCH REVOCATION SHALL NOT BE EFFECTIVE TO THE EXTENT THAT ACTION PREVIOUSLY HAS BEEN TAKEN IN RELIANCE ON MY CONSENT.

_____ _____
SIGNATURE OF RESIDENT DATE

_____ _____
SIGNATURE OF WITNESS DATE