



HEALING HOUSING
LOVE LIVES HERE

First Name: **Last Name:** **Birthdate:** **Address:**

Contact

Current Location:

Expected Discharge Date:

Case Manager Name:

Case Manager Phone Number:

Case Manager Email Address:

Emergency Contact Name:

Emergency Contact Phone Number:

Demographics

Sex at Birth:

Gender Identity:

Ethnicity/Race:

What is the highest level of education you completed?

What is your primary language?

Are you a veteran?

Family

Are you fleeing a domestic violence situation?

Do you have children?

Age of children:

Do you have legal custody of your children?

What is your minor children's current living arrangement?

Are your children safe?

Is there DCS involvement?

If so, what is required of your parenting plan?

Substance Use History

Drug(s) of Choice:

For how many years have you been using alcohol and/or drugs?

What is your date of last use?

What is your sobriety date?

List any previous times of recovery (best estimate of dates):

Medical

List any allergies:

How would you describe your current health?

Do you have any concerns about your current health that you would like to address?

Do you have any chronic medical (physical) conditions or disabilities that interfere with your day-to-day tasks:

Do you have a history of seizures?

List any medical equipment or aids:

Tuberculosis Screening

Date of last Tuberculosis Test:

Have you lived or traveled for more than 2 months in Asia, Africa, Central or South America or Eastern Europe?

Were you born on one of these continents?

Have you ever been vaccinated with BCG (Bacillus Calmette-Guerin)?

Have you ever had a positive TB skin test or a history of active tuberculosis infection?

Has anyone living in your household ever had a history of active tuberculosis?

Have you worked, volunteered, or lived in a nursing home, hospital, homeless shelter, prison, or other healthcare facility?

Have you experienced any of the following symptoms in the last 30 days:

A bad cough that's lasted 3 weeks or longer

Pain in the chest

Coughing up blood or phlegm from deep inside the lungs

Weakness or fatigue

Weight loss

No appetite

Chills

Fever

Sweating at night

Mental Health

List any mental health diagnoses and when you received each diagnosis:

Please describe any history of self-harm:

Please describe any history of suicidal ideation, attempts, or inpatient psychiatric stays:

Please describe any history of disordered eating:

Do you have a history with human or sex trafficking?

Describe any involvement with violent and/or aggressive behaviors:

Medication

Please list all prescription medication(s):

Please list all over-the-counter medication(s) that are taken regularly:

Please list any drug replacement (MAT/MAR/MOUD) medication(s):

Treatment History

Please list all previous treatment centers and dates:

Courts & Criminal Justice

Are you currently involved in any legal proceedings or criminal justice issues?

Do you have any pending sentencing or possible jail time upcoming?

Have you ever been charged or convicted of Arson?

Have you ever been charged or convicted of any violent crimes in any jurisdiction?

Have you ever been charged or convicted of abuse or neglect of any person, including but not limited to disabled persons, seniors, or children?

Are you affiliated with any gang?

Are you required to register as a sex offender?

Are there any Restraining Orders or Orders of Protection against you or by you?

Admissions

Do you have a personal relationship with anyone who works for Healing Housing?

Do you know anyone currently in the Healing Housing program? If so, who?

Have you previously been a participant at Healing Housing?

Are there any issues that could prevent you from completing the program?

Healing Housing is a 1-year program. Are you willing to commit to staying for 1 year?

Client Statement

Please describe what led you to seek housing with Healing Housing. Be specific as to details such as how, when, where, and your personal responsibility:

Why do you think you are a good fit for sober living?

What do you want to accomplish while residing at Healing Housing?

Employment:

Are you able to work at least 32 hours a week?

Are you currently employed?

Describe your work history:

Additional Info

Please enter any other information about yourself or your situation that you feel we need to know:

Signature:

Date: