

HISTORY AND PHYSICAL

Name _____ SS# _____ Date _____
 Address _____ Occupation _____
 Phone (Home) _____ (Work) _____ Birth Date _____
 Chief Complaint _____

DRUG ALLERGIES

CURRENT MEDS

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease	☐	☐	☐	☐	☐	☐
Highblood pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

PAST MEDICAL HISTORY

☐ Headache	☐ Lactose intolerance	☐ Depression	
☐ Shortness of breath	☐ Gall Bladder disease	☐ Gout	
☐ Heart palpitations	☐ Prostate disease	☐ Scarlet fever	
☐ Heart murmur	☐ Bowel Irregularity	☐ Chronic rashes	
☐ Chest pain	☐ Incontinence	☐ Rheumatic fever	
☐ Dizziness/fainting	☐ Sexual/Menstrual dysfunction	☐ Mumps	
☐ Peripheral vascular disease	☐ Venereal disease	☐ Measles	
☐ Allergies/Hay fever	☐ Frequent infections	☐ Rubella	
☐ Asthma	☐ Hepatitis	☐ Polio	
☐ Bronchitis	☐ Anemia	☐ Diphtheria	
☐ Pneumonia	☐ Arthritis	☐ Tetanus	
☐ Ulcer	☐ Osteoporosis		
☐ GI disorder	☐ Nervousness		

SOCIAL MEDICAL HISTORY

☐ Smoke: Packs daily _____	How Long _____	When Stopped _____	☐ Continuity disturbances
☐ Exercise routine _____	☐ Coffee: Cups daily _____	☐ Other caffienes _____	☐ Daytime drowsiness
☐ Alcohol: Type/Amt _____	☐ Diet: Salt intake _____	☐ Fat Intake _____	☐ Contact with blood or body fluid
☐ Sleep: Difficulty falling asleep _____	☐ Snoring _____	☐ Early morning awakening _____	at work

Patient Information

Patient Name (Last, First, MI)	Marital Status M W S D	M	F	D.O.B.	AGE	SS#
Street Address	City, State, Zip					Phone 1
Employer	Occupation (indicate if student)					Work Phone
Spouse or Guardian's Name (Insurance Holder)				D.O.B.	SS#	
Street Address	City, State, Zip Code				Phone	
Spouse/ Guardian's Employer	Occupation (indicate if student)				Work Phone	
Name of Your Pharmacy:	Name of Family Doctor				Other Doctors Who See You	
In Case of Emergency Notify:	Phone				Alt. Phone	
Do You Have a Living Will? Yes / No	Does anyone have a "Durable power of Attorney for Healthcare" for you? Yes / No				Name and Phone if 'Yes'	
Primary Insurance Company	Secondary Insurance Company				Third Insurance Company	
Which Employer Carries the Above Insurance?	Which Employer Carries the Above Insurance?				Which Employer Carries the Above Insurance?	

Workman's Compensation / Auto Accident Information

Where you injured on the job? Yes / No	Date of Injury	Workman;s Comp. Claim #
Workman's Comp. Ins. Company	Street Address	City, State, Zip Code
Where you injured in an auto accident? Yes / No	Date of Accident	Name of Attorney

Adult Residential Information

Place of Employment	Address	Telephone #

Have you ever participated in another detox, residential, transitional living facility or community? ____ Ex: Halfway House, Mission Program, Salvation Army etc. If Yes, Please complete the following grid.

Facility	Date(s)	Completion. Yes or No

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

What is the main problem, as you see it in your life? _____

What have you attempted to do about this problem? _____

Describe your religious or spiritual beliefs.

Describe your emotional state and feelings about your current residence.



What was happening that prompted you to seek residency at Ensemble Recovery?

Who's idea was it for you to apply to Ensemble Recovery?

What issues/problems would you like to work on while at Ensemble Recovery?

Describe any short-term goals.

Describe any long-term goals.

Where and with whom were you living before your present living situation?

Where would you live now if not accepted at Ensemble Recovery?



Do you have any health problems that require special care on your part? _____ If yes, please explain _____

Are you, to your knowledge, medically stable at the time? _____ If no, please explain.

Have you ever been diagnosed with a mental illness? ____Yes ____No

If yes, what type and when _____

Have you experienced suicidal ideations (thoughts)? __Yes__No. If yes, please explain: _____

Have you ever attempted suicide? __Yes__No. If yes, please explain: _____

Are you currently taking prescribed Medications? _____ If so, List all prescribed medications for last year, including current Medications.

Name of Medication	Date of Diagnosis	Doctor Prescribing Medication

Have you ever been convicted of a felony? _____

If yes, please describe _____

Arrests /Convictions	Date	Status of conviction/Attorney/P.O

Where any of these legal issues alcohol/drug related? _____
 Do you have any court cases pending, upcoming court dates etc? _____ If yes, please explain.

Are you currently on probation or parole? Yes or No.

If yes, what type, city, county, state? _____

What is your Probation/Parole officer's Name? _____

What is you Probation/Parole officer Telephone #? _____

Have you ever drank alcohol?_____ If so please answer the following questions.

How old were you when you had your first drink? _____

How old were you when you were first intoxicated? _____

How old were you when you first thought you might have a problem? _____

Drink of preference? _____

Quantity? _____ How often? _____

Where and when did you usually drink? _____

Did you drink alone?_____ If so, how often? _____

When and how long was your longest period abstained from alcohol _____

Why/how did you return to drinking?

Do you think you can control your drinking? _____

When was your last drink? _____

Have you been involved with any 12 Step Programs? _____

If so, Which Program(s)? _____

Have you ever used Drugs? Is so, please answer the following questions.

List all drugs used:

Drug Preference? _____

How old were you when you used your first substance? _____

How old were you when you first thought you might have a substance abuse problem? ____

Drug of Choice? _____

Quantity? _____ How often? _____

Where and when did you usually use the substance? _____

Did you use drugs alone? _____ If so, how often? _____

When and how long was your longest period of abstinent from drugs? _____

Why/how did you return to using drugs?

Have you experienced any accidental or intentional overdoses? _____ If so, when:

Usual place or places of use:



Longest length of sobriety: _____ Date of last use: _____

Last date you used any mood or mind altering drugs, including alcohol? _____

Do you think of yourself as an alcoholic, addict, or both? What makes you think that?
(Give your own definition)

Please list 3 References:

Name _____ Relationship _____ Telephone # _____

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Name _____ Relationship _____ Telephone # _____

I understand that the information contained in this application form will be used to determine my eligibility for residency at Ensemble Recovery. I grant consent for management to verify information contained on this form and to obtain and verify other information affecting my eligibility. I certify that all the above information is true and complete to the best of my knowledge.

Date

Applicant's Signature