Genesis House Ministries, Inc.
Application for Treatment Admission

12/06/2024 _____ _____
Today's Date Staff receiving this information

PERSONAL INFORMATION

_____ _____ _____
Last Name First Name Middle Name

_____
Street Address Apartment Number

_____ _____ _____
City State Zip Code

_____ _____
Home Phone Cell Phone

_____ _____
Date Of Birth Current Age

Are You a US citizen?___Yes ___No If not, date entered U.S._____

Alien Registration Number_____

Are you on Megan's Law? Yes____ No____

What is the reason you chose Genesis House Ministries, Inc. for treatment at this time?
_____
_____

EMERGENCY CONTACT INFORMATION:

Name_____ Relationship_____

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____
Home Phone Cell Phone

FAMILY RELATIONSHIPS:

Full Name Of spouse_____
Do you have Children___yes ___no How many?_____

ACADEMIC HISTORY

What is the highest grade of school completed?_____
How would you rate your reading/comprehension skills? ___Good ___ Fair ___Poor___Learning Disability

Military History

Have you ever been in the military? ___Yes ___No If yes, which branch?_____

Dates of Service: From_____ To _____

What Type of Discharge? ___Honorable ___Dishonorable ___Medical DIshonorable ___Medical- Other than Honorable ___ General ___ Other than Honorable

Please Provide Details if not Honorable:
_____
_____

Drug/Alcohol History

Please list the chemicals including alcohol that you have used in the past or are currently using:

Name Of Drug	Frequency	Age Began	Last Use
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____

Have you ever overdosed ___yes ___no If yes please explain:_____

_____

Please List Name of previous drug/alcohol treatment/detoxification centers:

Admission Date	Name Of Center	Address (City/State)	Length Yes/No	Completed Yes/No	Released Yes/No
1._____	_____	_____	_____	_____	____
2._____	_____	_____	_____	_____	____
3._____	_____	_____	_____	_____	____
4._____	_____	_____	_____	_____	_____

LEGAL HISTORY

Have you ever been arrested?____Yes ____No

___Shoplifting	___Public Intoxication	___Theft by deception
___Robbery	___Forgery	___Terroristic Threats
___Prosititution	___Rape	___Minor in Possession
___Parole/Probation Violation	___DWI/DUI	___Underage drinking
___Assault	___Weapons Offense	___Resisting Arrest
___Disorderly Conduct	___Sexual Assault	___Receiving Stolen Property
___Drug Charges	___Burglary, larceny,B&E	___Criminal Mischief
___Arson	___Homicide,Manslaughter	

___Other_____

Do you have any pending charges? ___Yes ___No If yes, please complete the following:

Date arrested/ Charged	State arrested in	Name of Judge	List of present charges	Court date
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____

Do you have an attorney?___Yes ___NO If yes, please complete the following:

Name_____ Phone Number_____

Address_____

Have you been court ordered to complete treatment? ___Yes ___No If yes, Please give details:

Date of Sentence What exactly was the sentence stipulation Judge's Name

1._____ _____ _____

2._____ _____ _____

Are you presently on probation or parole? ___Yes ___No
If yes, what are the charges?_____

Date Probation/parole began_____ Date probation/parole scheduled to end_____

Please give name, telephone number, and address of current probation/parole officer:

Name_____ Phone Number_____

Address_____

EMOTIONAL/MENTAL/PSYCHIATRIC HEALTH
Have you ever been evaluated or treated by a psychiatrist or other mental health professional?
___Yes ___No

Therapist Names	Location	Dates Attended	Diagnosis	Medication Dosage	Permission to see records
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____

Check any of the following you have had. List age symptoms began

YES/NO - AGE - DIAGNOSIS YES/NO - AGE - DIAGNOSIS YES/NO - AGE - DIAGNOSIS

_____ -_____ Depression _____-_____ ADHD _____-_____PTSD
Anxiety/Panic Personality
_____-_____ Disordered _____-_____ Disordered _____-_____OCD

Bipolar
_____-_____Phobias _____-_____Mood Disorder _____-_____Disorder

_____-_____Schizophrenia _____-_____Eating disorder _____-_____ADD

Have you ever had thoughts of harming yourself or anyone in any way? ___Yes ___No
Did you have a plan___Yes___No If yes, were you under the influence? ___Yes ___No

Please explain _____
_____
_____

HEALTH AND MEDICAL HISTORY

Do you have Health Insurance? ___Yes ___No If yes, supply copy

Primary care physician ___Yes ___No if yes, provide information

Name_____ Phone _____ Fax_____

Address _____

Do you have a history of seizures? ___Yes ___No Date of last Seizure_____

Date of last physical_____ Do you have dental concerns? ___Yes ___No
Physical Disabilities ___Yes ___No Please describe all dental and physical concerns._____
_____
_____

Are you currently taking any prescribed medications? ___Yes ___No

Name of Medication Dosage Reason for Medication Date Started Doctor

1._____ _____ _____ _____ _____

2._____ _____ _____ _____ _____

3._____ _____ _____ _____ _____

Are you in An Outpatient Program? Yes___ No___
Providers Name_____ Phone Number_____
How long have you been a patient_____

EMPLOYMENT HISTORY

Are you currently employed? ___Yes ___No If yes, how long?_____

If no, reason_____

Are you certified or licensed in any particular area? ___Yes ___No

Do you have a Sponsor? Yes ____ No ____

CLINICIAN'S NOTES

The applicant was previously at GHM ____Yes ____No If Yes, dates_____
Reason for discharge___Dismissed/Policy Violation ____Medical____Wanted to terminate treatment ____Completion
General comments regarding admission:_____
_____
_____
_____

_____ _____
Intake Interviewer Signature Date Application Received