

APPLICATION FOR ADMITTANCE

Bridge House
Clean and Sober House
P.O. Box 2489
Kailua-Kona, HI 96745
Phone: 322-3305 Fax: 322-0809

Date: _____ Phone: (Home) _____ (Cell) _____

Name: (First) _____ (Middle) _____ (Last) _____

Mailing Address: _____

Is this address a treatment facility? Yes No

Male or Female: _____ Date of Birth: _____ / _____ / _____ SSN: _____

Circle Ethnicity: Portuguese, Aleutian/Eskimo American Indian, Black/African American, Cambodian, Caucasian, Chinese Hawaiian, Hispanic-Cuban, Hispanic-Mexican, Hispanic-Puerto Rican, Japanese, Korean, Micronesian, Okinawan, Filipino, Samoan, Vietnamese, Mixed-Part Hawaiian, Mixed-Not Hawaiian, Other Asian, Other Pacific Islander, Unknown, Other _____

Marital Status: Circle one: Married Never Married Separated Divorced

Level of education completed: _____ Veteran Status: Yes No

Are you an IV user? Yes No Are you pregnant? Yes No

Who referred you to our program? (self, Drug Court, CPS, Probation, etc...) _____

Do you have children? _____ If yes, how many & ages: _____

Do you have custody: _____

SUBSTANCE USE:

Do you think you have a problem with alcohol? Yes No Do you have a drug problem? Yes No

List drugs/alcohol you used addictively:

1st **Primary Substance:** _____ Route (smoke, oral, IV, etc.) _____

Date of last use: _____ Age of 1st use: _____

2nd **Secondary Substance:** _____ Route (smoke, oral, IV, etc.) _____

Date of last use: _____ Age of 1st use: _____

3rd **Tertiary Substance:** _____ Route (smoke, oral, IV, etc.) _____

Date of last use: _____ Age of 1st use: _____

TOBACCO USE:

Please choose one (1) answer from each of the questions below regarding tobacco use.

Have you ever used Tobacco/Nicotine products? _____

Circle One: Smoker Status: Current Everyday Current Some Days Former Smoker

At what age did you first use tobacco/nicotine products? _____

In the past 30 days, what tobacco /nicotine products did you most frequently use? _____

Circle One: In the past 30 days, how often did you use tobacco/ nicotine products?

1-3 times in the past 30 days once a week 3-6 times a week daily 3-6 times a day more than 6 times a day

In the past 30 days, how many cigarettes did you smoke per week? _____

RECOVERY

When did you attend your first AA or NA meeting? _____

How many AA/NA meetings have you attended in the past 30 days? _____

Do you have a 12-step sponsor? Yes No If so, who? _____

Do you want to stop drinking alcohol and using addictive drugs? _____

Date of longest period of abstinence: _____

Do you have a history of alcoholism or addiction in your family? Yes No

Have you ever been to a treatment facility for alcoholism and/or drug addiction? Yes No

Please list all facilities you have attended including names and dates:

_____ | _____ | _____

If you are currently in treatment list the treatment provider, phone number, and primary counselor, if any: _____

Did you complete these programs successfully? Yes No

If not, why? _____

Do you mind if we contact these facilities to discuss your treatment there? Yes No

EMPLOYMENT:

Are you employed? Yes No

Please list your vocational skills/specialized training or certifications: _____

List your last 3 Employers:

Company:

Supervisor:

Contact:

Are you receiving welfare or other non-job related income? Yes No

If yes, what? _____

If you don't have a job will you get one? Yes No

If yes, what job plans do you have? _____

What is your monthly gross income right now? _____

Do you have a valid driver's license? Yes No Do you have a car that is registered and "legal"? Yes No

MEDICAL:

Do you have a current TB test completed within the past year: Yes No

Do you have any current medical conditions or allergies? _____

Do you have a medical doctor? Yes No

If yes, list the doctor's name and phone number:

Doctor: _____

Phone number: _____

Do you take any prescription drugs? Yes No

If yes, list medication and the reason it has been prescribed:

Medication

Reason

Medication

Reason

Current weight: _____

Current height: _____

Have you ever been diagnosed with a mental health condition? _____

Do you see a therapist or a Psychiatrist? Yes No

If yes, list the Psychiatrist/therapist name and phone number:

Doctor/Therapist: _____

Phone number: _____

Do you have a history of an eating disorder? Yes No

Current status of eating disorder: _____

Do you have a history of bingeing, purging, or diuretic or laxative use? Yes No

Please list all psychiatric facilities you have attended including names and dates:

_____ | _____ | _____

LEGAL:

Have you been arrested in the past 30 days? Yes No

Are you currently on probation or parole? Yes No

If yes who is your probation/parole officer? _____ Ph#: _____

Please list any current legal problems (be specific about charges, upcoming trials/hearings, dates):

_____ | _____ | _____

OTHER INFO:

Please list your hobbies and special interests: _____

What would you say are your best characteristics? _____

Have you ever lived in close quarters with other people before? _____

Do you anticipate a problem with such and arrangement? _____

Any additional information that we may find important: _____

Date of move in? _____Immediately _____Other -- If "other" list the date you would want to move in, if accepted, and why the date is in the future rather than immediately.

Date: _____ Reason: _____

Emergency Telephone Numbers:

Name	Relationship	Telephone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I have read all of the material on this application form and I have also answered each question honestly and want to achieve comfortable recovery from alcoholism and/or drug addition without relapse.

Signature

Date