

PENIEL
Drug/Alcohol Residential Treatment Center

P.O. Box 250
Johnstown, Pennsylvania 15907
814-536-2111 (Fax) 814-539-2871
Application for Treatment Admission

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

E-Mail

Date of birth

Current age

Social security number
XXX - XX -

Can you provide copy of birth certificate? Yes No _____

Please explain if not available

Are you a United States Citizen? Yes No If not, date entered the U. S.: _____

Alien registration number _____

What is the reason you chose Peniel for treatment at this time? _____

EMERGENCY CONTACT INFORMATION:

Name _____

Relationship _____

Street address

City

State

Zip code

Home phone

Cell phone

FAMILY RELATIONSHIPS: Single Married Separated Divorced Widowed

Full name of spouse _____

Do you have children? Yes No If yes, 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 did you receive?

- Honorable Dishonorable Other than Honorable
 Medical – Other than Honorable Medical – Dishonorable General

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

Have you ever overdosed? Yes No If yes, was it accidental or intention? Please explain: _____

Please list name of previous drug/ alcohol Treatment/Detoxification Centers:

Date of admission	Name of treatment center	Address (City/ State)	Length of program	Did you successfully complete	If you did not complete, what was the reason?	Release Obtained? (Yes/ No)

LEGAL HISTORY

Have you ever been arrested? Yes No If yes, please indicate the number of times that you have been charged for the following crimes.

- | | | |
|---|---|--|
| <input type="checkbox"/> Shoplifting _____ | <input type="checkbox"/> Public Intoxication _____ | <input type="checkbox"/> Theft by deception _____ |
| <input type="checkbox"/> Robbery _____ | <input type="checkbox"/> Forgery _____ | <input type="checkbox"/> Terroristic Threats _____ |
| <input type="checkbox"/> Prostitution _____ | <input type="checkbox"/> Rape _____ | <input type="checkbox"/> Minor in possession _____ |
| <input type="checkbox"/> Parole/Probation Violation _____ | <input type="checkbox"/> DWI/DUI _____ | <input type="checkbox"/> Underage Drinking _____ |
| <input type="checkbox"/> Assault _____ | <input type="checkbox"/> Weapons Offense _____ | <input type="checkbox"/> Resisting arrest _____ |
| <input type="checkbox"/> Disorderly Conduct _____ | <input type="checkbox"/> Sexual Assault _____ | <input type="checkbox"/> Receiving Stolen Property _____ |
| <input type="checkbox"/> Drug charges _____ | <input type="checkbox"/> Burglary, larceny, B&E _____ | <input type="checkbox"/> Criminal Mischief _____ |
| <input type="checkbox"/> Arson _____ | <input type="checkbox"/> 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

Do you have an attorney? Yes No If yes, please provide 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

Are you presently on probation/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

Name of Doctor/Therapist	Location	Dates Attended	Diagnosis	Medication prescribed include dosage	Peniel has permission to request treatment records (Yes/ No)

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

Yes/No	Age	Diagnosis	Yes/No	Age	Diagnosis	Yes/No	Age	Diagnosis
		Depression			ADHD			PTSD
		Anxiety/ Panic Disorder			Personality Disorder			OCD
		Phobias			Mood Disorder			Bipolar Disorder
		Schizophrenia			Eating Disorder (Bulimia) (Anorexia)			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, please supply copy (front & back) of insurance cards. Attach to application.

Do you have a regular Primary Care Physician? Yes No If yes, please complete the following:

Name: _____ Phone: _____ Fax: _____

Address _____

Do you have a history of seizures? Yes No Date of last seizure: _____

Date of last physical examination _____

Do you have any medical or dental concerns or physical disabilities? Yes No

Please describe all medical and dental concerns: _____

If you have any dental needs, can they be taken care of after the completion of treatment? Yes No

Are you currently taking any prescribed medications? Yes No

Name of medication	Dosage	Reason for medication	Date started taking this medication	Doctor's name

“FEMALE APPLICANTS THIS SECTION ONLY”

Is there any chance that you are pregnant now? Yes No If yes, please give your due date _____

Have you used any illegal substances or alcohol during this pregnancy? Yes No

If yes, please list the substance and the frequency: _____

EMPLOYMENT HISTORY

Are you currently employed? Yes No If yes, how long? _____

If no, reason _____

Will your employment be in jeopardy if in treatment? Yes No

Are you certified or licensed in any particular area? Yes No **If yes, please provide copy.**

REFERRAL/ CHURCH INFORMATION

Applicant's church affiliation _____

Referred By: _____
Name Relationship

Street address _____ City _____ State _____ Zip code _____

Phone Number: _____ Cell Phone Number: _____

CLINICIAN'S NOTES

The applicant was previously at Peniel Yes No If yes, dates attended: _____

Reason for discharge Dismissed/ Policy Violation Medical Wanted to terminate treatment Completion

General comments regarding admission: _____

 Intake Interviewer Signature

 Date application received