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

_____ _____ _XXX – _XX - _____
Date of birth Current age Social security number

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.

☐ Shoplifting _____
☐ Robbery_____
☐ Prostitution_____
☐ Parole/Probation Violation__
☐ Assault _____
☐ Disorderly Conduct_____
☐ Drug charges_____
☐ Arson_____
☐ Public Intoxication_____
☐ Forgery_____
☐ Rape_____
☐ DWI/DUI_____
☐ Weapons Offense_____
☐ Sexual Assault_____
☐ Burglary, larceny, B&E_____
☐ Homicide, manslaughter____
☐ Theft by deception_____
☐ Terroristic Threats_____
☐ Minor in possession_____
☐ Underage Drinking_____
☐ Resisting arrest_____
☐ Receiving Stolen Property___
☐ Criminal Mischief_____

☐ 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: _____

Do you have any allergies at all? ☐ Yes ☐ No
If so, please list allergies. _____

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