PENIEL

DRUG AND ALCOHOL RESIDENTIAL TREATMENT CENTER

PO BOX 250
JOHNSTOWN PA 15907
Phone: (814)536-2111 **Fax:** (814)539-2871

APPLICATION FOR TREATMENT ADMISSION

________________________ ____/___/_____
Staff Receiving Information Today's Date

PERSONAL INFORMATION

Name: ______________________, ________________________ _________________ DOB: ____/____/_____
Last First Middle

SSN: _________ Gender: ☐ **M** ☐ **F** ☐ Other *(specify)*: ______________________________
(*Last 4)*

Current Placement: ☐ Home ☐ Program ☐ Jail ☐ Other: ____________________________

If in *program* or *jail* please list name and county of facility: ____

Home Address: ____
Street Name Apt. Number City State Zip code

____________________________ ________________________________ ___________________________
Home Phone Cell Phone E-Mail Address

Can you provide a copy of your birth certificate? ☐ Yes ☐ No

If no, please explain*:* ____

Are you a United States Citizen? ☐ Yes ☐ No

If no, date entered U.S.: ______________________ Alien Registration Number: _____________________

Describe the reason(s) you chose **Peniel** for treatment at this time:

____
____

FAMILY/RELATIONSHIPS

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse *(if applicable)*: ________________________ ___________________ ______________________
First Name Middle Name Last Name

Do you have any children? ☐ Yes ☐ No *If yes,* how many? _____________

Emergency Contact Information

Name: _____________________________________ Primary Phone Number: ______________________

Home Address: ____
Street Name Apt. Number City State Zip code

Relationship to you: ___________________________

ACADEMIC HISTORY
Highest level of education completed:

☐ High School ☐ GED ☐ Associates Degree ☐ College ☐ Graduate School ☐ Doctorate

Other degrees/certifications you'd like us to know about: ____
If education incomplete, what is the highest grade/level reached? ____

How would you rate your reading and comprehension skills?

☐ Good ☐ Fair ☐ Poor ☐ I have a learning disability

MILITARY HISTORY

Have you ever been in the military? ☐ Yes ☐ No *if yes*, which branch? __________________

Are you currently Active? ☐ Yes ☐ No Dates of service from: ___/___/_____ to: ___/___/_____

If discharged, what type of discharge did you receive?

☐ Honorable
☐ Dishonorable
☐ Medical *(Other than Honorable)*
☐ Medical *(Dishonorable)*
☐ Other than Honorable
☐ General

If not an Honorable discharge, please provide details of your discharge:
____
____
____

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 ☐ Intentional

Please explain:
____
____
____

(Drug/Alcohol History continued)

Please list the name of previous DRUG/ALCOHOL TREATMENT or DETOX CENTERS:

Date of Admission	Name of Treatment Center	Address *(City/State)*	Length of Stay	Successfully Completed?	*If no, why?*
				Y/N	
				Y/N	
				Y/N	
				Y/N	

LEGAL HISTORY

Have you ever been arrested? ☐ Yes ☐ No

If yes, please indicate the number of times you've 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 indicate the following:

Arrest Date	County and State	Name of Judge	List of Present Charges	Court Date

Do you have an attorney? ☐ Yes ☐ No

If yes, please indicate below:

Attorney Name and Practice: _________________________________ Phone Number:_____________________

Address: ____

Street Address Suite City State Zipcode

Have you been court ordered to complete treatment? ☐ Yes ☐ No
If yes, please give details as follows:

Date Sentenced	Sentence Stipulations	Judge Name / County

Are you presently on probation/parole? ☐ Yes ☐ No What county?: ________________________
If yes, what are the charges? ____

Date probation/parole began: _________________ Date probation/parole scheduled to end: ________________

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

Name: ____ Phone: ______________________________

Address: ____
Street Name Suite City State Zipcode

HEALTH AND MEDICAL HISTORY
Do you have Health Insurance? ☐ Yes ☐ No
ANY KNOWN ALLERGIES OR FOOD PREFERENCES:____
If yes, please supply a copy of the front and back of the card and attach it to this application.
Do you have a Primary Care Physician? ☐ Yes ☐ No
If yes, please complete the following:
Physician's Name and Practice: ____

Phone Number: ____________________________________ Fax Number: _________________________________

Address: ____
Street Address Suite City State Zipcode

Do you have a history of seizures? ☐ Yes ☐ No If yes, date of last seizure: ____/____/______

Date of last physical examination: ________________
Do you have any medical/dental concerns or physical disabilities? ☐ Yes ☐ No
If yes, please describe all concerns or disabilities:
____
____
____
If you have any dental needs, can they be taken care of after completion of treatment? ☐ Yes ☐ No
If you have any medical needs, can they be taken care of after completion of treatment? ☐ Yes ☐ No

****FEMALE APPLICANT'S SECTION ONLY****
Are you or is there any chance that you are pregnant now? ☐ Yes ☐ No Due Date *(if known)*: ___/___/_______

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

If yes, please describe the substance and frequency:
____
____

MEDICATION

Are you currently taking any prescribed medication(s)? ☐ Yes ☐ No

Name of Medication	Dosage *(how much/ how often)*	Reason Medication Prescribed *(diagnosis)*	Date Medication Started	Prescribing Doctor's Name

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	Does Peniel have permission to request treatment records? *(circle one)*
					Y / N
					Y / N
					Y / N

Please check if ever diagnosed and list age symptoms began:

✓	Diagnosis	Age Began	✓	Diagnosis	Age Began	✓	Diagnosis	Age Began
	Depression			ADHD			PTSD	
	Anxiety/Panic Disorder			Personality Disorder			OCD	
	Phobias			Mood Disorder			Bipolar Disorder	
	Schizophrenia			Eating Disorder (Bulemia/Annorexia)			ADD	

Have you ever had thoughts of harming yourself or anyone in any way? ☐ Yes ☐ No

If yes, did you have a plan? ☐ Yes ☐ No *If yes*, were you under the influence? ☐ Yes ☐ No

Please explain the situation to the best of your ability:

____

____

EMPLOYMENT HISTORY

Are you currently employed? ☐ Yes ☐ No
If yes, please list the location, position, and length of employment:
____
____

If no, please explain:
____
____

Will your employment be in jeopardy if you enter treatment? ☐ Yes ☐ No

Are you certified or licensed in any particular occupation? ☐ Yes ☐ No
If yes, please provide a copy of license or certification and attach to this application.

REFERRAL/CHURCH INFORMATION

Referred by: ______________________________ Relationship: ______________________________

Church Affiliation: ____

Address: ____
Street Name City State Zipcode

Church Phone Number: _______________________ Mobile Contact: ___________________________

CLINICIAN'S NOTES

Was this application previously at **Peniel**? ☐ Yes ☐ No If yes, date(s) attended: ___/___/_______

Reason for discharge:

☐ Dismissed/Policy Violation ☐ Chose to Terminate Treatment

☐ Medical ☐ Completed

Comments/ Concerns regarding admission applicant:
____
____
____
____

________________________________ ________________________________
Intake Interviewer's Signature **Date Application Received**

CC: Client File
Emily Cooper, Clinical Supervisor

Revised 11/2024