New Day Recovery

Today's Date:_____

ADMISSION APPLICAITON

Client First Name (only) _____

Client ID (Last 4 of SSN): _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Contact #: _____

Sex: ☐ Male ☐ Female Gender Expression: ☐ Masculine ☐ Feminine

PHYSICIAN INFORMATION:

Name: _____

Telephone #: _____

MEDICAL SCREENING QUESTIONS:

Our intention is to get every qualified client into our facility; however, Detoxification Facilities have limits to medical care that can be provided. Below is a list of some medical conditions that will exclude clients from being admitted to New Day Recovery.

- *Pregnant Clients*
- *Advanced Cirrhosis of the Liver*
- *Having had Liver or Kidney transplants*
- *Severe Lung Disease requiring supplemental oxygen*
- *Unstable psychiatric/schizophrenia symptoms (active hallucinations)*
- *Open wounds*
- *Lice or Bed Bugs*

Additional medical problems may require stabilization from your primary care doctor or from an acute care hospital prior to admission to New Day Recovery.

As potential client please answer the following screening questions:

1. Have you ever had a severe head injury? If yes – When? ☐ No ☐ Yes
2. Have you had a recent fall? If yes – When? ☐ No ☐ Yes
3. Have you ever had a stroke? If yes – When? ☐ No ☐ Yes
4. Have you had heart surgery within the last 6 months? ☐ No ☐ Yes
5. Have you ever had a seizure? If yes – When? ☐ No ☐ Yes
6. Have you had a heart attack within the last 6 months? ☐ No ☐ Yes
7. Have you had any heart issues? If yes – What? When? ☐ No ☐ Yes
8. Are you diabetic? ☐ No ☐ Yes

   Do you take pills? ☐ No ☐ Yes Do you take insulin? ☐ No ☐ Yes
9. Do you have high blood pressure? ☐ No ☐ Yes
10. Do you have kidney problems? ☐ No ☐ Yes
11. Do you have respiratory problems? Asthma? COPD? Other? ☐ No ☐ Yes
12. Are you actively suicidal? ☐ No ☐ Yes
13. Have you been in the hospital this past week? If yes – for what? ☐ No ☐ Yes

    _____
14. History of Violence? ☐ No ☐ Yes
15. Are you currently being treated for mental health issues? If yes – please explain. ☐ No ☐ Yes

    _____

    _____

SUBSTANCE HISTORY:

1. Drug of Choice: _____

2. Have you been to treatment before? If yes: ☐ No ☐ Yes

   *When? _____ *Where? _____

3. Recent Drugs: ☐ Alcohol ☐ Benzos ☐ Cannabis ☐ Cocaine ☐ Crack Cocaine

   ☐ Heroin ☐ Meth/Speed ☐ Oral Opiates ☐ Other _____

   How Much? _____ How Often? _____ How Long? _____

4. Allergies: _____

   _____

   *Food Allergies: _____

   *Special Diet: Diabetic: ☐ Sodium: ☐ Other: _____

5. Medications: _____ _____ _____ _____

   _____ _____ _____ _____

INSURANCE INFORMATION:

Insurance Carrier: _____

Plan #: _____ Group #: _____

Telephone #: _____ _____

Pharmacy Name: _____ Location: _____

Pharm. Telephone #: _____ Pharm. Fax #: _____

How did you hear about New Day Recovery?

☐ Friend/Family ☐ Counselor ☐ Treatment Facility ☐ Doctor/Hospital

☐ Court/Law Enforcement ☐ Facebook ☐ Internet Search ☐ Advertisement

☐ Other: _____