

FREEDOM HOUSE

Admission Application

Thank you for your interest in coming to Freedom House. We would be honored to work with you on your recovery journey. We take the screening process seriously so please read all of the information carefully and follow the steps below:

Step 1 Please read all information and complete the entire application. You must fill all of the application out yourself. Give as much detail as possible to prevent delay in your application process. Once completed, please mail the application to:
Freedom House, Post Office Box 38215, Greensboro, NC 27438.

Step 2 If it is determined that we can adequately meet your needs in our program, someone will be in contact with you within two business days of receiving your application. You will then participate in a screening before you receive an admission date.

Please answer all questions honestly. **Please do not leave any blanks in your application.** If a question is not applicable to you please put N/A next to it.

General Information:

Name: _____ Date: _____ Phone: (____) - ____ - _____

Email: _____ Date of Birth: _____ Age: _____

Present Address: _____ City: _____ State: _____ Zip: _____

List all names and relationships of those you are currently living with:

How long have you been living at this location? _____

City, State and County of Birth Place: _____ Social Security Number: _____

Driver's License Number: _____ Driver's License Expiration Date: _____

Marital Status: Single Married Divorced Separated Widowed In a Relationship Height: _____ Weight: _____

Race: White Black or African American Hispanic or Latino Native American Asian or Pacific Islander Other

How did you hear about us? DSS Court Parents Friends Internet Other (Specify): _____

Financial Assistance:

Do you receive any type of financial assistance? Yes No If yes, state the amount you receive: _____

If you are admitted into our program, who might help you with your financial needs during your stay? _____

Children:

How many children do you have? _____ Who has legal custody of your children? _____

Who are they currently living with? _____

List names and ages of all your children:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Who will you allow to be involved with your children while they are living with you at Freedom House? _____

Are you currently pregnant? Yes No Approximate Due Date: _____

Have you used any drugs during this pregnancy? Yes No If yes, list all used: _____

What involvement do you anticipate the birth father having with you during your pregnancy? _____

Have you ever used drugs during past pregnancies? Yes No If yes, list all used: _____

Have you ever had an abortion? Yes No If yes, explain the situation: _____

Number of full-term pregnancies: _____ Number of Miscarriages: _____ Number of total pregnancies: _____

Do you have normal periods? Yes No If no, explain: _____

What type of birth control are you currently using: _____

Family:

Addiction and other mental health issues can be caused by genetics. It is extremely important that we get as much information as possible about your family in order to best help you in your recovery process.

Parents Name(s): _____ Telephone #: (____) - ____ - ____

Address: _____ City: _____ State: _____ Zip: _____

Relative/Name	Age	Emotional Problems	Health Problems	Drug & Alcohol Problems	Living/ Deceased	Cause of Death
Mother:						
Father:						
Sister(s):						
Brother(s):						

Please list any additional family issues that you may be aware of: _____

Relationship Status:

As you are probably very aware, your intimate relationships greatly effect your addiction. It is extremely important that we receive as much information as possible in order to best help you in your recovery process.

Please give specifics about ALL past or current relationships: (Use back of the page if necessary)

Education:

Highest level of education completed: _____ Did you graduate from high school? Yes No If you did not complete high school, did you obtain your GED? Yes No Did you have any learning difficulties while in school? Yes No If yes, explain: _____

Employment History:

Are you currently employed? Yes No If yes, explain: _____
Please list all your employment history: _____

Personal/Medical History:

Current Medications:

List all medication that you are currently taking:

Medication	Reason	For how long?

Medical Treatment:

List all hospitalizations, surgeries, or any other treatment that you have received below:

Disease/Injury	Inpatient/Outpatient	Length of Treatment	Discharge Date

Psychological Treatment:

List all mental health treatment(s) you have received below:

Diagnosis/Disorder	Inpatient/Outpatient	Length of Treatment	Discharge Date

Substance Abuse Treatment:

List all substance abuse treatment(s) you have received below:

Program Name	Inpatient/Outpatient	Length of stay	Did you complete? If no, explain	Discharge Date

Have you ever had any problems or been diagnosed with any of the conditions below:

Problems	Y	N	If yes, please explain
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma/shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	
Black out spells	<input type="checkbox"/>	<input type="checkbox"/>	
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
HPV	<input type="checkbox"/>	<input type="checkbox"/>	
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth pain	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Scales/sores	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever had any problems or been diagnosed with any of the conditions below:

Problems	Y	N	If yes, please explain
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Bi-polar disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Borderline personality disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Dissociative identity disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	
OCD	<input type="checkbox"/>	<input type="checkbox"/>	
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	
PTSD	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Personal:

Have you ever attempted suicide? Yes No If yes, explain: _____

Has this ever required hospitalization: Yes No If yes, explain: _____

Have you ever attempted self-harm? Yes No If yes, explain: _____

Has this ever required hospitalization? Yes No If yes, explain: _____

Have you ever been a victim of abuse? Yes No If yes, complete the following information:

Sexual Molestation: Yes No Frequency/Duration: _____ Age: _____

Rape: Yes No Frequency/Duration: _____ Age: _____

Physical Abuse: Yes No Frequency/Duration: _____ Age: _____

Mental Abuse: Yes No Frequency/Duration: _____ Age: _____

Verbal Abuse: Yes No Frequency/Duration: _____ Age: _____

Drug Use:

How did you support your alcohol/drug use?

Stealing Dealing Friends Family Sexual Favors Other: _____

How much money have you been spending on alcohol/drugs each week? _____

What is the longest period of time that you have been alcohol/drug free? _____

Substance Use:

Please indicate use of the following substances.

What do you consider your drug of choice? _____ Date of last use: _____

Alcohol:

Age of first use: _____

Frequency of use: _____

Length of use: _____

Quantity: _____

Date of last use: _____

Black outs: Yes No

Cocaine:

Age of first use: _____

Frequency of use: _____

Length of use: _____

Method of use: _____

Quantity: _____

Date of last use: _____

Heroin:

Age of first use: _____

Frequency of use: _____

Length of use: _____

Method of use: _____

Quantity: _____
Date of last use: _____
LSD/Hallucinogens:
Age of first use: _____
Frequency of use: _____
Length of use: _____
Method of use: _____
Quantity: _____
Date of last use: _____

Quantity: _____
Date of last use: _____
Methamphetamines:
Age of first use: _____
Frequency of use: _____
Length of use: _____
Method of use: _____
Quantity: _____
Date of last use: _____

Quantity: _____
Date of Last use: _____
Other Drugs:
Age of first use: _____
Frequency of use: _____
Length of use: _____
Method of use: _____
Quantity: _____
Date of last use: _____

Marijuana:
Age of first use: _____
Frequency of use: _____
Length of use: _____
Method of use: _____

Narcotics:
Age of first use: _____
Frequency of use: _____
Length of use: _____
Method of use: _____

Legal Background:

Have you ever been arrested? Yes No If yes, please explain: _____
Have you ever been charged with assault? Yes No If yes, please explain: _____
Have you ever been charged with child abuse or neglect? Yes No If yes, please explain: _____
Have you ever been charged with a violent crime? Yes No If yes, please explain: _____
Are you currently on probation? Yes No If yes, Length of time remaining? _____
Do you have any current legal charges pending? Yes No If yes, please explain: _____
Do you have an attorney? Yes No If yes, please explain: _____

Spiritual:

Were you raised going to church? Yes No If yes, what denomination: _____
Do you presently attend church? Yes No If yes, name of church: _____
Do you currently attend any type of spiritual group? Yes No If yes, please explain: _____

Personal Statement:

Please write a personal statement of no less than 100 words including the answers to all the following questions. First, how your drug use has effected your children, your education, your employment, your housing, your self esteem, and your relationships. Secondly, how would you describe your understanding about God? Lastly, why have you chosen to come to Freedom House? (Use additional paper if necessary)

Release of Information for Admissions

All matters relating to applicant records and information are considered confidential and are treated as such by the staff of the Freedom House. Information regarding such matters cannot be given without the written consent of the applicant.

Name of Applicant: _____ Date: _____

I, _____, do hereby give permission for Freedom House to share information related to my application process to the following:

- | | |
|----------------|-----------------|
| 1. Name: _____ | Relation: _____ |
| 2. Name: _____ | Relation: _____ |
| 3. Name: _____ | Relation: _____ |
| 4. Name: _____ | Relation: _____ |
| 5. Name: _____ | Relation: _____ |

Signature of Applicant

Date

Signature of Witness

Date

Witness Printed Name

Witness Phone Number

Witness Address

Criminal Record and Sexual Offender Inquiry

I, _____, hereby give Freedom House permission to obtain my criminal record. I understand that should there be any illegal activity Freedom House has concerns about, I will not be accepted into the program.

Signature: _____ Date: _____

Applicant's Full Printed Name: _____

Maiden Name (If applicable): _____

Social Security Number: _____ - _____ - _____ Date of birth: _____

Drivers License Number: _____ State: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

List the addresses, cities and states which you have resided for the previous seven years:

Address: _____ City: _____ State: _____

Address: _____ City: _____ State: _____

Address: _____ City: _____ State: _____

Address: _____ City: _____ State: _____

Address: _____ City: _____ State: _____