Client Record ID #: _____

Application for Services

17670 Technology Boulevard ~ Hagerstown, MD 21740 ~ 240-267-2230 ~info@brookeshouse.org

***** TB Test results must be submitted with application for service *****

TB Results Attached: ❒ Yes ❒ No Last test date: _____ Results: _____

Date Received: _____ ❒ Not Appropriate for Services: _____

Full Name:			**Today's Date:**
Address:			
City:	**State:**	**Zip Code:**	**County:**
Telephone:	**Social Security #:**		**DOB:**
Email:		**Sobriety Date:**	
Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Partnered ❒ Single ❒ Widowed			
Insurance: ❒ Yes ❒ No Insurance Type:		**Insurance Carrier (other than self):**	
Group #:	**Member #:**	**Contact #:**	
Current Forms of ID (please check all that apply): **❒ Driver's License ❒ ID Card ❒ Birth Certificate ❒ Social Security Card ❒ Passport ❒ Other:**			**Military Veteran: ❒ Yes ❒ No**
Are you currently employed: ❒ Yes ❒ No If yes, where:			

Presenting Problem (check all that apply)

Primary Substances	Mental Health	Medical	Physical Environment	Legal Problems
☐ Alcohol	☐ Exposure to Violence	☐ Pregnant	☐ Homeless / Shelter needs	☐ Alcohol Crimes
☐ Cocaine	☐ Domestic Violence	☐ Physical Disability	☐ Food needs	☐ Drug Charges
☐ Fentanyl	☐ Grief	☐ Allergies	☐ Employment needs	☐ Sex Crimes
☐ Heroin	☐ Physical Abuse	☐ Other: _____	☐ Financial needs	☐ Violent Crimes
☐ Hallucinogens	☐ Sexual Abuse		☐ Sanitation	☐ Cyber Crimes
☐ Inhalants	☐ Self Harm		☐ Safety needs	☐ Crimes against Justice
☐ Marijuana	☐ Suicidal Ideation/Attempts			☐ Public Safety Violations
☐ Methamphetamines	☐ Victim of Discrimination (i.e. Sexual orientation, race, gender)			☐ Fraud/Financial Crimes
☐ Tobacco/Nicotine	☐ Eating Disorder _____			☐ Property Crimes
☐ K2/Spice	☐ Mental Health Disorder _____			☐ Attempt, Conspiracy/Aiding
☐ MDMA				☐ Homicide
☐ Other _____				☐ Other _____

Any Other Information(explain)_____

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LEGAL INFORMATION

Is the person incarcerated? ❒Yes ❒ No		**Facility Type: ❒ Jail ❒ Prison**
Facility Name:	**Inmate ID:**	**Scheduled Release Date:**
If applicable, enter current charge(s)		
Is this charge considered a: ❒ misdemeanor ❒felony ❒both		Is this client considered pre-court with charges pending? ❒Yes ❒ No
Is this client currently on probation? ❒ Yes ❒ No		Is this client a repeat offender?: ❒Yes ❒ No

MEDICAL INFORMATION

Name of Current Physician: **Office Telephone#:**			
Pregnant : ❒ Yes ❒ No	**HIV: ❒ Yes ❒ No**	**Hepatitis C: ❒ Yes ❒ No**	**IV Drug Use: ❒ Yes ❒ No**
Drug Allergies: ❒ Yes _____ ❒ No		**Food Allergies: ❒ Yes _____ ❒ No**	
Are you currently on any form of Medically Assisted Treatment: ❒ Yes ❒ No	**If yes, please list: (suboxone, vivitrol, methadone)**		
Other medical problems or physical limitations:			
Are you able to take medications by yourself?: ❒ Yes ❒ No	**Are you able to climb stairs without assistance: ❒ Yes ❒ No**		**History of Seizures: ❒ Yes ❒ No**

Substances Used	Frequency	Method: Orally, Injection, Inhaled, Smoked	Date of Last Use
1.			
2.			
3.			

MENTAL HEALTH INFORMATION

Do you have a mental health diagnosis: ❒ Yes ❒ No **If yes, please list DSM 5 with description:**	
Are you taking medication for this condition: ❒ Yes What: _____ ❒ No	**Are you currently receiving psychiatric services for this condition : ❒ Yes By whom: _____ ❒ No**
Do you have a history of suicidal ideation or attempts: ❒ Yes ❒ No **How many times: _____** **Date of last attempt: _____**	**Do you have a history of homicidal ideation or attempts: ❒ Yes ❒ No**

Client Record ID #: _____

HISTORY

Within the last calendar year; Have you been in treatment? ❒ Yes ❒ No

How many times: Detox Only: _____ Inpatient: _____ Outpatient: _____

If Yes,

1. Where: _____ When: _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

2. Where: _____ When: _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

3. Where: _____ When: _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

Have you had a period of sobriety in the past year: ❒ Yes ❒ No How long did you remain sober: _____

What did you do to maintain your sobriety and why did you relapse?: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Signature: _____ Date: _____

Authorized Referring Signature: _____ Date: _____