Admissions Form:

Name of person filling out this form:
Relationship to resident:
E-mail Address:
Street Address:
City:
State:
Zip:

Phone Numbers:
Only list the numbers that you can be contacted on

Home:

Cell:

Resident Information
Name of resident:

Marital Status:
Number of children ages 6 - 12:
Resident Street Address:
City:
State:
Zip:
I am having a problem with:
Alcohol Date Last Used:

Other Drugs Date Last Used:

Have you had prior treatment for alcohol or other drugs?

If yes, please specify:
*Have you been hospitalized within the past 30 days?

Are you taking prescribed medications?

No If yes, please specify:
Are you currently under the care of?
Psychiatrist
Therapist/Counselor
Treatment Center
None Who will be the guarantor of the account?

Please indicate method of payment: