APPLICATION FOR THE WILLOWS SOBER LIVING

RESIDENT INFORMATION			
Date Submitted:			
Expected to Enroll:			
Full Name:			
Pronouns:			
DOB:			
Driver's License # (if valid):			
State:		Expiration Date:	
Previous Home Address:			
Cell Phone #:			
Email:			
How did you hear about The Willows Sober Living:			
Please give name(s) of the referral source, if any:			

EMERGENCY CONTACT	
Name:	
Phone Number:	
Address:	
Email:	

HISTORY	
Sobriety/Sober Date:	
Longest Period of Sobriety:	

HISTORY (CONTINUED)	
Length of Most Recent Substance Use:	
Please list behaviors and/or substances that you are in recovery from:	
What programs or therapies are you currently participating in to maintain your sobriety(s)?	
Please list previous treatment programs attended (including full name, city, and state):	

LEGAL INFORMATION
Do you have legal issues in the past or currently?
Are you currently on probation?

LEGAL INFORMATION (CONTINUED)

If yes, what is your current offense?

Do you have a history of lying, stealing, vandalism, or criminal activity? If yes, please describe in detail and include dates:

MEDICAL INFORMATION

Please list any necessary to include physical limitations or illnesses:

Describe the way in which you express anger:

Have you had any physical confrontations in the home or at while at primary treatment? Please include those involved and the circumstances of the event(s):

Have you ever intentionally hurt yourself? If yes, please describe in detail. Please include date, reason, what was used, where on the body the self-harm occurred, if medical attention was needed, how many times it occurred, and/or for how long.

Have you ever run away? If yes, please describe (specify date, how long, from where, reason, etc.).

MEDICAL INFORMATION (CONTINUED)
Have you ever had thought of suicide, made a plan, or attempted suicide? If yes, please describe in detail (specify date, reasons, if thoughts are active or passive, manipulation, and/or general history).
Please describe any risky, aggressive, or inappropriate sexual behaviors:
Please list action plan and/or coping mechanisms for potential SI/SH resurfacing:
Do you currently take any prescribed or over the counter medications? If so, please provide details of medication type, reason, dosage, frequency, and prescribing physician.
Do you have any allergies?
Do you carry an inhaler or epinephrine pen?
Are you fully vaccinated?

OTHER INFORMATION

Please list any goals that you have in moving toward this transition of more independence: