DAVID LAWRENCE CENTERS FOR BEHAVIORAL HEALTH™

Application for Hope Home Residency

Return to: hopehome@dlcmhc.com, or
6075 Bathey Lane, Naples, FL 34116

Resident Candidate Name: _____ Id # I (if known): _____

Current address: _____

Telephone: _____ Email: _____

Date of Birth: _____

What is your current history of sobriety (How long have you been sober from each drug)?:

_____

_____

Drug(s) of choice:

_____

_____

Method of administration (IV, oral, snorting, other method):

_____

Date(s) of last use and frequency:

_____

_____

History of substance use disorder treatment, explain (how many times in detox, how many treatment episodes other than detox? When was your last treatment episode? Where?):

_____

_____

_____

Recovery Supports:

Home group: Yes _____ NO: _____Date of last attendance: _____

Sponsor: Yes No: _____Date of last contact with sponsor: _____

Peer support specialist/recovery coach: Yes: _____ No: _____

A.A., N.A., C.A., or other social support group: Yes: _____ No: _____

Date of last meeting: _____

Celebrate Recovery: Yes: _____ No: _____ Date of last attendance: _____

SMART Recovery: Yes: _____ NO: _____ Date of last attendance: _____

Other (please identify and explain):

_____

Recovery/Sobriety plan:

_____

_____

How do you consider your overall health? : Good _____ Fair:_____ Poor: _____

Current Health condition (s):_____

Are you able to self-care: yes:_____ No: _____ If no, please explain:

_____

Please list current medications-include over-the-counter medications (please explain the purpose for each medication) (use back of paper if more room is needed):

_____

_____

_____

_____

Do you have a primary care physician? Yes:_____ No: _____

Have you had any recent thoughts of harming yourself or others? Yes: ____ NO: ___

Do you have past history of self-harm or harming others? If so explain: Yes:____ No: _____

_____

History of violence: yes (explain each incident, provide month /year): Yes: _____ No : _____

_____

_____

_____

Married/significant other/divorced/separated? _____

Children Yes: _____ No: _____ (living situation)

_____

Current living situation: _____

Are you currently employed?: Yes: ____ NO:_____

Are you currently participating in a Medication Assisted Therapy Program: Yes___ NO____

If yes be explain, location, medication and current dosage:

_____

_____

MAT Physician: _____

Are you in need of detoxification services: Yes:_____ No: _____