Name of Guest: _____

REFERRAL SOURCE: _____ DATE: _____

Contact Person: _____ Phone: _____

Email: _____

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

GUEST INFORMATION:

Client Name: _____ Phone: _____

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

Age: ____ ( ) Male ( ) Female ( ) Other

Are you physically independent? ( ) Yes ( ) No.

EMERGENCY CONTACT(S):

(1). Name: _____ Relationship: _____ Phone:_____

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

(2). Name: _____ Relationship: _____ Phone:_____

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

BEHAVIORAL HISTORY:

History of suicide attempts/gestures/ideations? ( ) Yes ( ) No . If yes, explain:

_____

_____

History of violent/assaultive behavior? ( ) Yes ( ) No. If yes, explain:

_____

_____

History of malicious behavior such as fire setting or retaliation? ( ) Yes ( ) No. If yes, explain:

_____

_____

Are you a RSO? Yes ( ) No ( )

Name of Guest: _____

SUBSTANCE USE HISTORY:

History of alcohol or drug use? ( ) Yes ( ) No. If yes, please be specific:

_____

_____

_____

Date of Last Use: _____ Longest period of abstinence? _____

Types of substance abuse treatment received in the past. (IP, OP, Rehab, Residential, etc.)
(please specify dates to the best of your knowledge)

_____

_____

_____

_____

HEALTH CONCERNS/CURRENT HEALTH CONDITIONS:

Have you ever been diagnosed or treated for any of the following? Check all that apply and explain below.

( ) Allergies
( ) Blood Pressure
( ) Cancer
( ) Diabetes
( ) Eating Disorders
( ) Gait/Balance Problems
( ) Gynecological Problems
( ) Hearing Problems
( ) Heart Disease
  ( ) Heart Attack
  ( ) Endocarditis
  ( ) Other: _____
( ) Hepatitis A, B, or C.
( ) Hyponeutremia
( ) Kidney Disease
( ) Liver Disease
( ) Muscular/Skeletal Problems
( ) Pancreatitis
( ) Respiratory Problems
( ) Seizure Disorder
( ) SexuallyTransmitted Diseases
( ) Sleep Problems
( ) Thyroid Problems
( ) Tuberculosis
( ) Ulcer
( ) Vision Problems
Other: _____

Briefly explain any medical condition (s) identified above.

_____

_____

_____

List ALL prescription and over the counter medications you are currently taking.

_____

_____

_____

_____

Name of Guest: _____

ASSISTANCE/ RESOURCES/METHOD OF PAYMENT:

Type(s) of assistance you are currently receiving.

SSI - ( ) Amount per month? _____. SSDI - ( ): Amount per month? _____

Welfare - ( ): _____. Food Stamps ( ): _____

Medicaid ( ) Yes ( ) No Medicaid #: _____

Medicare? ( ) Yes ( ) No Medicare #: _____

How will you pay for accommodations while staying at Progressive Living?

SSI [ ] SSDI [ ] Private pay [ ]

What are your goals for the next six (6) months, and how do you plan to accomplish them?

_____

_____

_____

_____

_____

_____.

I understand that there will be house specific rules and expectations for the entirety of my stay, and I want to proceed with submitting this form for consideration.

Signature: _____ Date: _____

****Guests are not required to pay a security deposit. There is a one-time non-refundable $75 fee which covers administrative costs, maintenance, and cleaning for the entirety of each stay. This is due prior to or on day of check in.****

For official Use Only:

_____

_____

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