ARDY House Men's Recovery Home

Intake Application

Ardyhouse@urbanlightmuncie.com

765-591-3224

Date: ____

Intake Staff: __________________________________

November 7, 2022

ARDY HOUSE INTAKE APPLICATION

PERSONAL DEMOGRAPHICS

First Name: ____

Last Name: ____ MI ______

Date of Birth: **______/______/_______ Age: ________________**

Address: ____

City: ____

State: ___________________ Zip Code: _______________________

Telephone:

(Home)________________________ (Work) ___________________ (Cell)_________________

Email Address: ____

Driver's License / State ID: #______________________________ State Issued: _____________

EDUCATION:

Highest Level of Education:

- ☐ High School not completed
- ☐ High School Diploma
- ☐ Trade School
- ☐ GED
- ☐ College Degree: Type ______________________
- ☐ Graduate Degree: Type ______________________
- ☐ Other ____________________________________

EMPLOYMENT:

Occupation: ____

Employed by: ____

How long employed: ____

Military Service: Yes ______ No ______ Branch ____________Years of Service _____

CRIMINAL HISTORY:

Have you ever been incarcerated: Yes _________ No __________

Date: ___________________

Probation / Parole: Yes _______ No _________

Name of Probation / Parole Officer ____

Sex Offender Registry: Yes ________ No ________

If on the Sex Offender Registry, what state? ________________

RELIGION:

- ☐ Christian
- ☐ Buddhism
- ☐ Hinduism
- ☐ Islam
- ☐ Other ___________________
- ☐ Prefer not to say

REFERRAL SOURCE:

Referred by:

- ☐ Doctor ________________________________
- ☐ Pastor / Church _________________________
- ☐ Former Client ___________________________
- ☐ Website ________________________________
- ☐ Insurance _______________________________
- ☐ Community Agency _______________________
- ☐ Department of Corrections
- ☐ Other ___________________________________

MARITAL HISTORY:

______ Single

______ Never Married

______ Engaged / How Long: ________________

______ Living Together / Date Started: _______________ How Long: ______________

______ Married / Date Married: _____________________ / Months / Years Married:_________

______ Separated / Date: _______________ How Long: __________________

Spouse / Significant Other's Name: ____

Phone number: ____

Previous Marriages / Significant Others:

- ☐ 1st Marriage / SO: Years Together ___________
- ☐ 2nd Marriage / SO: Years Together __________
- ☐ 3rd Marriage / SO: Years Together ___________

FAMILY HISTORY:

Your Children:

Name	Age	Gender	Biological/Step/Adopted

CHILDHOOD FAMILY EXPERIENCE:

Please describe your childhood experience below:

Home Environment: _____ Excellent _____ Very Good _____Good _____ Fair _____ Poor

Child Welfare (CPS) Involvement: ______Yes ______ No

Domestic Violence in the home: ______ Yes _______ No

Substance related issues in the home: ______ Yes ______ No

If yes, please explain: ____

Abuse	Witnessed	Experienced
Physical	☐	☐
Verbal	☐	☐
Sexual	☐	☐

HEALTH HISTORY:

Do you currently have medical insurance: Yes _______ No _______

Insurance Provider: ____

Policy Number: ____

Phone Number: ____

Primary Care Provider (doctor, nurse practitioner, etc.)

Name:____

Office Phone: ____________________ City: ___________________ State: ________________

Do you have any known allergies: Yes _______ No ______

If yes, please explain: ____

____

Prior Detox / Recovery History: Yes _________ No ______________

Name of Provider: _______________________________________

City and State: ____

Date: ____

Completion of treatment: Yes _________________ No ______________

Name of Provider: _______________________________________

City and State: ____

Date: ____

Completion of treatment: Yes _________________ No ______________

Name of Provider: _______________________________________

City and State: ____

Date: ____

Completion of treatment: Yes _________________ No ______________

Name of Provider: _______________________________________

City and State: ____

Date: ____

Completion of treatment: Yes _________________ No ______________

Name of Provider: _______________________________________

City and State: ____

Date: ____

Completion of treatment: Yes _________________ No ______________

CURRENT SYMPTOM CHECKLIST

Directions: Please check all symptoms you are currently experiencing or have experienced in the past two weeks:

Mild = Impacts quality of life, but no significant impairment of day to day functioning

Moderate = Significant impact on quality of life and or day to day functioning

Severe = Profound impact on quality of life and day to day functioning

Symptom	Functioning	Symptom	Functioning
☐ Depressed Mood	☐ Mild ☐ Moderate ☐ Severe	☐ Sleeping Problems	☐ Mild ☐ Moderate ☐ Severe
☐ Eating Problems	☐ Mild ☐ Moderate ☐ Severe	☐ Elimination Problems	☐ Mild ☐ Moderate ☐ Severe
☐ Poor Concentration	☐ Mild ☐ Moderate ☐ Severe	☐ Mood swings during day	☐ Mild ☐ Moderate ☐ Severe
☐ Sad, cry often for no reason	☐ Mild ☐ Moderate ☐ Severe	☐ Grief	☐ Mild ☐ Moderate ☐ Severe
☐ Hopelessness	☐ Mild ☐ Moderate ☐ Severe	☐ Worthlessness	☐ Mild ☐ Moderate ☐ Severe
☐ Fatigue/low energy	☐ Mild ☐ Moderate ☐ Severe	☐ Irritability	☐ Mild ☐ Moderate ☐ Severe
☐ Thoughts of death / self-harm	☐ Mild ☐ Moderate ☐ Severe	☐ Body movements slow and difficult	☐ Mild ☐ Moderate ☐ Severe
☐ Personal grooming is difficult	☐ Mild ☐ Moderate ☐ Severe	☐ Elevated mood (energetic, feel as though you can do anything)	☐ Mild ☐ Moderate ☐ Severe
☐ Social Isolation (few friends/social contacts)	☐ Mild ☐ Moderate ☐ Severe	☐ Ongoing relationship problems	☐ Mild ☐ Moderate ☐ Severe

☐ Generally anxious most of day	☐ Mild ☐ Moderate ☐ Severe	☐ Excessive worry most of day	☐ Mild ☐ Moderate ☐ Severe
☐ Confused, or jumbled thoughts	☐ Mild ☐ Moderate ☐ Severe	☐ Frequently agitated	☐ Mild ☐ Moderate ☐ Severe
☐ Nervous / fearful most of day	☐ Mild ☐ Moderate ☐ Severe	☐ Racing thoughts	☐ Mild ☐ Moderate ☐ Severe
☐ Tight chest, racing heartbeat	☐ Mild ☐ Moderate ☐ Severe	☐ Dizzy / room spinning	☐ Mild ☐ Moderate ☐ Severe
☐ Light-headed / Faint	☐ Mild ☐ Moderate ☐ Severe	☐ Panic attacks	☐ Mild ☐ Moderate ☐ Severe
☐ Chest pain / feels like heart attack	☐ Mild ☐ Moderate ☐ Severe	☐ Fretful / muscle tension / fidget a lot / can’t sit still	☐ Mild ☐ Moderate ☐ Severe
☐ Losing or gaining at least 7-10 lbs within a month	☐ Mild ☐ Moderate ☐ Severe	☐ Phobias (i.e., snakes, heights, elevators, planes)	☐ Mild ☐ Moderate ☐ Severe
☐ Obsessions (thinking about the same thing over and over)	☐ Mild ☐ Moderate ☐ Severe	☐ Compulsions /rituals (doing the same things over and over)	☐ Mild ☐ Moderate ☐ Severe
☐ Binging / purging (eating a lot and throwing up or laxatives)	☐ Mild ☐ Moderate ☐ Severe	☐ Laxatives / diuretic abuse	☐ Mild ☐ Moderate ☐ Severe
☐ Anorexia (restricting food intake)	☐ Mild ☐ Moderate ☐ Severe	☐ Aggressive (intimidating, controlling, hurting others, damaging property)	☐ Mild ☐ Moderate ☐ Severe
☐ Guilt / Shame	☐ Mild ☐ Moderate ☐ Severe	☐ Health Complaints	☐ Mild ☐ Moderate ☐ Severe

☐ Self-mutilation (hurting yourself / cutting)	☐ Mild ☐ Moderate ☐ Severe	☐ Sexual Problems	☐ Mild ☐ Moderate ☐ Severe
☐ Victim of emotional trauma / abuse	☐ Mild ☐ Moderate ☐ Severe	☐ Victim of physical trauma / abuse	☐ Mild ☐ Moderate ☐ Severe
☐ Victim of sexual abuse	☐ Mild ☐ Moderate ☐ Severe	☐ Perpetrator of emotional trauma / abuse	☐ Mild ☐ Moderate ☐ Severe
☐ Perpetrator of physical trauma / abuse	☐ Mild ☐ Moderate ☐ Severe	☐ Perpetrator of sexual trauma / abuse	☐ Mild ☐ Moderate ☐ Severe

SUBSTANCE USAGE: (Alcohol, Drugs, Nicotine, Caffeine, etc.)

Type of substance	Amount	Frequency	First Use (age)	Last Date Used
☐ **Alcohol**				
☐ **Marijuana**				
☐ **Opioids / Heroin**				
☐ **Prescription Medications**				
☐ **Hallucinogens**				
☐ **Cocaine**				
☐ **Meth**				
☐ **Benzodiazepines**				
☐ **Inhalants**				
☐ **Other(s)**				

MEDICAL HISTORY Continue…:

Medications (Name)	Dosage	Frequency

Do you currently have any medical issues? Yes _________ No ________

If yes, please explain:

Medical Issue	What accommodation is needed?

What are you looking for in this program? (Use the area below for your answer)

Informed Consent

- I am aware that I am completing this application to apply for recovery services with the ARDY House. I acknowledge that I have been made aware that information in this application may be shared with service providers that partner with the ARDY House should I be accepted into the program. ____________

- I understand that I need to provide accurate information about myself and my concerns to the Intake Staff so that I can receive effective services. I also agree to play an active role in my treatment. ______________

- I understand that I may end services at the ARDY House at any time. I agree to inform the ARDY House staff should I wish to terminate the program. ______________

- I understand that all information shared with the ARDY House is confidential. However, I am aware that confidentiality can be broken in the case that I could harm myself, someone else or if a court of law requires the staff to break confidentiality. __________

Confidentiality

Confidentiality and privileged communication remain rights of all staff; however, some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or oneself, it is the staff's duty to warn appropriate authorities of such intentions. Staff are mandated by Indiana law to report any incidences of "Reasonable Suspected Child Abuse" (physical or sexual).

I have read the above statements and understand the staff's social and ethical responsibility to warn when harmful, dangerous, or criminal action is evident.

___________________________________   ________________________

Name of applicant (Print)   Date

___________________________________   ________________________

Signature of applicant   Signature of Staff