HANNAH'S HOUSE
PEACE IN THE MIDST OF THE STORM
Providing Hope for the Hopeless

Intake Application

- **For Office Use Only:**
- *Date Application Received:* _____ *Referred By:* _____
- *Interview Date:* _____
- *Notes:* _____
- *Admission Date:* _____

1. Demographic Information

- **Full Name:** _____
- **Preferred Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____
- **Home Address:** _____
- **Do you have children?** Yes/No **If yes, are they currently living with you?** Yes/No
- **Are you currently incarcerated?** Yes/No **If yes, where?** _____
- **Marital/Relationship Status:** Single ___ Dating ___ Married ___ Divorced ___ Separated ___
- **Are you ordered to Register as a Drug and/or Sex Offender?** Yes/No **If yes, explain:**
  _____

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2. Emergency Contact

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

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3. Presenting Concerns

- **Primary reason for seeking treatment:**

- **What motivated you to seek help now?**

- **Treatment goals:**

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4. Substance-Use Screening

This section helps Hannah's House understand patterns and risks in a supportive, non-judgmental way.

- **Have you ever used substances in a way that caused problems for you?**
  ☐ Yes ☐ No If yes, which substances: _____Last Date Used: _____
- **Have you ever tried to cut back and found it difficult?**
  ☐ Yes ☐ No
- **Have you ever experienced physical or emotional discomfort when reducing use?**
  ☐ Yes ☐ No
- **Has substance use affected school, work, relationships, or health?**
  ☐ Yes ☐ No
- **If you'd like, describe any patterns or concerns in your own words:**

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5. Treatment History

- **Previous counseling or rehab participation:**
  ☐ Yes ☐ No
  If yes, where and when:

- **What approaches or supports have been helpful?**

- **What approaches have not been helpful?**

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6. Medical Information

- **Primary Care Provider:** _____
- **Current Medications:**

- **Allergies:**

- **Medical conditions or concerns:**

- **Recent hospital or urgent-care visits:**
  ☐ Yes ☐ No
  If yes, describe: _____

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7. Mental & Emotional Health

- **Have you ever met with a mental-health professional?**
  ☐ Yes ☐ No
- **Current emotional concerns (check all that apply):**
  ☐ Anxiety ☐ Depression ☐ Mood changes
  ☐ Difficulty sleeping ☐ Feeling overwhelmed
  ☐ Trouble concentrating
- **Additional concerns:**

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8. Safety & Wellness Screening

This helps staff ensure you receive the right level of support.

- **Have you ever had thoughts of harming yourself or others?**
  ☐ Yes ☐ No
  If yes, please describe in general terms so staff can support you safely:

- **Do you feel safe in your current living situation?**
  ☐ Yes ☐ No
- **Are there situations or triggers that make things harder for you?**

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9. Social & Environmental Factors

- **Supportive people in your life:**

- **Current school or work status:**
  ☐ Employed ☐ Student ☐ Disability ☐ None
  Details: _____
- **Housing stability:**
  ☐ Stable ☐ Unstable
- **Any legal or school-related concerns staff should be aware of?**
  ☐ Yes ☐ No
  If yes, describe: _____

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10. Insurance / Payment Information

- **Insurance Provider:** _____
- **Policy Number:** _____
- **Group Number:** _____

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11. Consent & Acknowledgment

I understand that this information helps staff determine the safest and most supportive treatment plan. I certify that the information provided is accurate to the best of my knowledge.

- **Signature:** _____ **Date:** _____