

RAINFOREST RECOVERY CENTER
APPLICATION FOR SERVICES

Date	Last Name	First Name	Middle Name
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Please mark the level of service you're applying for? Outpatient Residential

CLIENT INFORMATION

Maiden Name (or other names you may be known as): _____

Gender: Female Male Date of Birth: _____

SSN: _____ Driver's License Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Message: _____

Employer Name and Address: _____

Spouse/Guardian Name: _____ Phone: _____

Address _____

Name of Emergency Contact: _____ Relationship To You: _____

Home Phone: _____ Work Phone: _____ Message: _____

Address: _____

Who referred you to RRC: JASAP/ ASAP Probation Court OCS Self

Other referral source: _____

Where do you plan to obtain continuing care? _____

Describe your problem. Why are you applying to RRC? _____

DRUG AND ALCOHOL HISTORY

This questionnaire provides valuable information that helps us conduct a thorough assessment of your treatment needs. Federal Law protects the confidentiality of this information. Please note: a urine drug screen is required at the time of your assessment and will detect drug use, honesty is noticed and appreciated.

DRUG OF CHOICE: (1) _____ (2) _____

Check any symptoms experienced: Cravings Tolerance Blackouts Withdrawals

Do you consider your drug(s) of choice a problem? Yes No

Have you tried to cut down on your drug and/or alcohol use in the past? Yes No

USE HISTORY

ALCOHOL:

Have you used alcohol? Yes No (If yes complete this section)

At what age did you **start** drinking? _____ When did you **last drink** any alcohol? _____
Over the **past year**, about how often did you drink? Daily 3-5xWk 1-2xWk 1-2xMnth Less
How much (on average) in one sitting? # beers _____; # shots _____; # mixed drinks _____; # wine glasses _____

CANNABIS:

Have you used cannabis? Yes No (If yes complete this section)

At what age did you **start** smoking? _____ When did you **last smoke** pot? _____
At what age were you using the **heaviest**? _____
Over the **past year**, about how often did you smoke? Daily 3-5xWk 1-2xWk 1-2xMnth Less
Amount you smoked at a time? _____

COCAINE:

Have you used cocaine? Yes No (If yes complete this section)

At what age did you **start** using cocaine? _____ When did you **last use** cocaine? _____
At what age were you using the **heaviest**? _____
How do you use cocaine? Smoke Insufflate (snort) Inject
Over the **past year**, how often did you use cocaine? Daily 3-5xWk 1-2xWk 1-2xMnth Less
Amount you typically used at a time? _____

METHAMPHETAMINES (includes crank, speed, crystal, etc.):

Have you used methamphetamines? Yes No (If yes complete this section)

At what age did you **start** using meth? _____ When did you **last use** meth? _____
At what age were you using the **heaviest**? _____
How do you use meth? Ingest Smoke Insufflate (snort) Inject
Over the **past year**, how often did you use cocaine? Daily 3-5xWk 1-2xWk 1-2xMnth Less
Amount you typically used at a time? _____

OPIOIDS (includes Heroin, Codeine, Vicodin®, Oxycontin®, Methadone, Morphine, etc.):

Have you **abused** (taken more than prescribed or bought off street) opioids? Yes No (If yes complete this section)

At what age did you **start** using opioids? _____ When did you **last use** opioids? _____
At what age were you using the **heaviest**? _____
How do you use opioids? Ingest Smoke Insufflate (snort) Inject
Over the **past year**, how often did you use cocaine? Daily 3-5xWk 1-2xWk 1-2xMnth Less
How much did you typically at one time? _____

BENZODIAZEPINES AND TRANQUILIZERS (SEDATIVES) (includes Klonopin, Valium, Xanax, Librium, etc.)

Have you **abused** (taken more than prescribed or bought off street) benzodiazepines? Yes No (If yes complete this section)

At what age did you **start** using benzodiazepines? _____ When did you **last use** benzodiazepines? _____

At what age were you using the **heaviest**? _____

How do you use benzodiazepines? Ingest Smoke Insufflate (snort) Inject

Over the **past year**, how often did you use benzodiazepines? Daily 3-5xWk 1-2xWk 1-2xMnth Less

How much did you typically at one time? _____

AMPHETAMINES (includes Ritalin, Adderall, diet pills, Dexedrine, etc.)

Have you **abused** (taken more than prescribed or bought off street) amphetamines? Yes No (If yes complete this section)

At what age did you **start** using amphetamines? _____ When did you **last use** amphetamines? _____

At what age were you using the **heaviest**? _____

How do you use amphetamines? Ingest Smoke Insufflate (snort) Inject

Over the **past year**, how often did you use amphetamines? Daily 3-5xWk 1-2xWk 1-2xMnth Less

How much did you typically at one time? _____

OTHER DRUGS:

Check all that you have used in the past and put # times used (approximate) in blank:

Ecstasy Roofies MDMA GHB Yellow Jackets Mushrooms

Peyote LSD Acid Steroids corcidine

Other _____

INHALANTS: (includes gasoline, paint, nitrous oxide or other gases)

At what age did you **start** using inhalants? _____ When did you **last use** inhalants? _____

At what age were you using the **heaviest**? _____

Over the **past year**, how often did you use inhalants? Daily 3-5xWk 1-2xWk 1-2xMnth Less

How much did you typically at one time? _____

OVER THE COUNTER (OTC) MEDICATIONS (includes Tylenol, Ibuprofen, Sudafed, etc.):

Do you take any over the counter (OTC) medications? Yes No (If yes complete this section)

How often do you take OTC meds? Daily 3-5xWk 1-2xWk 1-2xMnth Less

For what **physical problem(s)**? _____

When you think about getting clean and sober, are any of the following areas going to be an obstacle? (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Partner uses | <input type="checkbox"/> Friends use | <input type="checkbox"/> Family uses |
| <input type="checkbox"/> People use at work | <input type="checkbox"/> Stress | <input type="checkbox"/> Money problems |
| <input type="checkbox"/> Conflict in relationships | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Feeling of loneliness | <input type="checkbox"/> Feeling of emptiness |
| <input type="checkbox"/> Confusion about life direction | <input type="checkbox"/> Other _____ | |

TOBACCO USE

Do you use tobacco products? Yes No (If yes complete this section)

What kind of tobacco products and how much do you use daily? _____

If you have quit using all tobacco products, how long ago did you quit? _____

CAFFEINE USE

Do you drink beverages with caffeine? Yes No (If yes complete this section)

How many of the following do you drink daily?

Cups of coffee _____ Cups of tea _____ Cans of Soft drinks _____ Cans of energy drinks _____

Other caffeine products? _____

PRIOR DRUG AND ALCOHOL TREATMENT

Start with your most recent treatment (Attach extra sheet if necessary)

Have you ever been to substance abuse treatment before? Yes No

If yes what was your date of last treatment: Outpatient _____ Inpatient _____ Individual _____

Where Were You Treated?	Reason for Treatment (self, court, job, etc.)	Date	Did you complete Aftercare?	How long Clean & sober

MEDICAL INFORMATION

Known Allergies: _____

Name of Medical Doctor: _____ Date Last Seen by Doctor: _____

Have you ever experienced **Seizures?** Yes No **DTs?** Yes No
 Blackouts? Yes No **Withdrawals?** Yes No
 Heart Problems? Yes No **Brain Injury?** Yes No

If yes to any of the above, please explain (circumstances, dates, etc.): _____

Have you ever used IV drugs? Yes No

If yes, when was last IV use? _____

How frequently are you injecting drugs now? _____

How long have you been using IV drugs? _____

Have you ever been tested for **HIV?** Yes No **Hep C?** Yes No

If yes, date(s) tested? **HIV?** _____ **Hep C?** _____

TB SCREEN: Have you ever had tuberculosis? Yes No

When and where was your last PPD (TB Skin Test)? _____

PLEASE HAVE TB TEST RESULTS FORWARDED TO RRC WITH YOUR CURRENT HISTORY AND PHYSICAL

List any medical diagnoses or medical problems that you have or believe are important (Attach extra sheet if necessary)

List all hospitalizations for surgery or illness and provide dates (Attach extra sheet if necessary)

Current Prescription Medications (Attach extra sheet if necessary and label with your name and today's date)

TYPE DOSE FREQUENCY REASON TAKING

Current Over-the-Counter Medications (Attach extra sheet if necessary and label with your name and today's date)

TYPE DOSE FREQUENCY REASON TAKING

Are you pregnant? Yes No If Yes, what trimester? _____

MENTAL HEALTH INFORMATION

Are you currently being treated for a mental health disorder? Y N Diagnosis: _____

Have you been treated for a mental health disorder in the past? Y N Date of last contact: _____

Have you ever attempted suicide? Y N When was most recent attempt? _____

FAMILY HISTORY INFORMATION

Where were you born? _____

Where were you raised? _____

Who was your primary caregiver? _____

How many siblings do you have? _____ What number are you in birth order? _____

Do you have a family history of depression, emotional problems, or mental illness? Y N

If yes, who in your family has these problems? _____

Was alcohol and/or drugs a problem for anyone in the home where you were raised? Y N

If yes, for whom: _____

LIVING ENVIRONMENT

You are currently living with: Family Relatives Friends Alone Other _____

Are you satisfied with this arrangement? Y N

How many children do you have? _____ List names and ages: _____

Does anyone hit or abuse you? Y N If yes, are you safe now? _____

Where do you do most of your socializing? _____

Do the majority of your friends use alcohol and/or other drugs? Y N

What did you do last weekend? _____

Does your spouse or significant other use alcohol or drugs? Y N

LEGAL SITUATION

List all prior and current legal history, including juvenile history and current charges: _____

Do you have any pending court appearances/dates scheduled? Y N When: _____

Do you have any outstanding warrants? Y N What for? _____

Are you involved with Alcohol Safety Action Program (ASAP)? Y N

Have you completed all your court requirements? Y N _____

Are you on probation or parole? Y N

Attorney's name: _____ Name of Probation or Parole Officer: _____

List any past felonies you were convicted of and dates: _____

Have you ever been fired, disciplined, or quit a job due to alcohol or drug misuse? Y N When? _____

RAINFOREST RECOVERY CENTER

3250 Hospital Drive
Juneau, Alaska 99801
Phone: (907) 796.8690 – Fax: (907) 586.5605

NO-SHOW POLICY

- Scheduled assessments must be cancelled **24 hours in advance** to ensure proper rescheduling.
 - Scheduled **ASSESSMENT CANCELLATIONS MUST** be called in to the front desk.
 - **ALL OTHER APPOINTMENT CANCELLATIONS**, you must speak directly with your counselor.
- If a client receives **two (2) consecutive No-Shows**, they may be discharged from the program and will have to reapply if they wish to continue treatment.

IF YOU COME TO RRC UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS

- ◆ You will not be allowed to participate in any program at RRC if you are under the influence of alcohol or other drugs and your presence at RRC will not count toward completion of your program.
- ◆ If RRC personnel believe you may be impaired, you will be asked about your current use and if you deny use you will be asked to submit to a Breathalyzer test or a urine drug screen (UDS).
- ◆ Anyone who is under the influence of alcohol or other drugs will be asked to leave the RRC campus. If you have driven a vehicle to RRC, you will be asked to leave your vehicle in the parking lot and arrange for safe transportation. RRC staff will be happy to assist you in arranging for transportation.
- ◆ If RRC personnel believe you are impaired and you drive your vehicle from the RRC campus, RRC personnel will notify Juneau Police Department that an impaired driver is leaving the RRC parking area and a description of your vehicle will be given to them.

Please sign acknowledging that you have read and understand the above policy.

Signature of Client

Date

**Rainforest Recovery Center At Bartlett
3250 Hospital Drive
Juneau, Alaska 99801**

PAYMENT INSTRUCTIONS

Client Name _____ DOB _____ SSN _____ Date _____

1. Payment is expected at time of service. You may pay for the entire program in advance if you prefer and RRC billing department will estimate your program fee for you. Co-payment is required if you have insurance coverage. Contact the billing department to determine your co-payment amount. If you do not have insurance, you may apply for our discount program ("Sliding Fee Scale"). Contact RRC billing department to see if you qualify. To apply for the discount program, please complete the Sliding Fee application and provide proof of income or disability.
2. Payments must be kept current. Services may be delayed until account is current. Contact our billing department to set up an affordable payment plan.
3. Letters of compliance will be issued upon completion of the program only when account is paid in full or a payment agreement has been made and payments are current.

FINANCIAL INFORMATION

Do you have insurance? Y N (If yes please answer lines 1-5 below)

If you have MEDICAID, Skip to line 11

1. Name of insurance company _____ Phone Number _____
2. Address of insurance company _____
3. Subscribers Name: _____ Phone # _____ DOB: _____
4. Subscriber's SSN: _____ - _____ - _____ Group # _____ Policy # _____
5. Subscriber's Employer: _____ Actively Employed _____ Retired _____

Do you have a secondary insurance company? Y N (If yes please answer lines 6-10 below)

6. Name of secondary insurance company _____ Phone Number _____
7. Address of insurance company _____
8. Subscribers Name: _____ Phone # _____ DOB: _____
9. Subscriber's SSN: _____ - _____ - _____ Group # _____ Policy # _____
10. Subscriber's Employer: _____ Actively Employed _____ Retired _____

11. Are you eligible for Medicaid? Y N

12. If you are eligible for Medicaid:

Have you received services at another treatment facility within the last 12 months? Y N

If Yes Where? _____

If Yes how many days were you there? _____

If you have no means of payment, you are required to complete a separate application for a **sliding fee**. The sliding fee scale application can be obtained online or at RRC reception.

I have read and understand the above payment instructions. I certify that the information I have provided is true and accurate to the best of my knowledge. I give consent to the release of information to my insurance company and authorize payment directly to Rainforest Recovery Center at Bartlett.

Signature: _____ Date: _____