LHI - Lowell House Inc.

## Sheehan Women's Program Phone (978) 640-0840 Fax (978) 640-1708

## Application for Admissions PLEASE PRINT

| Today's Date:                            | _                    |  |  |
|--|----------------------|--|--|
| Name of Applicant:                       | DOB:                 | AGE  |  |
| SS#:                                     | Insurance Y N Type:  | AGE:   |  |
| Home Address:                            |                      |  |  |
| Referring Agency/ Case Manager:          |                      |  |  |
| Applicant previously at Sheehan Progr    |                      |  |  |
|  |                      |  |  |
| If so, explain                           |                      | The state of the s |  |
| SUBSTANCE ABUSE HISTORY                  |                      |  |  |
| Drugs Used: Alcohol                      | Cocaine              | Heroin   |  |
| Rx Pills                                 |                      | Other  |  |
| Date of Last Use:                        |                      |  |  |
| Have you ever overdosed? If              | yes, number of times |  |  |
| Have you ever witnessed an overdose?     |                      |  |  |
| Data(a) of Data Of                       |                      |  |  |
| Date(s) of Detox Stays:                  | 20                   |  |  |
|  |                      |  |  |
|  |                      |  |  |
| Other Substance Abuse Treatments:        | 1                    |  |  |
| ,  |                      |  |  |
| 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1 |                      |  |  |
| LEGAL WATER                              |                      |  |  |
| LEGAL HISTORY                            |                      |  |  |
| On Probation: Y N Where:                 |                      |  |  |
| On Parole: Y N Where:P.O. Name:Phone#:   |                      |  |  |
| Conditions of Probation or Parole        |                      |  |  |
|  |                      |  |  |
| Current Charges:                         |                      |  |  |
|  |                      |  |  |

## **CURRENT MEDICAL CONDITIONS AND SIGNIFICANT MEDICAL HISTORY**

- Please attach the most recent physical exam information.
  Current proof of TB Test is required for admissions.

|  | MEDICAL  Has client ever had seizures: Y N Explain:                    |        |             |  |  |
|--|--|--------|-------------|--|--|
|  | Has client ever had dementia: Y N Explain:                             |        |             |  |  |
|  | 3 (tuberculosis) Skin Test Date: If positive, date of last chest X-Ray |        |             |  |  |
| Specific Physical Conditions:                            |  |        |             |  |  |
|  | Allergies Cane/Crutches/Wheelcha                                       | air    | Prosthesis  |  |  |
|  | Diabetes Special Diet  | _      | Other       |  |  |
| 331  | PSYCHIATRIC HISTORY: DSM-IV Diagnosis                                  |        |             |  |  |
|  | Axis I   |        |             |  |  |
|  | Axis II  |        | Axis IV     |  |  |
|  | Axis III   | Axis V |             |  |  |
| Hospitalizations: Therapist/ Psychologist Name: Phone #: |  |        |             |  |  |
|  | Psychiatrist Name:   |        |             |  |  |
|  | DMH Case Manager Name:   |        |             |  |  |
|  | Suicidal Ideation: Current: Y N Past History:                          |        |             |  |  |
|  |  |        |             |  |  |
|  |  |        |             |  |  |
|  |  |        |             |  |  |
|  |  |        |             |  |  |
|  | Signature/ Date:   |        | Print Name: |  |  |