ACT LIKE MEN | SOBRIETY HOUSE
RESIDENTIAL APPLICATION

Send completed application to: James MacDonald Ministries, PO Box 6688, Elgin IL, 60121 or ALM@JamesMacDonaldMinistries.org.

Name: _____

Age: _____ **Birth Date:** _____

Gender: Male | Female

Phone: _____ **Email**: _____

Marital Status: Married | Divorced | Single | Widowed | Common Law

If you have a spouse or partner, please list their name, address, and phone:

_____

_____

_____

If you have children, please provide their name(s) and age(s):

_____

_____

Driver's License #: _____ State: ____ Exp Date: _____

State ID/Passport #: _____

Previous Home Address:_____

_____

Able to work full time or part time? Yes | No

If unable to work, explain:

_____

_____

Present or Recent Employer: _____

Employer Address: _____

Employer Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

Do you have a means of transportation: Yes | No

If yes, state type: *car, truck, motorcycle, other* _____

License Plate #: _____ State: _____

How were you referred to the ALM Sobriety House? *PO, Agency, Friend, Family, Facility, Internet, Member, etc.*

_____

Do you need SNAP? *supplementary food program* Yes | No

Do you have medical insurance? Yes | No

Do you need Social Security or Driver's License assistance? Yes | No

Are you on probation? Yes | No

Do you need a primary care physician? Yes | No

Do you need a dentist? Yes | No

Do you need counseling? Yes | No

If you are in active counseling, what is the organization's name:

_____

Counselor Name: _____ Phone: _____

City/State/Zip: _____

Do you have other social service needs not mentioned?

_____

Have you ever worked a 12-step program of recovery? Yes | No

If yes, what program: _____

Sponsor: _____ Phone: _____

What is your highest degree of education: _____

Are you a veteran? Yes | No

If yes, which branch of the military: _____

Have you lived in a Sobriety House before? Yes | No

If yes, what is the name and location:

_____

What were your preferred substances?

_____

What other drugs or alcohol have you used in the last 6 months?

_____

Have you completed detox? Yes | No

If yes, when: _____

If yes, where: _____

What is your sobriety/clean date?_____

What is your longest period of sobriety? _____

What was your longest period of active use? _____

TREATMENT HISTORY

Treatment Center #1

Name: _____ Phone: _____

Address: _____

Started: _____ Ended: _____

Reason Left: _____

Treatment Center #2

Name: _____ Phone: _____

Address: _____

Started: _____ Ended: _____

Reason Left: _____

Treatment Center #3

Name: _____ Phone: _____

Address: _____

Started: _____ Ended: _____

Reason Left: _____

Treatment Center #4

Name: _____ Phone: _____

Address: _____

Started: _____ Ended: _____

Reason Left: _____

MEDICAL INFORMATION

List all prescription or over-the-counter medications you are currently using.

Medication #1

Medication: _____

Dosage: _____ Quantity: _____

Frequency: _____

Notes: _____

Medication #2

Medication: _____

Dosage: _____ Quantity: _____

Frequency: _____

Notes: _____

Medication #3

Medication: _____

Dosage: _____ Quantity: _____

Frequency: _____

Notes: _____

Medication #4

Medication: _____

Dosage: _____ Quantity: _____

Frequency: _____

Notes: _____

Medication #5

Medication: _____

Dosage: _____ Quantity: _____

Frequency: _____

Notes: _____

Primary Physician: _____

Phone: _____ City/State: _____

Preferred Hospital: _____ City/State: _____

Dentist: _____

Phone: _____ City/State: _____

Do you have health insurance? Yes | No

If yes, company: _____

ID #: _____ Group #:_____

Contact Phone #: *back of card* _____

Are you covered with Medicare/Medicaid? *retired or on disability SSD/SSI*

Plan: _____ ID #: _____

Do you have any medical issues? Yes | No

If yes, briefly explain. _____

MEDICAL HISTORY

Hepatitus C Tested: Yes | No **Results:** Positive | Negative

Tuberculosis Tested: Yes | No **Results:** Positive | Negative

HIV Tested: Yes | No **Results:** Positive | Negative

Do you have allergies: Yes | No

What, if any, allergies affect you? *foods, animal, medicinal, seasonal*

_____

Do you have a history of seizures: Yes | No

If yes, date of last seizure? _____

Have you ever overdosed? Yes | No

If yes, how many times? _____

Have you ever abused: *circle all that apply*

Alcohol	Cocaine	Amphetamines	Heroin	Crack
Hallucinogens	THC	Methadone	Buprenorphine	
Benzodiazepine	Ecstasy	Pain Medications	Molly	Bath Salts
K2	Gabapentin	PCP	LSD	Suboxone
Glue	Inhalants	OxyContin	Percocet	Codeine
Dusting	Fentanyl	Methamphetamines	Other _____	

Have you ever attempted suicide? Yes | No

If yes, how many attempts: _____ Date of most recent: _____

LEGAL INFORMATION

Have you ever committed a felony? Yes | No

If yes, please explain: _____

Are you part of any specialized courts? Yes | No

If yes, which court? *DUI, substance abuse, mental health, veterans, etc.*_____

Are you on state or federal parole? Yes | No

If yes, please explain: _____

_____

If yes, your parole officer: _____ Phone: _____

Are you on county probation? Yes | No

If yes, please explain: _____

_____

If yes, your probation officer: _____ Phone: _____

Have you ever been charged with a DUI? Yes | No

If yes, how many times? _____

DUI #1 State: _____ Date: _____

DUI #2 State: _____ Date: _____

DUI #3 State: _____ Date: _____

Are any charges pending against you? Yes | No

If yes, what charges? _____

Are you a registered sex offender? Yes | No

Do you have any assault charges on record? Yes | No

If yes, please explain:

_____

Why do you want to live at the Act Like Men Sobriety House?

_____

_____

_____