The Landing Residency Application

The Warren Coalition

Name:________________________________ Age:_____ DOB:________________________

Email:______________________________________Address:______________________________________

City:_______________________________________ Phone Number:___________________________

Insurance (HMO and Number):____

Is it okay to leave a message? ☐ Yes ☐ No

If No, How should I communicate with you?____

Ethnicity:______________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Never Married

How severe, on a scale of 1-10 (1 being most severe) would you rate your substance use concern/problem?

MOST SEVERE LEAST SEVERE

1 2 3 4 5 6 7 8 9 10

How long have you suffered from a substance use disorder?

1-3 months 4-6 months 6mo.-1 year 1-5 years 5-10 years 10-15 years 15+ years

Employment

Currently Employed? ☐ Yes ☐ No Occupation:_______________________

FOR OFFICE USE ONLY:

☐ **APPROVED**
☐ **DENIED**

"The Landing" by Warren Coalition
200 N. Royal Ave., Front Royal VA, 22630
www.warrencoalition.org
540-636-6385

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Do you require assistance in obtaining a job? ☐ Yes ☐ No

Please explain why you would benefit from Residency at The Landing:

____
____
____
____
____
____
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____

Mental Health History

Please List any Mental Health Diagnosis' and date of Diagnosis:

____
____
____
____
____

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Please list any counseling or psychiatry services you've had in the last 5 years (when, where, and how long):

____
____
____
____
____

Health History

Do you have any health concerns I should be aware of that could be an issue or problem during a session (ex. Seizures)? ____

Who is your primary care physician?_________________________ Located at:_______________

Are you currently taking medications? ☐ Yes ☐ No

If YES, please list those below:

Medication Dosage Frequency

____
____
____
____
____

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Substance Use History

Current or Past history of Substance use? ☐ Yes ☐ No

What is your substance of choice? _______________ Date of Last Use: ____________________________

Do you plan on remaining on MAT treatment, or do you plan to tapper off? _______________________

If you plan to tapper off, when do you plan to do this?____

Legal Involvement

Please indicate by checking below your legal status.

☐ No Involvement ☐ Probation l Length:__________ ☐ Parole l Length:_____________

☐ Charges Pending ☐ Prior Incarceration ☐ Law Suit or Other

Charges:____ PO's Name:________________

Any additional information:____

____

Strengths / Resources /Supports

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What limitations do you have in your recovery/ life?____

Do you need any resources right now?____

Who supports you (emotionally/mentally)?

☐ Parents ☐ Spouse ☐ Significant other ☐ Siblings

☐ Pastor ☐ Family ☐ Friends ☐ Neighbors

☐ Church ☐ School ☐ Therapist ☐ Group Session

☐ Doctor ☐ Other:_______________

What do you feel is your biggest need right now?____

What would you like to gain from 'The Landing'?____

____

Pick three goals that you feel you can accomplish in the next 6-12 months

Goal #1: ____

Goal #2:____

Goal #3:____

What is your plan if you were to begin to develop cravings?____

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____
____
____

What is your plan if you were to relapse?

____
____
____
____
____

Client Signature:____ Date:_______________

Client Name (Printed):____________________________________

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