

The Nest 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
SEVERE

LEAST

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 Nest” by Warren Coalition
200 N. Royal Ave., Front Royal VA, 22630
www.warrencoalition.org
540-636-6385

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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 taper off? _____

If you plan to taper 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: _____

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Strengths / Resources / Supports: _____

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 Nest'? _____

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

Goal #1: _____

Goal #2: _____

Goal #3: _____

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

What is your plan if you were to relapse?

Client Signature: _____ Date: _____

Client Name (Printed): _____

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