FIRST at Blue Ridge, Inc.

Application for Admission

FIRST at Blue Ridge, Inc.
32 Knox Road
Ridgecrest, NC 28770

www.firstinc.org

Important
For this application to be considered, All forms must be filled out COMPLETELY including appropriate signatures (personal, witness, and physician signatures).

Updated 12/3/2015
APPLICATION FOR ADMISSION

Today’s Date __________________________ Name __________________________

Program Applying to:
Short Term (7 - 90 Days) ○ # of days Long Term (1yr) ○ Veteran Program (2yrs) ○

Applicant:
Name ___________________________________________ Age __________

Current Address:
Street __________________________________________
City __________________ State ______ Zip Code ______ Phone _________________

Social Security # ________________________________
DOB ____________ Birthplace ______________________ County ________________
Height _____ Weight _____ Hair Color _______ Eye Color _______ Race _________

Distinguishing Marks (tattoos, scars) ________________________________

Marital Status: Married/Cohabitating ○ Divorced ○ Single/Never Married ○
If married/cohabitating: Spouse’s/Significant other’s name _________________________
If divorced: Date(s) __________________ County ______________ State ________
Do you have children? Yes ○ No ○ If so, how many? ____________
Name ___________________________________________ Age __________
Name ___________________________________________ Age __________
Name ___________________________________________ Age __________
Name ___________________________________________ Age __________
Who are the children living with? ________________________________
Applicant’s parents living? Father ☐  Mother ☐  Still together? ☐
If not, why? ___________________________________________________________

Father’s occupation __________________ Mother’s occupation __________________

Fathers’ Name _________________________________________________________
Address _______________________________________________________________
City ___________________________ State _________ County ____________________

Mothers’ Name _________________________________________________________
Address _______________________________________________________________
City ___________________________ State _________ County ____________________

In case of emergency, notify _____________________________________________
Telephone __________________________ Relationship ___________________________

Referral by:

Name _________________________________________________________________
Street Address _________________________________________________________
City _________________ State _________ Zip Code __________ Phone ____________

Have you ever applied to FIRST, Inc. before? Yes ☐  No ☐
If yes, please list the state(s) and the year(s) you resided there
__________________________________________________________
__________________________________________________________
__________________________________________________________

Do you have a current valid Driver’s License? Yes ☐  No ☐
If yes, what is the Driver’s License number and state issued
__________________________________________________________

If no, please list any outstanding tickets, fines, etc. with the county and state where the
infractions took place _____________________________________________
__________________________________________________________
Military Service

Branch ___________________________ Service Number ___________________________

Type of Discharge __________________ Year ________ Eligible for benefits? Yes ☐ No ☐

Criminal Justice Information

Are you currently incarcerated? Yes ☐ No ☐

If yes, which facility __________________ City _______________ State ______

Expected release date __________________

If not currently incarcerated, are you on probation? Yes ☐ No ☐

County __________________ State _______

*** WHAT IS YOUR PROBATION/PAROLE OFFICER’S NAME? ____________________________

Address ____________________________

Telephone # ________________________ Fax # __________________________

Do you have pending legal actions or outstanding warrants? Yes ☐ No ☐

If yes, please list them by name and date ________________________________

Criminal Justice Information

What is your current offense and status? __________________________________________

________________________________________

If the case(s) have not been disposed of, when is your next court date? ________________

City _______________ State _______ County _______________ Judge ________________

*** ATTORNEY’S NAME ____________________________

ADDRESS ____________________________

CITY ___________________ STATE _______ ZIP CODE __________________

TELEPHONE # ________________________ FAX # ________________________
LIST ALL PRIOR CONVICTIONS

<table>
<thead>
<tr>
<th>Offense</th>
<th>Disposition</th>
<th>Date of Disposition</th>
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EMPLOYMENT INFORMATION

Currently Employed? Yes ☐ No ☐
Employer’s Name ________________________
Previous Employer’s Name/Dates Employed ________________________
Reason no longer there ________________________

FINANCIAL INFORMATION

Outstanding debts (child support, installment loans, IRS, etc.) ________________________

Arrangement for Payments ________________________

Do you own property? Yes ☐ No ☐
If yes, describe ________________________

Do you own an automobile? Yes ☐ No ☐
If yes, describe ________________________

Are you ordered to pay child support? Yes ☐ No ☐
Are you behind? Yes ☐ No ☐
How much? ________________________
Do you receive any ongoing financial reimbursement for any reason? (Such as disability, trust fund, etc.)? Yes○ No○ If yes, explain

__________________________________________________________

**SUBSTANCE ABUSE INFORMATION**

(This information is confidential and will not affect your acceptance into the program)

List in order of preference all drugs used or tried; past or present (This **MUST** be complete)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Age at first use</th>
<th>Amount used at peak</th>
<th>Date of last use</th>
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</table>

Prior drug program (dates completed) __________________________________________

__________________________________________________________

**EDUCATION INFORMATION**

High school graduate/GED? Yes○ No○ Last grade school completed? ________

Difficulty reading? Yes○ No○

Vocational/occupational skills __________________________________________

Special areas of study _________________________________________________

**MEDICAL INFORMATION**

Are you on Medicaid? Yes○ No○

Do you have insurance? Yes○ No○
If “yes” please list your insurance information ________________________________

_______________________________________________________________________

Do you have dental problems? If yes, explain ________________________________

_______________________________________________________________________

List any medical problems ____________________________________________

_______________________________________________________________________

_______________________________________________________________________

Hospital(s) and date(s) ________________________________________________

_______________________________________________________________________

History of:

- Seizures □
- TB □
- Diabetes □
- Hepatitis □
- Heart Disease □
- Epilepsy □

Are you currently on medications? (Prescribed or over-the-counter) Yes o  No o

If yes, please see physicians orders for medications (at the end of the packet)

Are you currently under the care of a physician? Yes o  No o  If yes, list contact info: __________________________________________________________

Reason __________________________________________________________________

Who is paying for and/or providing your medications? _______________________

This party will sign an affirmation that they will pay for the meds.

Have you had a TB test in the past year? Yes o  No o

Positive or negative? ________________________________________________

When is the last time you have had unprotected sex? ______________________

Have you ever been tested for HIV/AIDS, STDs, HEP A,B,C,D? Yes o  No o

Date ______________________ Results __________________________

_______________________________________________________________________

Have you ever been hospitalized and/or treated for any mental health issues? Yes o  No o

Voluntary or Involuntary? _____________________________________________
Hospital(s) and Date(s) ____________________________

_____________________________________________________

Reason/Diagnosis ____________________________

Have you ever been given a mental health diagnosis? Yes ☐ No ☐ If yes, please list your specific diagnosis(es) ____________________________

_____________________________________________________

Have you ever heard voices? Yes ☐ No ☐ if yes, When? ____________________________

Outcome? ____________________________

Have you ever had visual hallucinations? Yes ☐ No ☐ if yes, When? ____________________________

Outcome? ____________________________

Are you currently on any mental health medications? Yes ☐ No ☐

* If yes, please see physicians orders for medications (at the end of the packet)

If yes, what medications are you taking? ____________________________

Who is paying for and/or providing your medications? ____________________________

* This party will sign an affirmation that they will pay for the meds

Have you ever been sexually assaulted? Yes ☐ No ☐ Date____________________

Have you received counseling for this? Yes ☐ No ☐

Are you currently suicidal? Yes ☐ No ☐

Have you tried to commit suicide? Yes ☐ No ☐ If yes, date ______________________

Have you ever overdosed? Yes ☐ No ☐ How many times? ______________________

Circumstances surrounding overdose (when, where, why, etc.) ______________________

Have you ever been a victim of a violent crime? Yes ☐ No ☐

If yes, please explain ____________________________

_____________________________________________________

8
Do you currently have a mental health provider? Yes ☐ No ☐ If yes, please list current provider(s) __________________________

Have you received counseling in the past? Yes ☐ No ☐ If yes, please list past provider(s) __________________________

On a scale of 1 to 10:

(No problem) 1 2 3 4 5 6 7 8 9 10 (very serious problem)

How serious a problem do you think you have with drugs or alcohol?

How motivated are you to make changes in your life at this time? __________________________

AFFIRMATION

I affirm that my answers and information provided by me in this application are true and accurate. I understand that if I am accepted in the program, any misinformation and/or dishonest answer may be grounds for my dismissal from the FIRST at Blue Ridge Program. I also understand that should any other information concerning me arise while I am in the FIRST at Blue Ridge Program that renders me ineligible to continue, I will be discharged.

Signature __________________________________________ Date __________________
# Medical History Form

Name ___________________________ Age _______ Date ____________

Birth Place ___________________________ Birth Date ____________

## Personal History

### Illnesses: Have you ever had?

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>German Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whooping cough</td>
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<td></td>
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<tr>
<td>Scarlet Fever or scarletina</td>
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<tr>
<td>Diptheria</td>
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<tr>
<td>Small pox</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Influenza</td>
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<tr>
<td>Pleurisy</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
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<tr>
<td>Arthritis or Rheumatism</td>
<td></td>
<td></td>
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<tr>
<td>Any bone or joint disease</td>
<td></td>
<td></td>
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<tr>
<td>Neuritis or neuralgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis, Sciatica, Lumbago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio or Meningitis</td>
<td></td>
<td></td>
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<tr>
<td>Nephritis</td>
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<td></td>
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<tr>
<td>Gonorrhea or Syphilis</td>
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<tr>
<td>Gallbladder disease</td>
<td></td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Jaundice</td>
<td></td>
<td></td>
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<tr>
<td>Condition</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Bladder Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Migraine headaches</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cancer</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>High or low blood pressure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Colitis or bowel disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hemorrhoids, rectal disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nervous breakdown</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Food poisoning</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chemical or drug poisoning</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hay fever or asthma</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hives or Eczema</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Frequent infections or boils</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Any other disease</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Ever been unconscious   Yes  No

Have you ever been advised to have any surgical operation which has not been done?   Yes  No

WEIGHT:

Now __________ one year ago __________

Maximum _______ when? ____________

Have you been hospitalized for any illness?   Yes  No

Have you had any seizures   Yes  No

Details _____________________________

_______________________________

_______________________________

_______________________________

TRANSFUSIONS: Have you ever had?

Blood, plasma transfusions   Yes  No

Used IV Drugs   Yes  No

SURGERY: Have you had?

Tonsillectomy   Yes  No

Appendectomy   Yes  No

Any other operation   Yes  No

Type ___________________ year __________

Type ___________________ year __________

Type ___________________ year __________
FIRST at Blue Ridge, Inc.

Information for Applicants

- No violence, threats of violence or use of drugs/alcohol will be tolerated at the FIRST program.
- You will be discharged and the proper authorities will be notified.
- The preppie phase will last 30 days or until initial treatment plan goals have been met, depending on how you work the program. During the preppie phase, between the hours of 6:30 AM – 9:30 PM, clients will be scheduled a variety of activities including educational classes, group therapy, 12-step meetings, work assignments, chores etc.
- During the first 30 days, you are allowed 1 brief phone call to family upon arrival. After preppie phase, three 15 minute phone calls to approved numbers are allowed per week.
- After the preppie phase, residents can earn a day pass every 30 days.
- You may be eligible to go on a home visit after (90) days for 4 days and 3 nights, depending on how well you are doing in the program.
- Do not bring cash. However, credit cards and debit cards are okay, but will be stored in the administrative office, not kept on the client.
- Do not bring computers, cell phones, TVs, stereos, weapons, pornography, and clothing with alcohol/drug symbols or profanity.
- Do not bring any tight fitting or revealing clothing.
- All clients will receive a work assignment after completion of the preppie phase in order to help support the House. These will be based upon client skills, House needs and other criteria.
- You must use the chain of command if you have any questions. If you need anything, ask your Peer Leader or House Manager.
- Be humble and do what is asked of you. If you have a problem with something you are asked, do it anyway and then follow the chain of command in order to let someone know how you feel about what you were asked to do.

By signing below, you are confirming that you have been made aware of these rules during the Application process, and if accepted into the program, agree to abide by them.

Applicant’s signature_________________________________ Date __________________
FIRST at Blue Ridge, Inc.

AUTHORIZATION TO RELEASE INFORMATION
(CRIMINAL JUSTICE SYSTEM REFERRALS)

Resident’s Name __________________________________ authorize the following:

Name of program which is to exchange information:

FIRST at Blue Ridge, Inc.
P.O. Box 40
32 Knox Rd.
Ridgecrest, NC 28770

Name or title of the person(s) or organization(s) with which the disclosure is to be made:

Court having jurisdiction over the resident
Probation and/or parole officers or their agencies
TASC referral units
Prosecuting attorney withholding charges against the resident
Defense attorney
Department of Social Services and/or its agents

Purpose or Need for the Disclosure:

For assessment and treatment planning; to monitor progress in treatment and compliance with conditions of referral

Extent or Nature of Information to be Exchanged:

Any and all pertinent information contained in files

This consent is subject to revocation at any time except to the extent that FIRST, Inc. has already taken action in reliance on it. If not previously revoked, this consent will terminate three hundred sixty-five (365) days after termination of treatment.

Signature of Resident ________________________________ Date _________________

Signature of Witness ________________________________ Date _________________
FIRST at Blue Ridge, Inc.

AUTHORIZATION TO RELEASE INFORMATION

(GENERAL CONSENT)

Resident’s Name ________________________________ authorize the following:

Name of program which is to exchange information:

FIRST at Blue Ridge, Inc.
P.O. Box 40
32 Knox Rd.
Ridgecrest, NC 28770

Name or title of the person(s) or organization(s) with which the disclosure is to be made:

Family and significant others of resident; employers and potential employers; funding sources; the Department of Social Services; psychiatric, medical, or treatment personnel; Social Security Administration; Food Stamp offices.

Purpose or Need for the Disclosure:

In order to provide relevant information as to resident’s treatment status or progress and for follow-up investigation.

Extent or Nature of Information to be Exchanged:

Only such information as is reasonable and necessary for the particular circumstance.

This consent is subject to revocation at any time except to the extent that FIRST, Inc. has already taken action in reliance on it. If not previously revoked, this consent will terminate three hundred sixty-five (365) days after termination of treatment.

Signature of Resident ________________________________ Date ________________

Signature of Witness ________________________________ Date ________________
AGREEMENT TO ACCEPT TREATMENT AT FIRST AT BLUE RIDGE

I, ______________________________ (print name), acknowledge and agree to each of the following:

As a client and participant in the long-term treatment program offered at FIRST at Blue Ridge, I am expected to participate in work therapy assignments under the direction of FIRST staff and its community partners. I understand this means that any and all situations where my ability to participate in work therapy as directed is compromised or otherwise affected may conflict with FIRST’s goals for my long-term treatment, and therefore such situations require FIRST’s reconsideration as to my appropriateness for the program.

_______________________ (initial and date)

Such situations include, but are not limited to: recommendation for Intensive Outpatient Programs, medical diagnosis that affect my ability to participate in work therapy, changes in medication that affect my ability to participate in work therapy, prescriptions for medications that are not allowed in the FIRST program, operations and surgery that affect my ability to participate in work therapy, and recommendations for treatment that conflict with, or are contrary to, FIRST’s recommendations for treatment.

_______________________ (initial and date)

I understand and agree that FIRST makes every effort to assist with transition planning for its clients, and that my acceptance and pursuit of other treatment recommendations may mean that my transition would best be handled by those making such recommendations. This includes, but is not limited to, other agencies and their personnel, family, friends, doctors, and other medical providers.

_______________________ (initial and date)

By signing and dating below, I am acknowledging and agreeing to the above and confirming that I desire the treatment provided by FIRST at Blue Ridge.

_____________________________________________ (sign name)

_____________________________________________ (date)

_____________________________________________ (witness to the agreement)
FIRST at Blue Ridge, Inc.

PHYSICIAN ORDERS

Client: ______________________    ___________________    _______
          Last Name    First Name   Middle Initial

Allergies (Food, Drugs, Etc.):

**PRESCRIBED MEDICATION**: List **ALL** medication prescribed by Medical Professionals **INCLUDING** ALL OVER THE COUNTER ITEMS. Sample Medications should be dated & marked by Physician.

Clients **MUST** have a 30 day supply and **AT LEAST** a 90 day refill in order to gain acceptance into our program.

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication Name</th>
<th>Strength</th>
<th>Administration Directions</th>
<th>Quantity</th>
<th># of Refills</th>
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______________________________________    ______________________________________
Physician Signature                                                         Physician Print

☆ Even if not on prescription medications ALL forms must be signed. ☆
Medication Self Administration/Self Possession Authorization

Self-administration means _______________________________ (the client) can administer his/her medication in a manner directed by their physician without additional direction or supervision by FIRST at Blue Ridge Inc staff. Self-possession means that under the direction of the physician, the client may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, topical creams, patches and sprays, only that day's supply (24 hours) of medication is to be carried. FIRST at Blue Ridge Inc recommends that spare medication, properly labeled in its original container, to be kept in the FIRST at Blue Ridge Medical Office.

The client agrees to:

1. Never share his/her medication with another person
2. Carry the medication in a responsible manner so as not to lose it
3. Take medication only at the prescribed/frequency and dose
4. Keep a copy of this form and back up medication in the FIRST at Blue Ridge Inc Medical Office

If the client fails to meet any of the agreements listed above, FIRST at Blue Ridge Inc may discontinue the Self-Administration/Self-Possession privilege without notice. If FIRST at Blue Ridge Inc revokes the Self-Administration/Self-Possession privilege, client may be discharged from the program.

Physician’s Printed Name ______________________

Physician’s Signature ______________________ Date _______________

Client’s Signature ______________________ Date _______________
OVER THE COUNTER MEDICATION FORM

Client/Patient Name: ___________________________ DOB: ______________

STANDING ORDERS FOR OVER THE COUNTER MEDICATIONS

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>TREATMENT GOALS</th>
<th>STRENGTH</th>
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</thead>
<tbody>
<tr>
<td>Allergy and Cold Preparations</td>
<td>For relief of allergy or cold symptoms</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Kaopectate concentrate or Generic</td>
<td>For relief of loose bowel movements</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Milk of Magnesia or Generic</td>
<td>For relief of Constipation</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Tylenol or Generic</td>
<td>For relief of minor aches &amp; pains, and /or fever</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Ibuprofen or Generic</td>
<td>For relief of minor aches &amp; pains, and /or fever</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Benadryl or Generic</td>
<td>For relief of allergy symptoms</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Multivitamin and Nutrition Supplements</td>
<td>Food Supplement</td>
<td>As dispensed OTC</td>
</tr>
<tr>
<td>Cough and Cold preparation</td>
<td>For relief of cold and cough symptoms</td>
<td>As dispensed OTC</td>
</tr>
</tbody>
</table>

Comments:

Read Carefully:
By my signature below, I acknowledge that during my participation in the First at Blue Ridge, Inc. residential treatment program, I will take only take those over-the-counter medications listed above. Further, I agree only to take recommended doses and for the indicated uses on the over-the-counter medication packages. I recognize that it is my responsibility to review the package information, with each dose taken, for any potential adverse interactions and contraindications to my use. Further, I hereby agree to hold First at Blue Ridge Inc., and the healthcare provider listed below harmless if I take any over the counter medication not listed above or outside the parameters of recommended dosages, uses and warnings or contraindications.

_____________________________  ____________________________  Date ______________________
Physician Signature                                                  Physician Print

Client’s signature ________________________________________  ______________________

☆ Even if not on prescription medications ALL forms must be signed. ☆
Outline for Applicant’s Autobiography

“We admitted we were powerless over our addiction and that our lives had become unmanageable”

It would be impossible to over-estimate the importance of being thoroughly and completely honest with yourself and others. Each client is required to write an autobiography including a history of their substance use, mental health issues, and goals for treatment and recovery.

Issues to be covered in your autobiography are:

1. Describe your substance use history including what and how long you have used.
2. Have you ever been in the hospital for mental health reasons? Explain in detail.
3. Have you ever tried to commit suicide?
4. Discuss any mental health issues including diagnoses and history.
5. List what meds you are taking and why.
6. Describe your present situation – be specific as possible.
7. Why do you want to be admitted to FIRST?
8. Discuss specific changes you want to make in your life.
9. What goals do you want to achieve while at FIRST?
10. What are your goals for recovery?
11. How will you contribute to the program and your fellow residents?

Length: Your personal autobiography should be at least 3 to 4 pages in length, and should be neatly written or typed in chronological order as to how and when events occurred. Please do not write over 6 pages.

This autobiography is CONFIDENTIAL. At your request, it will be returned to you at time of discharge. This autobiography will help us determine if you are appropriate for our program and how we may best serve you.