



***This section is about your educational background.***

High School Attended: \_\_\_\_\_ City/State: \_\_\_\_\_  
College or Vocational Training: \_\_\_\_\_ City/State: \_\_\_\_\_  
Last Grade Completed: \_\_\_\_\_ General Course of Study: \_\_\_\_\_  
Do you wish to Complete:        Y        N        Can you read:        Y        N        Can you write:        Y        N  
Do you have any documented Learning Disabilities: Y        N        If yes, List: \_\_\_\_\_

***This section is about any military background.***

Have you ever served in the Armed Forces: Y        N        Branch: \_\_\_\_\_  
Dates of Service: \_\_\_\_\_  
Rank: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_  
Are you eligible for VA benefits: Y        N        Have you used benefits before: Y        N

***This section is about any previous treatment you have had in the past. Attach extra sheets, if necessary.***

Treatment Center: \_\_\_\_\_ Phone: \_\_\_\_\_  
Counselor: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
Patient Number: \_\_\_\_\_ Aftercare: \_\_\_\_\_

Treatment Center: \_\_\_\_\_ Phone: \_\_\_\_\_  
Counselor: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
Patient Number: \_\_\_\_\_ Aftercare: \_\_\_\_\_

Treatment Center: \_\_\_\_\_ Phone: \_\_\_\_\_  
Counselor: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
Patient Number: \_\_\_\_\_ Aftercare: \_\_\_\_\_

Treatment Center: \_\_\_\_\_ Phone: \_\_\_\_\_  
Counselor: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
Patient Number: \_\_\_\_\_ Aftercare: \_\_\_\_\_



*This section is about any previous medical and psychiatric diagnoses you have been given. If you are on medication give the name of the medication, daily doses, doctor's name and directions for use.*

Disorders other than addiction: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a recent skin test or chest x-ray for Tuberculosis within the past 6 months? :           Y       N

Have you had a recent R.P.R. blood test for Syphilis within the past 6 months? :           Y       N

***Both TB and RPR are required by the State of Georgia prior to admission to Alpha Recovery Centers. Make arrangements for having the results of these tests sent to Alpha Recovery Centers on or before the date of admission. If you answered no to either of these questions you must schedule an appointment with a doctor or your local health department to obtain these tests. No client will be admitted to Alpha Recovery Centers without these test results. You may have the results sent by mail or fax to the address or number listed below, or you may hand deliver the results on the day of admission:***

**ATLANTA**  
Alpha Recovery Centers  
P. O. Box 501608  
Atlanta, GA 31150  
(770) 587-0807 [FAX]

**BRUNSWICK**  
Alpha Recovery Centers  
10 Alpha Circle  
Brunswick, GA 31525  
(912) 554-2031 [FAX]

Current Medications being used: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever attempted suicide:   Y    N    If yes, when and how: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***This section is about your driving privileges. You must provide a photocopy of a valid license and proof of insurance in order to bring a vehicle to Alpha facilities.***

Do you have a vehicle available for your use:   Y    N    (Circle No if your license is suspended or revoked)

If yes,   Year: \_\_\_\_\_   Make: \_\_\_\_\_   Model: \_\_\_\_\_

Insurance Company: \_\_\_\_\_   Policy Number: \_\_\_\_\_

License Status:   Valid                   Suspended                   Revoked

License # \_\_\_\_\_                   State of Issue: \_\_\_\_\_



