Simply Grace Application

Simply Grace Counseling Center ATT: Admissions
580 W Arapaho Rd STE 208
Richardson, TX 75080
Call 214-774-9808 with any questions.

Please email the application to: brehn@simplygracehouse.com **Please complete all questions below.**

Date Submitted: **Submitted by:**

Client Information

Name: **Gender/Gender Identity:**
DOB: **Age:** **SSN:**
Address: **City/State/Zip:**
Mobile Ph.: **Email:**
Expect to Enroll:
Ethnicity: **Race:**
Height: **Weight:**
School Grade: **Religious Pref:**

Parent/Guardian/Sponsor Information

Parent/Guardian/Sponsor: (PRIMARY CONTACT)
Name: **Relationship:**
Address: **Home Phone:**
Mobile Phone: **Email:**
Contact Method:

Sponsor Name: **Phone:**
Preferred Email:

Emerg. Contact: *(if different from above)*

Referral Information

How did you first hear about Simply Grace?
Briefly describe the relationship between this person and the applicant:

Please give the name(s) of the referral source including phone, fax number and email:
Name: **Phone:** **Fax:** **Email:**
Can we Contact? Yes/No
Reason for referral: Chief complaint and symptoms *(please be very specific including issues at home and school as well as any symptoms noticed such as mood changes, etc.)*

Financial and Logistics

I will have Transportation YES/NO
I will be financially responsible for my program fees YES/NO
I will have support from family/other for my program fees YES/NO
I will be enrolled in a form of higher education YES/NO
I am employed YES/NO

Recovery Information

I am a recovering alcoholic YES/NO **I am a recovering drug addict** YES/NO
I am planning to attend an aftercare program YES/NO **I am planning to attend an IOP program** YES/NO
I am planning to attend 90 days of meetings YES/NO
Sobriety Date:
Are you discharging from a substance abuse program? YES/NO
If yes, list the facility name, address, counselor, and phone number:

Previous Treatment:

Medical History

Please list all allergies and medical restrictions:

Do you take prescription drugs? YES/NO
If yes, list the prescribed drugs, the reason, the prescribing doctor, and the frequency of doses. Remember, Simply Grace does not allow controlled substances of any type on the property.

Medications*:*

Please list all allergies and medical restrictions: (circle one)
Food allergies? yes/no ***If yes, please explain:***

Weight loss or gain of 10 pounds or more in the last 3 months? yes/no

If yes, please explain:

Decrease in food intake and/or appetite? yes/no ***If yes, please explain:***

Dental problems? yes/no ***If yes, please explain:***

Eating habits or behaviors that may be indicators of an eating disorder, such as binging or inducing vomiting?

yes/no If yes, please explain:

Are you currently experiencing any pain? yes/no ***If yes, please answer the below questions*.**

1. Pain Intensity

Please rate the severity of your pain: On a scale of 0 to 10, where 0 = No pain 10 = Worst possible pain

Current pain intensity: Worst pain in the last 24 hours: Least pain in the last 24 hours:

2. Pain Location

3. Pain Description

Please describe your pain using the following terms: ***sharp, dull, aching, burning, throbbing, stabbing, radiating, cramping, tingling, stiffness***

Other:

4. Pain Duration-When did your pain start?

How long does the pain last? (Circle all that apply)

Constant, Comes and goes, Lasts for a few minutes, Lasts for several hours
Other:

5. Pain Triggers
What seems to trigger or worsen your pain? (Circle all that apply)

Movement, Activity, Temperature(heat/cold), Stress, Specific positions, Lifting or bending, Eating or digestion, Resting

Other:

6. Pain Relief
What helps to relieve or decrease your pain? (Circle all that apply)

Rest, Heat therapy, Cold therapy, Massage, Stretching, Relaxation techniques, Physical therapy

7. Impact on Daily Activities
Please rate how much your pain affects the following activities:

Work or School, Household Chores, Socializing with Friends/Family, Sleeping, Exercising/Physical Activity Eating

8. Additional Comments
Please provide any other details about your pain or how it impacts your life:

Legal History

Do you have any pending court cases other than moving violations? YES/NO
If yes, explain: (bond, probation, pending court case)

Have you ever been convicted of a felony? YES/NO
If, yes please explain.

Have you ever been accused or convicted of a sexual offense? YES/NO
If, yes please explain.

Insurance Information

Primary Insurance Company:
Address:
Benefits Phone:
Policy Number:
Policyholder's Name:

Secondary Insurance Company ***(if you have secondary)***
Date of Birth: