WAY MAKER RECOVERY
Resident Evaluation

Date: _____

Name:

_____

DOB _____Age: _____

Gender (Male, Female, Non-binary, Other):

_____

Referral Source: _____ Entry Date:

Co-occurring Diagnosis: _____

Prior Treatment(s):_____

Recovery Residence History: _____

Substances with history of use: _____ Any IV Opiate Use: Y N

Recovery time:

_____ Medications:

_____ History of

Self-Harm (Y/N, if yes, describe): _____ Recent

Suicidal ideation Homicidal ideation (Y/N, if yes, describe): _____

Relationship Status: _____ Children (Y/N, age?): _____

Work Experience/Plan:

_____

Parent/Family Support (if applicable):
_____ Location:
_____

TB Test: Y N (Must bring or have copy of results)

Fees Discussed: Y N $125.00/wk .

Ever been arrested, convicted, or questioned for any violent or sexual crimes:

Any outstanding warrants: Y/N

Legal Issues:

_____

___ Are you legally mandated to be here? Y N Legal Charge?

_____ Vehicle: Y/N Valid License: Y/N Drug

Screens Discussed: Y/N