New Beginnings Adolescent Recovery Center
1649 Linwood Loop, Opelousas, LA 70570
Ph: 337-942-1171 Fax: 337-948-9101

Admission Form

Client Full Name:_____ Date of Birth: _____

Address: _____City_____State_____Zip_____

Social Security Number: _____ *(please provide copy of card if available)*

Insurance Information: (Please have copy of card available)

Company: _____ Policy Number: _____
Phone number for MH/ Substance Abuse Benefits: _____
Policy Holder: _____ Policy Holder Date of Birth: _____
Address associated with Policy: _____
City_____State_____Zip_____
Policy Holder Employer: _____
Policy Holder Social Security Number: _____

Client's parent / legal guardian / adoptive parents:

Mother: _____ Date of Birth: _____
Home Address: _____ City_____ State_____Zip_____
Phone number: _____ Email Address: _____
Social Security Number: _____ Employer: _____
Father: _____ Date of Birth: _____
Home Address: _____ City_____ State_____Zip_____
Phone number: _____ Email Address: _____
Social Security Number: _____ Employer: _____

Client's current or previous counselor / psychiatrist / psychologist:

Name: _____ Phone number: _____
How long: _____ Last Visit: _____
Name: _____ Phone number: _____
How long: _____ Last Visit: _____
Name: _____ Phone number: _____
How long: _____ Last Visit: _____

List of medication client currently prescribed:

Name: _____ Dosage: _____ Frequency: _____
Prescribing Dr: _____ Last Visit: _____
Compliant with meds: ☐ yes ☐ no Last taken: _____
Name: _____ Dosage: _____ Frequency: _____
Prescribing Dr: _____ Last Visit: _____
Compliant with meds: ☐ yes ☐ no Last taken: _____

Client's current school: _____Grade: _____ Status: _____
Guidance Counselor Name: _____ Number: _____

Legal consequences:

Arrests / Charges: _____

_____

_____

_____

Probation Officer Name: _____ Phone Number: _____

Upcoming Court Date/s and Location:_____

_____

_____

Attorney Name: _____ Phone Number: _____

Previous treatment:

Name of Facility: _____

Type of Treatment: ☐ Acute Care Psych ☐ Inpatient ☐ Intensive Outpatient

Dates of Admission: _____ Date of Discharge:_____

Recommendations for aftercare from that facility: _____

_____

_____

Were recommendations followed by family and client: _____

_____

_____

Name of Facility: _____

Type of Treatment: ☐ Acute Care Psych ☐ Inpatient ☐ Intensive Outpatient

Dates of Admission: _____ Date of Discharge:_____

Recommendations for aftercare from that facility: _____

_____

_____

Were recommendations followed by family and client: _____

_____

_____

Precipitating event that led to seeking treatment this time:

_____

_____

_____

_____

_____

_____

_____

How did you hear about New Beginnings?

_____

_____

How much involvement do you want your referral source to have?

_____

_____

Please check all documentation that will be provided for admission:

- ☐ Insurance Card
- ☐ Separate Prescription Coverage
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Immunization Records
- ☐ Court Order stating custody / guardianship
- ☐ Records from Previous facility