friends for recovery center

Enrollment Form

In order to participate in the Friends for Recovery Drop-In Center please provide the following information. All information is for our records and will not be shared without your consent.

Name_____ Sex _____ Date of Birth_____

Address_____City_____Zip_____

 Home # (_____)_____ Cell # (_____)_____

Emergency Contact
Name_____ Address _____

Phone # (_____)_____

List ALL food and Drug Allergies _____

* Please circle yes or no on the following:

Do you have Medicaid?   YES   NO

Do you have a Primary Care Physician?   YES   NO

Physician Name _____ Clinic_____ Phone # _____

Do you have a Mental Health Services Case Worker?   YES   NO

Do you have Transportation?   YES   NO

* Do you have any criminal sexual conduct charges?   YES   NO

(This is notification that Drop-in Center is located in close proximity to school grounds)

**2720 W. Genesee
Saginaw, MI 48602
Phone # (989) 401-7588
Fax #(989)401-5574**

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My FFRC Wellness Goals:		**PCP Date:**	
+ Emotional	+Financial	+ Social	+Environmental
+ Occupational	+Physical	+ Intellectual	+Spiritual

How many days a week do you plan on coming to the Friends for Recovery Center?

1   2   3   4   5   not sure

What goals do you want to achieve by attending Friends for Recovery Center?
Answer this question by circling Yes, No or Maybe with the following, to help address your goals.

I would like to work on my socialization skills by making new friends and visiting with people:

Yes   No   Maybe

I would like to become healthier, exercise more and learn about nutrition:

Yes   No   Maybe

I want to learn how to better manage money and finances:

Yes   No   Maybe

I am interested in gaining new job skills or working:

Yes   No   Maybe

I would like to learn how to cope with my emotions and life situations:

Yes   No   Maybe

I am interested in getting my G.E.D., going to college or gaining computer skills.

Yes   No   Maybe

CSM Name _____ Agency _____ Phone#_____
[Print]

Participant Signature_____Date_____