HOPE RESCUE MISSION
Grace House
Women's Recovery Home

Helping | Restoring | Transforming

PO Box 306 — Missoula, MT — 59806

Please answer every question. If the question does not apply to you, write N/A for that section. Our desire is to screen in and not to screen out. Please be completely honest in your answers as it will help us to serve you best.

Our mission is to serve, rescue and transform those in the greatest need by the grace of Jesus Christ.

PARTICIPANT APPLICATION FORM

Today's Date:

Name: Phone/Message #:

Address: Age: DOB:

Email Address:

Marital Status: □Single □Married □Divorced □Widowed □Separated □Common Law

Spouse/Partner Name: Age: DOB:

Emergency Contact: Phone # Relationship to

Other Agencies that you are involved with

Include Agencies such as CPS, Counselor, SNAP, SS, WIC, TANF, DSHS, Medicaid, Sect 8, Public Health, etc.

Agency	Contact Person / Phone #	Agency	Contact Person / Phone #

Transportation

What is your current method of transportation?

☐ Walking ☐ Special Mobility

☐ Friends/Family: ☐ Car ☐ City Bus ☐ Other:

If you have a working car:

Make:	Model:	Color:	Year:	License Plate	Insurance Carrier	Phone # of Carrier:

Finances

Are you receiving public assistance? (SSI, DISABILITY, WELFARE, QUEST, CHILD SUPPORT) Yes No

Are you in the process of applying for public assistance? Yes No

Please list all sources of income you currently receive & amount(public assistance, job, unemployment, financial aid, etc)

Savings:

Please list monthly bills/expenses and any outstanding debts that you owe (bills, fines, child support, etc.:

Belongings

Do you have belongings in storage somewhere? Yes No

If yes, describe what kinds of items you have stored, where they are stored and if there is a cost to store them:

Basic Needs

While at the Women and Children's Center (WCC), your basic needs for shelter and food will be provided for. Please list any ot basic needs you may currently have (clothing, hygiene, social service, spiritual, etc

Addictions

Directions: Answer each of the following questions as truthfully as possible. Do not skip questions or leave any blank. If you're working on something other than drugs or alcohol, simply exchange terms throughout this assessment. For example: describe your eating problem in the past.

Describe your drinking pattern in the past:

What is your typical drinking pattern? ☐ Daily ☐ Occasionally ☐ Binges

What was your longest period of sobriety in the past year?

What was your longest period of sobriety ever?

At what age did you take your first drink?

How long has drinking been a problem for you?

When was the last time you drank?_____

Describe your pattern of drug use in the last 30 days:___
_____
_____
_____
_____
_____
How long since you've used a drug other than alcohol?_____
How long has using drugs been a problem for you?_____
What did you use and how much?_____
_____

_____

Specific Drugs Used

Instructions: Fill in the chart below. Be as specific as you can:

DRUGS USED (Please answer the following questions for each drug listed below)

MARIJUANA
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

OPIATES/HEROINE
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

COCAINE
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

AMPHETAMINES
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

BARBITURATES
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

TRANQUILIZERS
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

INHALANTS
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

OVER THE COUNTER
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

PRESCRIPTION
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

METHADONE
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

CAFFEINE
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

NICOTINE
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

METH
Age Started? _____
Age Stopped? _____
Amount/Frequency?_____
How Administered?_____

List other compulsive problems (e.g. food, relationships, work, sex, etc.): _____

_____

Do you believe you're addicted to alcohol or drugs? ☐ Yes ☐ No ☐ Unsure
Please explain:_____

How many times have you made serious attempts to stay sober/clean? Circle your answer:
None (0) One (1) Two (2) Three (3) Four (4) Five (5) More than five (6+)

What's the longest period of time you've been able to stay sober/clean? Circle your answer:
I've never tried long-term abstinence (0) Less than four weeks (-4) Four weeks (4) Six weeks (6)

Twelve weeks or more (12+)

How many times have you been admitted for detoxification from alcohol and/or drugs?
Circle your answer:
None (0) One (1) Two (2) Three (3) Four (4) Five (5) More than five (6+)

Recovery Programs

List the recovery programs in which you have been:

Facility:	City/State:	in-patient or out: (circle)		Dates:	Treatment Completed
		in	out		□ yes □ no
		in	out		□ yes □ no
		in	out		□ yes □ no
		in	out		□ yes □ no

What has been most helpful in your past recovery attempts? Circle the letters:

a. Twelve-Step Program b. Church / Religion c. Friends d. Family e. Other

Do you currently have a Twelve-Step Sponsor? ☐ Yes ☐ No
If yes, Name:_____ Phone:_____

Briefly, what do you think has been missing in your past recovery attempts? _____

When were you most actively involved in your recovery?_____

How many recovery group (A.A., N.A., etc.) meetings did you attend during an average week?

Choose the statement that best describes how strongly you believe that you are addicted:
☐ Totally convinced ☐ Mostly convinced ☐ Partially convinced ☐ Not convinced

Are you currently in recovery and experiencing pain, or having a hard time staying abstinent?

- ❑ Yes, and I think I might relapse soon.
- ❑ Yes, but I'm not in any immediate danger of relapse. I just want to lower my risk.
- ❑ No, I'm not experiencing any pain or trouble functioning and I'm not worried about the immediate risk of relapse.

Legal Status

Are you currently involved in any of the following legal matters? ☐ Yes ☐ No If yes, which?

☐ Probation ☐ Parole ☐ Divorce Proceedings ☐ Civil Proceedings ☐ Child care custody

☐ Drinking driver program ☐ Assault charges ☐ Other _____

Do you have a court appearance pending? ☐ Yes ☐ No If yes, when / where?_____

_____

_____

How much time have you spent in: Prison: _____ Jail:_____

_____

List all prior convictions**:**

Conviction:	Date(s):	Time Served:

Parole / Probation Officer's Name:_____ Phone: _____

How often do you report? _____

Developmental History

Specific life events and traumas

- _____
- _____
- _____
- _____
- _____

Medical History

Height: _____ Weight: _____ Date / year of last physical:_____

Currently over / under weight? ☐ Yes ☐ No (+)_____ (-) _____

Have you ever had control problems with food? ☐Yes ☐ No If Yes, Explain:_____

_____

_____

Describe past and present physical health (include hospitalizations, and major accidents or illnesses): _____

_____

_____

_____

_____Number of pregnancies_____: Live Births_____ Miscarriages_____ Abortions_____

We require residents to do 10-15 hours' worth of chores weekly. Is there any reason you would not be able to participate in the chore system? ☐Yes ☐ No If Yes, Explain: _____

Are you currently under the care of: ☐ Physician ☐ Psychiatrist / Psychologist ☐ Therapist
Other?_____

If so, may we contact them? ☐ Yes ☐ No

Doctor:	Address:
Phone #	Diagnosis:
Prescribed Medications:	
Doctor:	Address:
Phone #	Diagnosis:
Prescribed Medications:	
Doctor:	Address:
Phone #	Diagnosis:
Prescribed Medications:	

Have you ever had a psychological evaluation? Yes or No If yes, what year?_____
What were the results/diagnosis?_____

If so, who was the Psychiatrist who administered the test?_____

Describe any family history of mental illness, alcohol / drug abuse, etc.

Medications

Prescription Medications you are currently taking & Dosage:	Purpose:	Prescribing Doctor:	Doctor's Phone #

Please list any non-prescription medications you are currently taking :

Do you have allergies to penicillin, other antibiotics, aspirin, codeine, morphine, bee stings, or any other drugs, or food, etc.?

List allergies and types of reactions you have. _____

_____

_____

Date of last TB test: _____Result: ☐ Pos. ☐ Neg.
Date of last AIDS test: _____Result: ☐ Pos. ☐ Neg.
Date of last Hepatitis test:_____Result: ☐ Pos. ☐ Neg.

General Medical Symptom

Please check any current medical concerns you have

_____ trouble sleeping
_____ loss of appetite
_____ eye/vision problems

_____ frequent headaches/ pains
_____ allergies
_____ blood in stool
_____ tremors

_____ high blood pressure
_____ rapid weight gain/loss
_____ diarrhea/ constipation

_____ sexual problems
_____ stomach problems/ ulcers
_____ liver problems
_____diabetes

Other Symptoms

Circle the numbers of the following withdrawal symptoms that you are currently experiencing:
1. Confusion **2.** Memory difficulty **3.** Mood swings **4.** Clumsiness **5.** Obsessions, thoughts or urges to use
6. Sleep disturbance a) too much b) too little **7.** Anxiety, or panic attacks **8**. Depression **9.** Stress
10. Suicidal thoughts

How many suicide attempts have you made?_____ Dates? _____ What method have you used?
(example: pills, alcohol, weapons, cutting self) _____

_____

Do you have health/medical insurance? ☐ No ☐ Yes: Type: _____

Relationships

Describe your relationship with your family of origin? (mother, father, siblings_____

_____

_____

_____

What is your current relationship with your family? (husband, ex, children) Explain: _____

_____

_____

_____

Do you have current friends you can count on and are healthy? If so, whom? _____

_____

_____

_____

Are you currently involved in a romantic relationship? ☐ Yes ☐ No
If yes describe your relationship with your significant other: _____

_____

_____

Have you ever had a problem with pornography, fantasy, chronic masturbation or prostitution? ☐ Yes ☐ No
Explain: _____

Child Information

Do you have any children living with you? ☐ YES ☐ NO
List all of your children: Check the last box if the child would be living w/ you at WCC:

Name of child (Last, First)	DOB	Gender	SS#	Father's Name	Custody?	WCC?

Would any of your children not currently living with you be joining you at CWC at a later time? _____
If yes, please explain circumstances and estimated time they would be joining you: _____
_____
_____

If you are pregnant, how many months?_____ What is the due date?_____
Do your children have health/medical insurance? ☐ No ☐ Yes, Type: _____
Is the father involved with the children? ☐ Yes ☐ No Is he safe? ☐ Yes ☐ No
Do your children have a healthy relationship with their father? ☐ Yes ☐ No
Do your children have a healthy relationship with each other? ☐ Yes ☐ No
If you answered NO to any of these questions, please elaborate: _____
_____

School-Age Children

Child	School your child attends?	How long at current school?	grade	Does your child enjoy school?	How does your child get to school?

Do any of your children have health concerns or physical limitations? ☐ Yes ☐ No
If yes, please elaborate: _____
_____

Do any of your children have behavioral challenges we should be aware of? ☐ Yes ☐ No
If yes, please elaborate: _____
_____
_____
_____What is your child/children's response to being separated from you? _____
_____
_____

Are any of your children on medications? ☐ Yes ☐ No If yes, please elaborate: _____
_____
_____

_____***Be prepared to provide up-to-date immunization records for each child living with you**

Spiritual Background

Did you attend church or participate in a religious activity as a child? ☐ Yes ☐ No

If yes, how many years? _____ How often? ☐ Seldom ☐ Occasionally ☐ Regularly

☐ Denomination: _____ Were you baptized? ☐ Yes ☐ No

Other information about your childhood experiences with Church, religion, or God?_____

_____

_____

What is your current relationship with God? _____

_____

_____

_____

Current trust level with God (Rate between 0-5, 0 being the lowest and 5 the highest): _____

Are you currently attending church? ☐ Yes ☐ No If yes, please give the following:

Name of church: _____

Pastor's name:_____

How are you involved (Bible studies, children's ministry etc.)?: _____

_____

Describe your current spiritual beliefs: _____

_____

What part does God play in your life / recovery plan? _____

_____

_____

What recent changes have you had in your religious life (if any)? _____

_____

_____

_____

Employment History

List previous employment: _____

_____

_____

_____

_____

List your ambitions: _____

_____

_____

_____

What are your hobbies? _____

_____

_____

_____

Education

Highest grade level completed: _____ Do you have a GED or diploma? _____ Year completed / attained: _____

List any schooling or special training you have:_____

_____

_____

Recovery

What is the major problem that caused you to seek help at this time? _____

_____

_____

_____

How is the problem related to your addictions? _____

_____

_____

_____

What do you need to do differently this time for your recovery to be successful? _____

_____

_____

_____

Goals

Write a description of your short and long-term goals, and what you will need to reach them: _____

_____

_____

_____

REFERENCES- Please list 3 personal references below.

1. Name_____
   Phone Number _____
   Email _____

2. Name_____
   Phone Number _____
   Email _____

3. Name_____
   Phone Number _____
   Email _____

Have you ever been diagnosed with any of the following? These will <u>NOT</u> Exclude you from entering our program.

☐ Schizophrenia, paranoid type

- ☐ Schizophrenia, Disorganized Type
- ☐ Schizophrenia, Catatonic type
- ☐ Schizoaffective Disorder
- ☐ Schizoaffective Disorder Depressive type
- ☐ Major Depressive Disorder Type
- ☐ Major Depressive Disorder w/o Psychotic features
- ☐ Major Depressive Disorder with Psychotic features
- ☐ Bipolar I Disorder most recent Episode Manic, Moderate
- ☐ Bipolar I Disorder, Most recent Episode Manic, severe
- ☐ Bipolar I Disorder, Most Recent Episode Manic, with Psychotic Features
- ☐ Bipolar I Disorder, Most Recent Episode Depressed
- ☐ Bipolar I Disorder, Most Recent Episode Depressed w/Psychotic Features
- ☐ Bipolar II Disorder
- ☐ Delusional Disorder
- ☐ Panic Disorder
- ☐ Obsessive compulsive disorder
- ☐ Borderline Personality Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Autistic
- ☐ Multiple personality Disorder
- ☐ Eating disorder

Date Diagnosed:_____
Treatment For Diagnosis:_____
Medication for Diagnosis:_____

I certify that the information provided in this application is true and correct.

Signature:_____
Printed Name:_____
Date:_____