Help People... Restore Hope... Change Lives!

PO Box 306 — Missoula, MT — 59803

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/ METH
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 you were 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 ______________________________

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

Signature:________________________

Printed Name:______________________
Date:_____________________________