RESIDENT APPLICATION

Name: _____
D.O.B. _____
Age: _____
Height: _____
Weight: _____
Current Address: _____
Emergency Contact: _____
Emergency Contact Address: _____
Contact Ph. _____

Are you currently homeless? Y / N
Do you currently have external supervision? (For example, parole, probation, or case management? Y / N

Name of parole, probation, or case management?
_____

List any crimes you have been convicted of:
_____
_____
_____

When was the last time you used alcohol or drugs?
_____

MEDICAL INFORMATION

List all medical problems (including drug/alcohol addiction/mental health diagnostics):
_____
_____

Are you presently under a physician or hospital's care? Y / N

If yes, name of physician or hospital:
_____

List all medications taken within the past ninety days:
_____
_____
_____

Are you presently under psychiatric care:
Y / N
If yes, name of doctor or hospital: _____

ADDITIONAL INFORMATION

Are you able to work? Y / N

If yes, please provide us with a brief summary of your previous work experience:

_____
_____
_____

What job skills do you possess?

_____
_____

Are you able to perform household chores? Y / N

Are you willing to attend a minimum of 3 supportive 12- Step meetings per week?
Y / N

BACKGROUND/GOALS

Why do you need Jericho House?

_____
_____
_____

What do you expect to receive from Jericho House?

_____
_____
_____

How long do you feel it will take you to accomplish your goals and become capable of living independently? _____

What goals will the staff and others be able to assist you in achieving?

_____
_____
_____

Express any other areas of concern or issues, which may allow us to make appropriate decisions regarding your application: _____

_____
_____
_____

Sign: _____Date: _____

SELF REPORTING FORM

Name: _____ Date: _____
Date of Birth _____ Age _____
Address _____ City _____ Zip Code _____
County _____
What is the reason you want to come to Jericho House?
_____
Who referred you? _____ Why were you referred? _____
Do you feel you need to be here?
_____
Describe your current living conditions (where, with whom, type of residence)
_____
_____
Please describe your Strengths/Attributes
_____
Please describe your Weaknesses/Limitations
_____
Additional Comments
_____

Drug/Alcohol Use History

Drug	Age of 1st Use	Age of 1st Intoxication	Frequency	Last Use
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Codeine	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Other	_____	_____	_____	_____

When you have cut down or stopped using alcohol or drugs, have you ever experienced? (Check all that apply)

__ shakes, tremors __ difficulty concentrating __ feel anxious __ diarrhea

__ convulsions __ nervous irritability __ confusion __ unusual dreaming

__ weakness/sickness __ nausea/vomiting __ fever __ fear, panic

__ runny nose __ heavy fatigue __ muscle aches __ rapid heart beats

__ heavy sweats __ sleep too much __ hallucinations __ feel depressed

Have you experienced any of the following? (Check all that apply)

__ Loss of control __ Blackouts __Binges __Using alone __Overdose __ Mixing Chemicals

__ Change in eating patterns __Legal history __Loss of family/friends __Self-mutilation

__ Use despite having problems __Giving up job or social activities

__ Absent/tardy from work/school __Homicidal/suicidal thoughts __Change in sleep

__ Tolerant changes (up or down) __ Withdrawal symptoms __ Relief use for withdrawal symptoms

__ Attempts to control or reduce amounts or frequency of use

__ All daily activities involve getting, using or recuperating from your use

__ Being intoxicated/under the influence (work, children, school)

Does it take more____ less____ same amount____ alcohol/drug to feel the effects?

HISTORY OF TREATMENT

Have you ever had Alcohol/drug treatment? Yes __ No __
Please list the date, type and where treatment took place.

_____
_____
_____
_____

Have you ever attended AA/NA? Yes __ No __
How long have you gone without using by choice?

_____

Have you ever received mental health counseling? Yes __ No __
If so when?

_____

Where?

_____

What did you receive treatment for?

_____

Have you had thoughts of suicide? Yes __ No __
Did you have a plan?

_____

What was the plan? -

_____

Have you ever had homicidal thoughts or attempted to hurt anyone? Yes __ No __
If yes please explain

_____
_____
_____
_____

Are you currently having thoughts of hurting yourself or someone else? Yes __ No __
If yes please explain

_____
_____
_____
_____

Have you ever been physically, sexually, or emotionally abused? Yes __ No __
If yes please explain

_____
_____
_____
_____

Did you receive counseling for this abuse? Yes __ No __
If so when? _____
Where? _____

EDUCATION

How old were you when you left high school? _____
Why did you leave? _____
Last grade completed _____ Graduation year _____GED year _____
Were you ever disciplined in school? Yes __ No __
If yes please explain

_____
_____
_____
_____

Were you ever in the military? Yes __ No __
If yes, which branch, rank, date of service and type of discharge

_____
_____
_____
_____

EMPLOYMENT

Are you currently working? Yes __ No __
If yes, place of employment

_____

May we contact you at work if necessary? Yes __ No __
In the past five years how many jobs have you had?

_____

What is the longest you held a job?

_____

If unemployed how long have you been unemployed and why?

_____
_____
_____
_____

FAMILY HISTORY

With who were you raised?

_____

Is your mother living? Yes __ No __ Is your father living Yes __ No __
If not, please list dates of death and cause

_____

How many full brothers and sisters do you have? _____
How many half brothers and sisters do you have? _____
How many stepbrothers and sisters do you have? _____
How many are older? _____
How many are younger? _____
Any family history of Diabetes _____ Heart problems _____ Cancer _____ High Blood Pressure _____
Depression _____ eating problems _____ Gambling _____

Does anyone in your family have a problem with alcohol and/or drugs? Yes __ No __
If yes, please explain

_____
_____
_____
_____

Are you married? Yes __ No __
How many times have you been married? Yes __ No __
Do you have children? Yes __ No __
If you do please list ages and gender

_____
_____
_____
_____

Who do your children live with and where? -

_____
_____
_____
_____

SOCIAL

What do you like to do for fun?

_____

Do most of your friends do drugs? Yes __ No __
Do you have friends that don't use? Yes __ No __

SPIRITUAL

Were you raised going to church? Yes __ No __
Do you attend church now? Yes __ No __
Do you believe in God? Yes __ No __
If you do not believe in God, what are your beliefs? -

_____
_____
_____
_____

CHEMICAL HISTORY

List all drugs (including alcohol) that you have used

_____
_____
_____
_____

What is your drug of choice?

_____

Describe your use in the past year

_____
_____
_____
_____

Describe your use in the last 30 days

_____
_____
_____
_____

When was your drinking the heaviest?

_____
_____
_____
_____

What is the substance you use most often?

_____

Do you think you have a problem with alcohol and/or drugs? Yes __ No __
If yes, what are you willing to do about this problem?

_____
_____
_____
_____

LEGAL HISTORY

Are you currently on probation or parole? Yes __ No __
If yes, name of P.O. _____
Are Children services involvement? Yes __ No __
If yes, name of case worker _____
Reason for involvement with Children services?

_____
_____
_____
_____

Have you ever received a DUI/Reckless Operation charge? Yes __ No __
If yes, how many?

_____

Have you ever had any of the following charges?

Public Intoxication	Yes __ No __	How many? ____	Date of occurrence? _____
Disorderly Conduct	Yes __ No __	How many? ____	Date of occurrence? _____
Drug Trafficking	Yes __ No __	How many? ____	Date of occurrence? _____
Possession of drugs	Yes __ No __	How many? ____	Date of occurrence? _____
Domestic Violence	Yes __ No __	How many? ____	Date of occurrence? _____
Underage Consumption	Yes __ No __	How many? ____	Date of occurrence? _____

Assault Yes __ No __ How many? ____ Date of occurrence? _____
Other _____ Yes __ No __ How many? ____ Date of occurrence? _____

Have you ever had non-drinking or non-using offenses? If yes, please list

_____
_____
_____
_____

How many times have you been arrested in the past 24 months? _____
Have you been in jail or prison Yes __ No __
If yes, when? _____
Where? _____
Length of incarceration? _____
Reason for incarceration?

_____
_____

MEDICAL HISTORY

Current physical/medical problems

_____
_____
_____
_____

Are you taking medications? Yes __ No __
If yes, please list the medications and why you are taking them

_____
_____
_____
_____

Do you have any allergies? Yes __ No __
If yes, please list allergies

_____
_____
_____
_____

In the past 12 months how many times have you been admitted to the hospital? _____ER visits _____
Regular Dr. visits ____ Regular Dentists visits ____ Date of last physical _____
Are there any other health problems from the past that are significant (accidents, surgeries, est.)?

_____
_____
_____
_____

SEXUAL HISTORY

What is your sexual preference?
Heterosexual _____ Homosexual _____ Bisexual _____
When you are sexually active do you use condoms? Always ____ Sometimes ____ Never _____
Do you use any other type of contraceptive? Always ____ Sometimes ____ Never ____
What other types of contraceptives are used?

_____

_____

Have you ever been forced to be sexual with someone when you did not want to? Yes __ No __
Have you ever forced someone to engage in sex when they did not want to? Yes __ No __

Have you ever been sexually active when you were under the influence of alcohol and/or drugs? Yes __ No __

Have you ever traded sex for food or a place to stay? (i.e. survival sex) Yes __ No__
Have you ever had sex with someone who has or might have AIDS or a sexually transmitted disease? Yes __ No __

Printed Name _____

Signature _____ Date _____

Witness _____ Date _____

SUPPORT NETWORK

1. Who are you able to talk to about things that are very personal?
   Name(s): _____
   Phone Numbers(s): _____

2. Who are some individuals that used their time and energy to help you take care of something that you needed to do? For example, personal helpers that help drive you someplace, help with some work around the house, go to the store for you, etc.
   Name(s): _____
   Phone Numbers(s): _____

3. Who are some people that you enjoy getting together with to have fun and relax?
   Name(s): _____
   Phone Numbers(s): _____

4. Identify three instances in which your needs for social support have gone unmet during the past year?
   _____
   _____
   _____

5. Identify three instances in which your needs for social support have been well met during the past year?
   _____
   _____
   _____