

New Life Recovery Program Application

Lighthouse Rescue Mission

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PERSONAL INFORMATION

Mr. _____ SS# _____
(LAST) (FIRST) (MI)

DOC# _____

Other Names (Alias's) _____

DOB ____/____/____ Age ____ Place of Birth _____ Height _____ Weight _____

State I.D./Driver's License # _____ State _____ Expires ____/____/____

Last known address _____ How long did you stay there? _____

Current living/mailling address _____

Emergency Contact (E.C.) and Relationship to You _____

E.C. address: _____ Phone #: _____

Church Affiliation

Religious preference _____ If Christian, specify _____

Church Affiliation _____

Address _____

Pastor's Name _____ Phone # () _____

Have you made Christ the Saviour and Lord of your life? Yes No

If Yes, briefly explain the situation surrounding your decision. _____

Family Information

Marital Status: Single Married Divorced Widow

Name of Person involved with _____

Address: _____ Phone #: _____

Describe the relationship: _____

Are you expecting to become a new parent? Yes No If Yes, due Date ____/____/____

Family information (Continued)

Children:

How many children do you presently have? Girls _____ Boys _____ None _____

Do you or will you have custody or visitation of them? _____

Child #1 Name _____ DOB _____ AGE _____ M/F _____

Address _____ Last lived with you _____

Phone _____ Mother or current custodial care person's name _____

Social worker _____ Child entering residential program Yes No

Child #2 Name _____ DOB _____ AGE _____ M/F _____

Address _____ Last lived with you _____

Phone _____ Mother or current custodial care person's name _____

Social worker _____ Child entering residential program Yes No

Child #3 Name _____ DOB _____ AGE _____ M/F _____

Address _____ Last lived with you _____

Phone _____ Mother or current custodial care person's name _____

Social worker _____ Child entering residential program Yes No

(List others on a separate sheet of paper.)

Family of Origin:

Mother _____ Maiden Name _____

Address _____ Phone: _____

Any addiction history, relationship? _____

Father _____

Address _____ Phone: _____

Any addiction history, relationship? _____

Siblings

Name _____ M/F _____ Age _____ Phone _____

Address _____

Any addiction history, relationship? _____

Name _____ M/F _____ Age _____ Phone _____

Address _____

Any addiction history, relationship? _____

(List others on a separate sheet of paper.)

Alcohol History

Describe your drinking pattern in the past: Daily Occasional Binges

Explain _____

Drug History

Describe your drug use pattern in the past: Daily Occasional Binges

Explain _____

Age of first use: Drugs _____ Alcohol _____

Length of time the following have been a problem for you: Drugs _____ Alcohol _____

Longest period of sobriety from using: Drugs _____ Alcohol _____

Longest period of sobriety in the past year from: Drugs _____ Alcohol _____

Check if used:

- Alcohol Date ___/___/___ Kind used _____
- Cocaine/Crack Date ___/___/___
- Heroin/Opiates Date ___/___/___
- Huffing Date ___/___/___ Product used _____
- Marijuana Date ___/___/___
- Meth Date ___/___/___
- Nicotine Date ___/___/___ Form(s): _____
- PCP/Angel Dust Date ___/___/___
- Prescription Abuse Date ___/___/___
- Other Date ___/___/___ What? _____
Date ___/___/___ What? _____

Have you ever suffered severe withdrawals from any of the above substances? Yes No

Have you ever used needles? Yes No Shared Needles? Yes No

NOTE: The New Life Program is a nicotine-free program. You will be subjected to drug/alcohol/nicotine tests.

Shelter/Program History

Previous Programs or Shelters (Starting with most recent)

Program #1 Name _____ Type _____

Location _____

Length of Stay _____ Dates __/__/____ - __/__/____

Did you graduate from the program? Yes No

Program #2 Name _____ Type _____

Location _____

Length of Stay _____ Dates __/__/____ - __/__/____

Did you graduate from the program? Yes No

If currently involved with AA, provide name of Sponsor & Phone # _____

Meetings per week ____ What do you think is missing? _____

If currently involved with NA, provide name of Sponsor & Phone # _____

Meetings per week ____ What do you think is missing? _____

Have you ever been asked to leave any program? Yes No If Yes, which one(s) and why? _____

Medical History

Names of medications you are currently prescribed to take and name of Physician:

Medication	Date Prescribed	Physician	Status (Have/Out of)

List any allergies to any medications _____

List any other life threatening allergies _____

Have you ever thought about, planned, or attempted suicide Yes No If Yes, explain when, where, how and why: _____

Do you have any physical disabilities that limit your ability to do certain types of work? Yes No

If yes, please describe _____

If you receive any pensions or benefits, list type(s) _____

Medical History (Continued)

MEDICAL PROBLEMS

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- Diabetes (Insulin Dependent) Ear Disease Eye Disease Heart Disease Hernia High Blood Pressure
 Kidney Disease Lung Disease (Type _____) Psychiatric Diagnoses Seizures Sinus Infections
 Spinal Injuries Ulcers Urinary Tract Issues Other _____

MEDICAL TESTS

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- AIDS Date ___/___/___ Results: Positive Negative
 Hepatitis A Date ___/___/___ Results: Positive Negative
 Hepatitis B Date ___/___/___ Results: Positive Negative
 Hepatitis C Date ___/___/___ Results: Positive Negative
 HIV Date ___/___/___ Results: Positive Negative
 Tuberculosis Date ___/___/___ Results: Positive Negative
If Positive, X-Ray Date ___/___/___ Results: Positive Negative

MEDICAL SIGNS, SYMPTOMS, AND OTHER MATTERS

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE PAST YEAR:

- Abdominal Pain Anxiety Blood in Stool or Urine Breathing Difficulty (including shortness of breath) Chills
 Constipation Cough Diarrhea Dizziness Fevers Headaches Hearing Difficulty Heartburn
 Nausea Obsessions Rash Sleeping Disorders Sore Throat Sputum Production (Color: _____) Stress
 Swallowing Difficulty Sweats Thoughts or urges to use Visual Problems Vomiting
 Weight Loss (Rapid or Unexpected) Wheezing Yellow Eyes/Skin Other _____
 Hospitalizations Explain _____
 Major Accidents Explain _____
 Food addictions (i.e. Caffeine, Corn Starch, Sugar, other) _____
 Eating disorders (Bulimia, Anorexia, other) _____
 Food or other non threatening allergies _____

Do you wear any of the following? Catheter Corrective Lenses Hearing Aids Pace Maker

Do you suffer from any of the following? Confusion Depression Memory difficulty Mood swings

** NOTE: Due to health code regulations, you may be restricted from some ministry assignments due to your medical condition(s). **

Sexual Activity

Describe your sexual activity: Virgin Monogamous Several Partners Numerous Partners

Have you had or is it your practice to have sex with partners you do not know? Yes No

Have you had or is it your practice to have sex with partners affected with an STD? Yes No

Sexually transmitted diseases Yes No If Yes, list _____

Do you view or read pornographic material? Yes No

The New Life Program espouses the following biblical doctrines in this area:

1. Any sexual lifestyle other than a heterosexual lifestyle is a sin.
2. Marriage is a covenant and a union between one man and one woman.
3. Sexual relations outside the confines of the marriage relationship are sinful relations.
4. Pornography is a sinful vice which can cause and lead to as many problems in one's life as drugs or alcohol.

Education

Check one: High School Graduate High School Equivalency (Type Diploma GED)

College: # of years _____ Degree _____

High School	Address

Business/Trade/Technical School	Address

College/University	Address

Are you enrolled in school? Yes No If yes, school attending _____

Course of study _____ Hours per week in school _____

Is Higher Education a goal you would like to pursue? Yes No

Hobbies _____

Employment & Finances

Please list your previous employers:

Employer	Address	Position	Dates

What job or vocation has been most satisfactory? _____

Describe your current financial obligations: _____

Criminal History

List all convictions. Use an extra sheet of paper if necessary.

County/State

Date of
Conviction

Date of
Release

Are you currently incarcerated? Yes No If yes, location _____

Parole Eligibility Date ___/___/___ Full-Term Release Date ___/___/___ Next Hearing Date ___/___/___

Institution Counselor's Name _____ Phone # _____

Probation/Parole Officer's Name _____ Phone # _____

Briefly explain why you are currently incarcerated _____

Incarceration classes currently attending:

Class:

Facilitator/Instructor:

What are your thoughts about being incarcerated for the crimes of which you were convicted?

Are you or will you be a registered sex offender? Yes No

Introspection

PLEASE HONESTLY ANSWER THE FOLLOWING QUESTIONS.

1. How did you hear about the New Life Program?

2. What are your thoughts about participating in an evangelical Christian, biblically based program?

3. Describe why you would like to be a part of the New Life Program and how you think we could best help you.

4. What do you feel is the most serious problem you have yet to overcome?

5. What are you willing to give up in your life in order to succeed?

6. What are you not willing to give up in your life for your recovery?

All information on this Application is requested to serve you better and will be kept in the strictest of confidence by Mission personnel.