

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 _____

Marital Status _____ Driver's License # _____ State _____ Expires ___/___/___

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

Current living/mailling address _____

Church Affiliation

What is your religious preference? Catholic ___ Protestant ___ Muslim ___ Judaism ___ Other _____

Church Attending _____

Address _____

Pastor's Name _____ Phone # () _____

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

Describe in your own words when, where, and how it happened. _____

Family Information

Relative Nearest to You _____ Phone # () _____

Marital Status: Single Married Divorced Widow

Name of Person involved with _____ their location _____

Describe the relationship: _____

Are you expecting to become a new parent? _____ Due Date ___/___/___

Name: _____
(LAST) (FIRST) (MI) SS# _____
DOC# _____

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 pattern of drug use in the past 30 days: Daily Occasional Binges

Explain: _____

At what age did you first use: drugs? _____ alcohol? _____

How long has drinking/drugs been a problem for you: drugs? _____ alcohol? _____

What is the longest period you have abstained from: drugs? _____ alcohol? _____

What was your longest period of sobriety in the past year from: drugs? _____ alcohol? _____

If used, list the date of last use:

- Alcohol Date ___/___/___
- Cocaine/Crack Date ___/___/___
- Heroin/Opiates Date ___/___/___
- Huffing Date ___/___/___ What was 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? _____

Have you ever used needles? _____ Shared Needles? _____

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

Have you ever been asked to leave any program? ___Yes ___No If yes, which one and why? _____

AA__ NA _ Name of Sponsor & Phone # _____

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

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? _____ If YES, explain: _____

If an attempt was made, when, where, and how was it made? _____

Do you have any physical disabilities that limit your ability to do certain types of work? ___Yes ___No

If yes, please describe _____

What type of pensions or benefits do you receive? _____

Medical History (Continued)

MEDICAL PROBLEMS

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please check if your answer is "YES".)

Diabetes (Insulin Dependent) Ear Disease Eye Disease Heart Disease Hernia High Blood Pressure
 Kidney Disease Lung Disease (i.e. Asthma, Bronchitis) Psychiatric Diagnoses Seizures Sinus Infections
 Spinal Injuries Ulcers Urinary Tract Issues Other _____

MEDICAL TESTS

HAVE YOU HAD ANY OF THE FOLLOWING? (Please check if your answer is "YES" and provide dates and results.)

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

DO YOU HAVE OR HAVE YOU HAD IN THE PAST YEAR ANY OF THE FOLLOWING? (Please check if your answer is "YES".)

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 (Reason(s) _____)
 Major accidents (Explain: _____)
 Food addictions (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

Do you have any sexually transmitted diseases? Yes No If YES, what? _____

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 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

Do you have any personal 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 Are you and will you be a registered sex offender? Yes No

Location SICI ISCI IMSI Other _____

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

Requesting parole to: Idaho, District # ___ Washington ___ Oregon ___ Other _____

Institution Counselor's Name _____ Phone # _____

Probation/Parole Officer's Name _____ Phone # _____

Briefly explain why you are currently incarcerated _____

Classes currently attending:

Class:

Facilitator/Instructor:

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

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.