

Application for New Life Recovery Program River Of Life Rescue Mission

(A MINISTRY OF THE BOISE RESCUE MISSION MINISTRIES)

575 S. 13TH Street

Boise, ID 83702

Phone: 208-389-9840

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? _____

Currently staying? _____

How long have you been homeless? _____

Relative Nearest to You _____ Phone # () _____

Church Affiliation

Church Attending _____

Address _____

Pastor's Name _____ Phone # () _____

Have you committed your life to Christ? ___ Yes ___ No When? _____ Where? _____

In your own words, describe what happened and how you felt _____

Family information

Marital Status: Single Married Divorced Widow

Name of Person involved with _____

Their address: _____ Phone # _____

Describe the relationship: _____

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

Children:

From any sexual relationships you have had in the past; how many children do you have? _____

Have any resulted in miscarriages? _____ How Many? _____

Have any led to abortions? _____ How Many? _____

On the following page please list your children;

Family information (Continued)

Children:

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
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
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
4. **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

Family of Origin

Mother _____ Maiden Name _____
Address _____ Phone: _____
Any addiction history, Relationship? _____

Father _____
Address _____ Phone: _____
Any addiction history, Relationship? _____

Siblings (Brothers & Sisters);

Name _____ M/F ___ Age _____ Phone _____
Address _____
Any addiction history, Relationship? _____

Name _____ M/F ___ Age _____ Phone _____
Address _____
Any addiction history, Relationship? _____

Name _____ M/F ___ Age _____ Phone _____
Address _____
Any addiction history, Relationship? _____

Name _____ M/F ___ Age _____ Phone _____
Address _____
Any addiction history, Relationship? _____

Alcohol History

Describe your drinking pattern in the past: Daily Occasionally Binges

Explain: _____

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

What is the longest period you have been abstinent? _____

At what age did you take your first drink? _____

How long has drinking been a problem for you? _____

Drug History

Describe your pattern of drug use in the past 30 days: Daily Occasionally Binges

Explain: _____

How long has using drugs been a problem for you? _____

Have you used any of the following drugs? List date of last use.

Cocaine/Crack _____

Marijuana _____

Heroin/Opiates _____

PCP/Angel Dust _____

Crystal Meth _____

Alcohol _____

Prescriptions (yours, others) _____

Huffing (What) _____

Caffeine _____ Other _____

Have you ever suffered severe withdrawal from any of these drugs? _____

Have you ever shared needles? _____

Do you have any specific concerns that you would like to discuss confidentially? _____

Do you smoke? ___ Yes ___ No Do you chew? ___ Yes ___ No

If you are currently incarcerated, did you smoke or chew before incarceration? ___ Yes ___ No

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? ___ Yes ___ No - If yes, why? _____

AA __ NA __ Name of Sponsor & Phone # _____

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

Medical History

All the following information is requested in order to serve you better. The Information provided will be kept in the strictest confidence by Boise Rescue Mission personnel.

Name: _____ Date: _____

Date of Birth: __/__/__

IMPORTANT! Do you have any allergies to any medications? _____

Do you have any other life threatening allergies? _____

Have you ever thought about, planned, or attempted suicide? Explain: _____

When and where was last attempt? _____

What was your method? _____

Medications you are currently prescribed to take and name of Physician:

Medication	Date Prescribed	Physician	Status (Have/Out of)

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? _____

PAST MEDICAL PROBLEMS

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

(Please circle if your answer is affirmative.)

- 1. Heart Disease
- 2. Lung Disease
- 3. Kidney Disease
- 4. Hernia
- 5. Sexually Transmitted Diseases
 - Gonorrhea
 - Syphilis
 - Herpes
 - Genital Warts
 - Chlamydia
 - Trichomonas
 - Crabs/Scabies
 - Other _____
- 6. Diabetes
 - Insulin Dependent
- 7. Tuberculosis
- 8. High Blood Pressure
- 9. Urinary Tract Infections
- 10. Test for Hepatitis
 - Date ___/___/___ A Results; Positive Negative
 - Date ___/___/___ B Results; Positive Negative
 - Date ___/___/___ C Results; Positive Negative
- 11. Test for HIV; Date ___/___/___ Positive Negative
- 12. Test for AIDS; Date ___/___/___ Positive Negative
- 13. Ulcer Disease
- 14. Eye Diseases
- 15. Ear Diseases
- 16. Sinus Infections
- 17. Previous Surgeries
- 18. Psychiatric History
- 19. Spinal injuries
- 20. Seizures
- 21. Other _____

SIGN AND SYMPTOMS

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

(Please circle if your answer is affirmative.)

- 1. Headaches
- 2. Visual Problems
- 3. Hearing Difficulty
- 4. Sore Throat
- 5. Difficulty Swallowing
- 6. Heartburn
- 7. Nausea
- 8. Vomiting
- 9. Diarrhea
- 10. Constipation
- 11. Blood in your Stool
- 12. Abdominal Pain
- 13. Cough
- 14. Sputum Production
 - Red
 - Green
 - Yellow
- 15. Shortness of Breath
- 16. Wheezing
- 17. Difficulty Breathing
- 18. Fevers
- 19. Chills
- 20. Sweats
- 21. Weight Loss
- 22. Dizziness
- 23. Yellow Eyes/Skin
- 24. Dark Urine
- 25. Painful Urination
- 26. Rash

* Please Note: Due to public health code regulations some ministry assignments may be restricted for compliance reasons.

Have you been hospitalized? Reasons _____

Have you had any major accidents? _____

Do you have any major life threatening illness/disease? _____

Do you wear glasses? _____

Do you have any of the following? Confusion: _____ Memory difficulty: _____ Mood swings: _____ Depression: _____

Obsessions: thoughts or urges to use: _____ Anxiety: _____ Stress: _____ Problems sleeping: _____

Food addictions? (Caffeine, Corn Starch, Sugar, other) _____

Eating disorders? (Bulimia, Anorexia, other) _____

Sexual Activity

Describe your sexual activity

Virgin Monogamous Several Partners Numerous Partners

Do you practice masturbation? ___Yes ___No Do you view or read pornographic material? ___Yes ___No

Frequency of activity:

several times daily several times a week once a week other

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

If yes what was the STD? 1. _____ 2. _____ 3. _____

Please circle the following with whom you have had sex?

Women Animal (species :) _____

Men Other _____

Do you understand that our program teaches the biblical doctrine of no sex out of the marriage covenant (Marriage being defined as the union between a man and a woman?) ___Yes ___No

Do you understand that our program teaches the biblical doctrine that only a heterosexual lifestyle is an acceptable lifestyle to God? ___Yes ___No

Education

High School Graduate? ___Yes ___No ___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

Please list your previous employers:

Employer	Address	Position	Dates

What job or vocation has been most satisfactory? _____

Criminal History

List all of your convictions County Date of Conviction Date of Release

Are you currently incarcerated? Yes No Are you a registered sex offender? Yes No

Location: SICI ISCI IMSI ICC Ada Co Jail Other _____

Parole Eligibility Date ___/___/___ Release Date ___/___/___ Next Hearing Date ___/___/___

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

If you are incarcerated, we must have a contact person in order to process your application in a timely manner:

Institution Counselor's Name _____ Phone # _____

Probation/Parole Officer's Name _____ Phone # _____

Attorney's Name _____ Phone # _____

Pre-Sentence Investigator's Name _____ Phone # _____

Briefly explain why you are currently incarcerated _____

Classes currently attending:

Class:	Facilitator/Instructor:

Criminal History Continued

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

How did you hear about the New Life program? _____

Do you understand what is expected of you and are you willing to cooperate? ___Yes ___No

Describe your Current financial obligations; _____

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND HONESTLY

1. What is your religious preference? Catholic ___ Protestant ___ Muslim ___ Judaism ___ Other _____
2. What are your feelings about participating in a biblically based program for self-improvement?
3. Briefly describe your family background (brothers, sisters, parents – married/divorced, etc.) as well as your relationship with them.
4. Are you married? If so, what is your relationship with your wife?
5. Do you have children? If so, will you have custody or visitation of them?
6. What are your feelings about being incarcerated for the crimes you were convicted of?
7. Describe why you would like to be a part of the program at Boise Rescue Mission and how you feel we could best help you.

**Personal Drinking Questionnaire
(SOCRATES 8A)**

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	No! Strongly disagree	No Disagree	? Undecided or unsure	Yes Agree	Yes! Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic.	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I have managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5
12. My drinking is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic.	1	2	3	4	5
18. I am working hard to change my drinking.	1	2	3	4	5
19. I have made some changes in my drinking and I want some help to keep from going back to the way I used to drink.	1	2	3	4	5

**Personal Drug Use Questionnaire
(SOCRATES 8A)**

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drug use*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	No! Strongly disagree	No Disagree	? Undecided or unsure	Yes Agree	Yes! Strongly Agree
2. I really want to make changes in my use of drugs.	1	2	3	4	5
2. Sometimes I wonder if I am an addict.	1	2	3	4	5
3. If I don't change my drug use soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drug use.	1	2	3	4	5
5. I was using drugs too much at one time, but I have managed to change that.	1	2	3	4	5
6. Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
7. I have a drug problem.	1	2	3	4	5
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drug use and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drugs.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5
12. My drug use is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop my use of drugs.	1	2	3	4	5
14. I want help to keep from going back to the drug problems that I had before.	1	2	3	4	5
15. I know that I have a drug problem.	1	2	3	4	5
16. There are times when I wonder if I use drugs too much.	1	2	3	4	5
17. I am a drug addict.	1	2	3	4	5
18. I am working hard to change my drug use.	1	2	3	4	5
19. I have made some changes in my drug use and I want some help to keep from going back to the way I used before.	1	2	3	4	5

River of Life Rescue Mission
575 S. 13th St.
Boise, Idaho 83702

RELEASE OF INFORMATION

Client Name _____
Last Name First Middle
Maiden Name Previously Married Name Date of Birth

I hereby request and authorize:

Name _____
Address _____
City _____ State _____ Zip _____

To Release to: Boise Rescue Mission Ministries
575 South 13th Street
P.O. Box 1494
Boise, ID. 83701

A copy of the following reports from the clients files:

- Medical Information
- Vocational Rehabilitation information and verification of services received.
- Health & Welfare program information and verification of services received.
- Employment agency information and verification of services rendered by _____
- Social service agencies services rendered by _____
- Other pertinent information _____
- _____ exchange of verbal information _____

This information will be used for:

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to ANY or ALL of the above.

My signature below authorizes release of all such information to and from River of Life Rescue Mission and Boise Rescue Mission Ministries.

Signature of Client or Responsible Party

Relationship to Client Date

Witness

To the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

To the party receiving this information; This information has been disclosed to you from the records, whose confidentiality is protected by Federal and/or State Law. Federal and/or State regulations prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Acknowledgement of Rules

The Policies and Rules
are subject to change at any time
without notice at the Directors Discretion

*Please note the date on the program introduction/policies and rules and familiarize
yourself with them.*

I have read the Boise Rescue Mission's policies and rules (DATED: __/ __/ __) in its entirety and agree to follow the rules found therein while a participant in the Discipleship Program. I hereby declare that my answers, information, and statements are true to the best of my knowledge and understand that I may be discharged from the program for providing any false information.

Signature

Date

This page shall be kept in the program member's case file.