



Thank you for your interest in the New Life Recovery Program at City Light Home for Women and Children. Please completely fill out this application and return it using one of the following.

Email: womenandchildren@boiserm.org
Mail: 1404 West Jefferson St. Boise, Idaho 83702
Fax: 208-368-9844

If you have questions you may call (208)-368-9901 or email womenandchildren@boiserm.org and leave a message for the New Life Intake Coordinator. We will process your application as quickly as possible.

**The New Life Program is a Nicotine-Free Program.
You will be Subjected to Drug/Alcohol/Nicotine Tests.**

Date: _____

PERSONAL INFORMATION

Name _____
Last First MI

Email _____

DOC# _____ Phone # _____
If Applicable

Other names (Aliases) _____

DOB _____ / _____ / _____

Current living/ mailing address

Emergency contact (E.C.) _____

Relationship to you _____

E.C. address _____

FAMILY INFORMATION

Marital status

Single

Married

Divorced

Widow

Name of person involved with _____

Address _____

Phone # _____

Describe relationship _____

Are you pregnant?

No

Yes, due date

____ / ____ / ____

CHILDREN

How many children do you have?

None

Girls #

Boys #

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

Child #1 Name _____

DOB _____

Age _____

M/F _____

Last lived with you _____

Phone# _____

Current custodial care person's name _____

Social worker name/phone#/email _____

Child #2 Name _____

DOB _____

Age _____

M/F _____

Last lived with you _____

Phone# _____

Current custodial care person's name _____

Social worker name/phone#/email _____

Address: _____

Phone: _____

FAMILY OF ORIGIN

Mother's name _____

Address _____ Phone: _____

Mother's addiction history: _____

Describe current relationship (healthy, not speaking, etc.)

Father's name _____

Address _____ Phone: _____

Father's addiction history, if yes please describe?

Describe current relationship

Sibling

Name: _____

Phone: _____ M/F: _____ Age: _____

Address: _____

Any addiction history? Describe current relationship.

Sibling

Name: _____

Phone: _____ M/F: _____ Age: _____

Address: _____

Any addiction history? Describe current relationship.

List other significant family relationships or family information on the reverse side of this page

Addiction History

Alcohol History

Describe your drinking pattern in the past or present:

Daily Occasional Binges Date last used / /

Explain _____

How old were you when you first used? _____

How long has it been a problem? _____

Longest period of time sober _____

Drug History

Describe your drug use pattern in the past or present:

Daily Occasional Binges

Explain _____

How old were you when you first used? _____

How long has this been a problem? _____

Explain how you stayed sober and circumstances (including approximate dates) _____

Longest period of time sober from drugs _____

Check if used:

Bath Salts

Date last used

 / /

Cocaine/ Crack

 / /

Heroin/ Opiates

 / /

Huffing

 / /

Product used

Marijuana

 / /

Meth

 / /

Nicotine

 / /

Form(s)

PCP/ Angel Dust

 / /

Prescription abuse

 / /

Psychedelics

 / /

Other

 / /

What?

Have you ever suffered severe withdrawals from any of the above substances?

No

Yes, please describe _____

Have you ever used or shared needles?

No

Yes, used

Yes, shared

List other addiction history information below. Use the reverse side of this page if necessary.

Program or Shelter History

Previous programs or shelters (starting with most recent):

Program #1 name: _____

Type of program: _____

Location: _____

Length of stay: _____ Dates: / / - / /

Did you graduate from the program? No Yes

Program #2 name _____

Type of program _____

Location _____

Length of stay _____ Dates: / / - / /

Did you graduate from the program? No Yes

Are you currently involved with AA, NA, or CR? No Yes

Sponsor name: _____

Phone # _____ Email address _____

Have you been asked to leave any program? No Yes

If yes, which one(s) and why?

List other program or shelter history information below. Use the reverse side of this page if necessary.

Medical History

Physician name (or group name) _____

List medications with date prescribed (note if running low)

List any life threatening allergies

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

No Yes Please describe

Medical Tests

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING TESTS:

	Date			
<input type="checkbox"/> HIV/AIDS	/ /	Results:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
<input type="checkbox"/> Hepatitis A, B or C	/ /	Results:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
<input type="checkbox"/> STDs	/ /	Results:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
<input type="checkbox"/> Tuberculosis	/ /	Results:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
If positive, X-ray	/ /	Results:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative

Hospitalization, explain

Major accidents, explain

Eating disorders (bulimia, anorexia, other)

List other medical history information below. Use the reverse side of this page if necessary.

Mental Health and Emotional History

Have you ever been treated for any of the following?

- Bipolar
- Depression
- PTSD (post traumatic stress disorder)
- Schizophrenia
- Explosive personality disorder (anger)
- Borderline personality disorder
- Self mutilation
- Suicide attempt
- Multiple personality disorder

Do you suffer from any or the following?

- Confusion
- Memory Difficulty
- Mood swings
- Depression

If you check any of the above mental diagnoses include copies of records if possible.

Have you ever thought about, planned, or attempted suicide?

- No
- Yes, explain when, where, how and why

List other mental health and emotional history information below. Use the reverse side of this page if necessary

Education

Check one: High school not yet completed

High school graduate High school equivalency (type Diploma, GED)

Last year of school completed _____

Are you currently enrolled in school? No Yes

If yes, school attending _____

Is higher education a goal you would like to pursue?

- No
- Yes

If yes, explain _____

List other educational information below. Use the reverse side of this page if necessary.

Employment and Financial

Please list your most recent employer:

Employer: _____

Position: _____

Dates: From: / / / To: / / / _____

What is the longest you have held a job? _____

What job or vocation has been most satisfactory? _____

Are you now /have you ever served in the U.S Military? No Yes

Which branch: _____

Discharge status: _____

Are you currently receiving VA services? _____

Describe your current financial obligations (rent, credit cards, debts,court fees, etc.)

Do you receive any alimony, child support, pensions, workman's comp, SSI, etc.?

Do you owe any alimony, child support or restitution?

List other employment and financial information below. Use the reverse side of this page if necessary.

Correctional History

List **ALL** convictions. **Use an extra sheet of paper if necessary**

Misdemeanor charge _____
Dates _____ Status _____

Misdemeanor charge _____
Dates _____ Status _____

Misdemeanor charge _____
Dates _____ Status _____

Felony charge _____
Dates _____ Status _____

Felony charge _____
Dates _____ Status _____

Felony charge _____
Dates _____ Status _____

Do you have any outstanding warrants? No Yes

List all outstanding warrants _____

Are you currently on probation or parole?
No Yes, probation Yes, parole

Probation/parole officer
Name: _____ Phone # _____
Email (best way of communication) _____

Are you currently incarcerated? No Yes
Location _____

Institution counselor or case worker
Name _____ Phone # _____
Email (best way of communication) _____

Correctional History cont.

Briefly explain why you are currently incarcerated.

What are your thoughts about being incarcerated for these charges?

Classes (or group meetings) currently attending while incarcerated

Class facilitator/instructor

Next court date: / /

Where: _____

Judge: _____

Attorney: _____

What will be addressed at next court date? (sentencing, preliminary hearing, PV etc.)

Are you or will you be a registered sex offender?

No

Yes

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 a 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. Is there anything else we should know to help us understand why you are applying for the New Life Program? Use the back of this page if necessary.

All information on this application is requested to serve you better and will be kept in confidence by mission personnel.