Application for New Life Recovery Program
Lighthouse Rescue Mission

(A MINISTRY OF THE BOISE RESCUE MISSION MINISTRIES)

Please reply to Dave Nelsen

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PERSONAL INFORMATION

Please fill out neatly and completely.

TODAY'S DATE: ____________________________

CURRENT MAILING ADDRESS: ____

____

____**PHONE #**________________________________

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 # ( ) ______________

Are you a registered sex offender? ___Yes ___No

Are you a Vet? ___Yes ___No How long did you Serve? ________ Branch of Service __________________

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 ☐Widowed

Name of Person involved with ____ ________________________

Their address: ____Phone #_________________

Describe the relationship: ____

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

Name:______________________________ **SS#**______________

(LAST) (FIRST) (MI) **DOC#**______________

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?________

Do you have you have custody or visitation of them?______

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;

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:______________________________

____

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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:______________________________

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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 ______________________________

Heroine/Opiates ______________________________

PCP/Angel Dust ______________________________

Crystal Meth ______________________________

Alcohol ______________________________

Prescriptions (yours, others) ______________________________

Huffing (What) ______________________________

Nicotine ______________

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 use tobacco/ nicotine products? ___Yes ___No If yes, what? ______________________________

If you are currently incarcerated, did you smoke or chew before incarceration? ___Yes ___No

This is a non-tobacco use program. Are you ok with giving up tobacco products? ___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? ____

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____

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? ____

Names of 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? ____

Do you have any of the following? Confusion: _____Memory difficulty: ___ Mood swings:____ Depression: ____

Obsessions: Thoughts or urges to use: ______ Anxiety: ____________Stress: ________ Problems sleeping: ______

Do you have any mental health/psychiatric issues or diagnoses?

____

____

____

Do you have a Learning Disability or diagnosis? ____

PAST MEDICAL PROBLEMS
D0 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

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 Men

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 ___ Completed GED ___Yes ___No ___ 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 a registered sex offender? ___Yes ___No

Where are you currently registered? ____

For which crime(s)? ____

Are you currently incarcerated? ___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 ______________________

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 ____

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____

____

Classes currently attending:

Class:	Facilitator/Instructor:

Criminal History Continued

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

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____

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; ____

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Testimony

Explain to us why you want to change your life and what made you decide to seek help with us. How do you think this program and a better relationship with God can help you? What are your expectations?_______________

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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. If previously incarcerated what are your feelings about the crimes you were convicted of?

6. 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.