

# New Life Recovery Program Application City Light

(A BOISE RESCUE MISSION MINISTRY)

**Please reply to Nora Mueller**

1404 W. Jefferson Street Boise, ID 83702 Phone: 208-368-9901 Fax: 208-368-9844

**[norap@boiserm.org](mailto:norap@boiserm.org) for further correspondence and/or questions**

## PERSONAL INFORMATION

Please fill out neatly and completely.

TODAY'S DATE: \_\_\_\_\_

CURRENT MAILING ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
PHONE # \_\_\_\_\_

\_\_\_\_\_  
(LAST) (FIRST) (MI) DOC# \_\_\_\_\_

Other Names (Aliases) \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Place of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you a registered sex offender? \_\_\_ Yes \_\_\_ No

Are you a Vet? \_\_\_ Yes \_\_\_ No Length of Service? \_\_\_\_\_ Branch of Service \_\_\_\_\_

## Family Information

Marital Status:  Single  Married  Divorced  Widowed

Name of Person involved with \_\_\_\_\_

Their address: \_\_\_\_\_ Phone # \_\_\_\_\_

Describe the relationship: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Due Date \_\_\_/\_\_\_/\_\_\_

Does your spouse/significant other struggle with addiction? \_\_\_\_\_

Do you understand that our program teaches the biblical doctrine that sexual intercourse belongs only within the bonds of marriage, with marriage being defined as the union of one man and one woman? \_\_\_ Yes \_\_\_ No

Do you understand that our program holds to the biblical doctrine that homosexual acts are morally wrong and should be avoided? Are you willing to adhere to this? \_\_\_ Yes \_\_\_ No

**Children:**

- 1. **Name** \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ M/F \_\_\_\_\_  
Address \_\_\_\_\_ Last lived with you \_\_\_\_\_  
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 \_\_\_\_\_  
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 \_\_\_\_\_  
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 \_\_\_\_\_  
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? Describe your relationship: \_\_\_\_\_

**Father** \_\_\_\_\_  
Address \_\_\_\_\_ Phone: \_\_\_\_\_  
Any addiction history? Describe your relationship: \_\_\_\_\_

**Siblings;**

**Name** \_\_\_\_\_ M/F \_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Any addiction history? Describe your relationship: \_\_\_\_\_

**Name** \_\_\_\_\_ M/F \_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Any addiction history? Describe your relationship: \_\_\_\_\_

**Name** \_\_\_\_\_ M/F \_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Any addiction history? Describe your relationship: \_\_\_\_\_

# Alcohol History

Describe your drinking pattern in the past:  Daily  Occasionally  Binges

Date last used: \_\_\_\_\_

What was your longest period of sobriety? \_\_\_\_\_

At what age did you take your first drink? \_\_\_\_\_

How long has drinking been a problem? \_\_\_\_\_

Explain: \_\_\_\_\_

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# Drug History

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

Date last used: \_\_\_\_\_

How long has using drugs been a problem for you? \_\_\_\_\_

Explain: \_\_\_\_\_

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Have you used any of the following drugs? List date of last use and how much you used:

Cocaine/Crack \_\_\_\_\_

Marijuana \_\_\_\_\_

Heroin/Opiates \_\_\_\_\_

PCP/Angel Dust \_\_\_\_\_

Crystal Meth \_\_\_\_\_

Bath Salts \_\_\_\_\_

Prescription Abuse \_\_\_\_\_

Huffing (What) \_\_\_\_\_

Nicotine \_\_\_\_\_

Other \_\_\_\_\_

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

Have you ever shared needles? \_\_\_\_\_

Do you use tobacco/ nicotine products? \_\_\_ Yes \_\_\_ No If yes, what? \_\_\_\_\_

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? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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.

**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? \_\_\_\_\_

Please list all medications currently prescribed to you:

Medication	

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: \_\_\_\_\_

Have you been diagnosed **by a medical doctor** as having any of the following?

Bipolar: \_\_\_\_\_ PTSD (Post Traumatic Stress Disorder): \_\_\_\_\_ Schizophrenia: \_\_\_\_\_ Explosive Personality Disorder (Anger): \_\_\_\_\_

Borderline Personality Disorder: \_\_\_\_\_ Self Mutilation: \_\_\_\_\_ Multiple Personality Disorder: \_\_\_\_\_

Do you have a learning disability or diagnosis? \_\_\_\_\_

PAST MEDICAL PROBLEMS

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

- 1. Heart Disease
- 2. Lung Disease
- 3. Kidney Disease
- 4. Sexually Transmitted Diseases
  - \_\_\_ Gonorrhea
  - \_\_\_ Syphilis
  - \_\_\_ Herpes
  - \_\_\_ Genital Warts
  - \_\_\_ Chlamydia
  - \_\_\_ Trichomonas
  - \_\_\_ Crabs/Scabies
  - \_\_\_ Other

- 5. Diabetes
  - \_\_\_ Insulin Dependent
- 6. Tuberculosis
- 7. High Blood Pressure
- 8. Ulcer Disease
- 9. Eye Diseases
- 10. Ear Diseases
- 11. Test for Hepatitis
  - Date \_\_\_/\_\_\_/\_\_\_ □A Results; □Positive □Negative
  - Date \_\_\_/\_\_\_/\_\_\_ □B Results; □Positive □Negative
  - Date \_\_\_/\_\_\_/\_\_\_ □C Results; □Positive □Negative
- 12. Test for HIV; Date \_\_\_/\_\_\_/\_\_\_ □Positive □Negative
- 13. Test for AIDS; Date \_\_\_/\_\_\_/\_\_\_ □Positive □Negative
- 14. Spinal injuries
- 15. Seizures
- 16. Other \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ Reasons \_\_\_\_\_

Please list all previous surgeries: \_\_\_\_\_

Have you had any major accidents? \_\_\_\_\_

Do you have any major life threatening illness/disease? \_\_\_\_\_

Food addictions? (caffeine, corn starch, sugar, other) \_\_\_\_\_

Eating disorders? (bulimia, anorexia, other) \_\_\_\_\_

### Education

High School Graduate? \_\_\_ Yes \_\_\_ No \_\_\_ Completed GED \_\_\_ Yes \_\_\_ No \_\_\_ College # of years \_\_\_\_\_

Degree \_\_\_\_\_

High School	Address

College/University	Address

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? \_\_\_\_\_

Describe your current financial obligations; \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Criminal History

**List all of your convictions**

	County/ State	Date of Conviction	Date of Release	Misdemeanor/ Felony

Are you currently incarcerated? \_\_\_ Yes \_\_\_ No

Parole Eligibility Date \_\_\_/\_\_\_/\_\_\_ Full-Term Release Date \_\_\_/\_\_\_/\_\_\_ Next Hearing Date \_\_\_/\_\_\_/\_\_\_

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:


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

## 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

Church Affiliation: \_\_\_\_\_

If you are not affiliated with a church or have not committed your life to Christ, are you open to acknowledging Christ as your higher power? \_\_\_\_\_

If you can, please explain your relationship with Christ or the one you hope to build:

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What are your feelings about participating in a biblically-based program?

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How does your family feel about your decision in joining a faith-based recovery program?

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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.

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