Physical - circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Level of Pain

Are you currently experiencing any pain? If so, on a scale from 1-10 (with 10 being the worst), what is your level of pain and explain. With any experience of chronic pain, intake services will require a letter from a doctor verifying that you are able to participate in the program. --

____

____

*Past 30 days - If you have experienced any of these in the past 30 days, list how many days.

**Lifetime - If you have experienced any of these throughout your lifetime, list how many years.

Mental Health medical records may be requested

	Past 30 days *		Lifetime**	
Serious Depression		days		years
Serious Anxiety/Tension		days		years
Hallucinations		days		years
Trouble Understanding/ Concentrating/remembering		days		years
Trouble controlling temper Or violent behavior		days		years
Suicidal Ideation		days		years
Suicide Attempts		days		years
Emotional Abuse		days		years
Physical Abuse		days		years
Sexual Abuse		days		years

Ever hospitalized or Baker Acted for psychological problems?

When/where/diagnosis/duration of hospital stay (s):

____

____

Ever entered an inpatient or outpatient treatment facility for psychological problems?

____

Ever received a diagnosis for a mental health disorder?

If yes, what/when was the diagnosis and who was the doctor for diagnosis:

____

____

Currently receiving help for psychological problems?

Have you ever struggled with: Anorexia_ Bulimia_ Abusing self (cutting)_ Abusing others_ Sex_ Pornography_ Gambling_ Over-eating_ Stealing_ Video Games _Overworking_
If yes, explain:

Do you feel that you are addicted to any kinds of foods? If yes, explain:

Amount you consume each day: _______________
Cigarette packs smoked per day: _______________Coffee cups consumed per day: _______________

Substance Abuse Treatment:

Have you ever been to Detox? Yes___ No__ If yes, how many times, when, and where?

Have you ever been in treatment for Substance Abuse/Addiction? Yes No___ How many times? _____ __
If Yes, When and Where:____ __
Did you complete the program?________________________
Did you stay clean and sober? Yes___ No___ How long? ___________________ __
Did you attend meetings? Yes____ No____ Did you get a Sponsor? Yes____ No____ _

-*Past 30 days - List how many days in the past 30 days that you've used a particular substance
-+Lifetime - List how many years you have been using a particular substance, and on average, how many times per week you use the particular substance.

Substance Abuse Historv.·

	Past 30 Days*		Lifetime (3x/week)+		Route of Admin	Age 1st Use
Alcohol - any use		days		vears		
Alcohol - to intoxication		days		vears		
Heroin		days		vears		
Methadone		days		vears		
Other opiate/analgesics		days		vears		
Barbiturates		days		vears		
Benzodiazepines		days		vears		
Cocaine		days		vears		
Amphetamine		days		vears		
Cannabis		days		vears		
Hallucinogens		days		vears		
Inhalants		days		vears		
More than one substance		days		vears		

Alcohol and Drug History:

Have you ever felt you should cut down on your drinking and/or drug use? Yes_ No_
Have people annoyed you by criticizing your drinking and/or drug use? Yes No
Have you ever felt bad or guilty about your drinking and/or drug use? Yes_ No_
Have you ever used alcohol or drugs in the morning to steady your nerves or get rid of a hangover? Yes_ No_
Have you ever had any drug or alcohol related arrests? Yes No_
Have you experienced any blackouts from drugs or alcohol? Yes_ No
Have you ever injected drugs? Yes_ No_

Substance(s) of Choice:

Currently clean and sober?

Experienced Withdrawal: Yes_ No_ If yes, how many time(s) _

Did any of the withdrawals give you seizures? Yes No

Legal Data:

Are you a sex offender? Yes___ No__ _
Have you ever been charged with a violent offense? Yes__ No_
Violent Charges:____
Why are you incarcerated now? _________________________________
Estimated Release Date: _________________________
Previous jail or prison served? Yes ____ no ____ _
If yes, how many times: ____________________________________ __
What are your previous charges?

Do you currently have any pending cases with DCF or other Social Service Agencies? Yes_ No_ If yes, please explain:

____

____

Do you have any outstanding fines? Yes_____No___ _
Amount owed: ______________________________________ __
Are you currently on Probation? Yes _______No___ _
Explain.____ __
Do you have any stipulations as a part of your probation? (community service hours, classes etc.) Yes_ No_ _
If so, what is required completion date? ____ __
Have you ever had a DWI (Driving While Intoxicated)? Yes --- No ___ How Many: ________ _
Arrest warrant__ Court appearance__ Criminal charges__ Sentencing__Other__

Religious Data:

Current Religious Preference:

____

In Childhood: --
Do you have a Home Church? Yes____ No___ where?

____

Have you accepted a higher power? If yes, please describe:

____

Relationships:

	Close Relationship	Serious Problems Last 30 days	Serious Problems Lifetime
Spouse or Signif. Other			
Mother			
Father			
Siblings			
Children			
Close Friends			
Other Family			
Neighbors			
Co-workers			

Family History

Have you witnessed or been involved in incidences of domestic violence?

Yes___________NO____ _

If YES please describe:

___

___

___

Have you experienced any significant loss within the past year?
Yes___________ NO____ _

If YES please describe (i.e., Who? How? Etc.):

___

___

___

Have you experienced any significant loss in your life time?
Yes___________ NO____________

If YES please describe (i.e., Who? How? Etc.):

___

___

___

Are you adopted? Yes________ NO________________

If known, please complete the following chart regarding blood relatives:

	Family Members								
Illness/Condition	Grandparents	Father	Mother	Brothers	Sisters	Sons	Daughters	None	Describe
Cancer (describe each type for each person)									
Heart Disease									
Diabetes									
Stroke/TIA									
High Blood Pressure									
Alcohol or Drug Abuse									
Anxiety, Depression or Psychiatric Illness									
Tuberculosis									

Program Participant: ____

Family and Friends Data:

Spouse: ____

Address: ____

Email: ____

Telephone: ____

Father: ____

Address: ____

Email: ____

Telephone: ____

Mother: ____

Address: ____

Email: ____

Telephone: ____

Grandparents: ____

Address: ____

Email: ____

Telephone: ____

Siblings: ____

Address: ____

Email: ____

Telephone: ____

Pastor: ______________________________

Address: ______________________________

Email: ______________________________

Telephone: ______________________________

Other: ______________________________

Address: ______________________________

Email: ______________________________

Telephone: ______________________________

Other: ______________________________

Address: ______________________________

Email: ______________________________

Telephone: ______________________________

Other: ______________________________

Address: ______________________________

Email: ______________________________

Telephone: ______________________________

Other: ______________________________

Address: ______________________________

Email: ______________________________

Telephone: ______________________________

Briefly describe why this is the program for you:

Have you read the Program Overview Form? Yes / No

Questions:

____

____

____

____

Signature: ______________________________________**Date:**________________________________ __

Intake Department
Email: Intake@stmatthewshouse.org
Phone:239-774-0500
Men's Program Ext: 183, 112
Women's Program Ext: 125
Fax: 239-774-7146

Allowable Items List

It is our priority to offer a respectable program for the applicants of Justin's Place. In order to do this, a mutual respect is needed. This starts with the way we present ourselves. There will be no apparel that refers or references to old behaviors or past lifestyles. This includes drug references, **gang** references, and other associated/related references.

Items to pack:

Personal Items

- 1 Book Bag (journal, stamps, appropriate reading material)
- Personal Hygiene [**CAN NOT CONTAIN ALCOHOL**]
- No more than 5 hats
- 2 pairs of sunglasses
- Jewelry/piercings (case by case)
- Hairstyles including beards and mustaches must be well kept

Clothing

- 2 pairs work pants
- 5 work shirts
- 2 pairs of non-work pants (class-wear, no holes)
- 5 shirts (t-shirt or otherwise, no inappropriate or no vulgar material)
- 3 pairs of shorts (no holes)
- 1 pair of swimming trunks
- 12 pairs of underwear
- 12 pairs of socks
- 1 jacket and 1 sweatshirt
- 7 white t's/undershirts

Shoes

- 2 pairs of tennis shoes
- 2 pairs of work boots
- 2 pairs of flip flops/sandals for free time
- 2 pairs of dress shoes

Formal Wear - (for attending Church services and dinners during Discovery Track)

- 2 dress slacks/khakis
- 5 button down (Oxford style) dress shirts
- 5 polo shirts
- No more than 5 ties

Notes:

- If lacking any above items, they will be provided as needed
- Justin's Place is not a storage facility. Each resident will be given a reasonable amount of space to store the amount of items listed above. Please pack accordingly.