

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 History:

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

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 Significant 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 History

Illness/Condition	Family Members								Describe
	Grandparents	Father	Mother	Brothers	Sisters	Sons	Daughters	None	
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

Justin's Place Women's Recovery Program

*Justin's Place Women's Recovery Program is a Christian discipleship, residential, 12 month addiction recovery program. The goal of Justin's Place Women's Recovery Program is to give women the time, tools and love of Jesus that will equip them to live full and productive lives of recovery. The program includes community living, 12 step facilitation, prayer, life groups, outreach, agriculture, life skills, cognitive and behavioral teachings, relapse prevention, as well as other classes and techniques to facilitate healing and recovery. The women live on **Jill's Place**, a quiet retreat center, designed to facilitate change, healing and growth. The women attend lectures, classes, groups, and outside meetings during all phases of the program. The 3 basic phases are motivational track, lasting 30-60 days, this is a time for each person and for St. Matthew's House to determine motivation for change. Then we have discovery track that lasts 7-8 months, during this phase the women are encouraged to discover who they are in Christ. Through bible study, classes, groups and counseling we offer the tools to choose truth, freedom and recovery. The program ends with transitional track, a 3-4 month part of the program, where the women work in our thrift store or other social enterprise. This part of the program is designed to help transition, while still in a safe, structured, environment. During this part of the program they will be able to practice the tools they have learned during the first 8-9 months of the program. Justin's Place Women's Recovery Program and Jill's Place is designed to empower women to take action, in their spiritual walk and in their recovery to offer the time and the tools needed to live, not just sober, but lives of RECOVERY and FREEDOM through the power and love of Jesus Christ. There is a one-time intake fee of \$1,000.*