



Women and Children's Center
 400 West Front St, Missoula, MT 59802

Please answer every question. If the question does not apply to you write N/A for that section. Our desire is to screen in and not to screen out. Please be completely honest in your answers as it will help us to serve you best.

Our mission is to serve, rescue and transform those in the greatest need by the grace of Jesus Christ.

RESIDENT APPLICATION FORM

Today's Date:



Name: _____ Phone/Message #: _____

Address: _____ Age: _____ DOB: _____

Email Address: _____

Marital Status: Single Married Divorced Widowed Separated Common Law

Spouse/Partner Name: _____ Age: _____ DOB: _____

Emergency Contact: _____ Phone # _____ Relationship to _____

Other Agencies that you are involved with

Include Agencies such as CPS, Counselor, SNAP, SS, WIC, TANF, DSHS, Medicaid, Sect 8, Public Health, etc.

Agency	Contact Person / Phone #	Agency	Contact Person / Phone #

Transportation

What is your current method of transportation? Walking Special Mobility

Friends/Family: Car City Bus Other: _____

If you have a working car:

Make:	Model:	Color:	Year:	License Plate	Insurance Carrier	Phone # of Carrier:

Finances

Are you receiving public assistance? (SSI, DISABILITY, WELFARE, QUEST, CHILD SUPPORT) Yes No

Are you in the process of applying for public assistance? Yes No

Please list all sources of income you currently receive & amount(public assistance, job, unemployment, financial aid, etc)

Savings:

Please list monthly bills/expenses and any outstanding debts that you owe (bills, fines, child support, etc.):

Belongings

Do you have belongings in storage somewhere? Yes No

If yes, describe what kinds of items you have stored, where they are stored and if there is a cost to store them:

Basic Needs

While at the Women and Children’s Center (WCC), your basic needs for shelter and food will be provided for. Please list any basic needs you may currently have (clothing, hygiene, social service, spiritual, etc

Addictions

Directions: Answer each of the following questions as truthfully as possible. Do not skip questions or leave any blank. If you’re working on something other than drugs or alcohol, simply exchange terms throughout this assessment. For example: describe your eating problem in the past.

Describe your drinking pattern in the past:

What is your typical drinking pattern? Daily Occasionally Binges

What was your longest period of sobriety in the past year? _____

What was your longest period of sobriety ever? _____

At what age did you take your first drink? _____

How long has drinking been a problem for you? _____

When was the last time you drank? _____

Describe your pattern of drug use in the last 30 days:

How long since you've used a drug other than alcohol? _____

How long has using drugs been a problem for you? _____

What did you use and how much? _____

Specific Drugs Used

Instructions: Fill in the chart below. Be as specific as you can:

DRUGS USED (Please answer the following questions for each drug listed below)

MARIJUANA

Age Started? _____

Age Stopped? _____

Amount/Frequency? _____

How Administered? _____

OPIATES/HEROINE

Age Started? _____

Age Stopped? _____

Amount/Frequency? _____

How Administered? _____

COCAINE

Age Started? _____

Age Stopped? _____

Amount/Frequency? _____

How Administered? _____

AMPHETAMINES

Age Started? _____

Age Stopped? _____

Amount/Frequency? _____

How Administered? _____

BARBITUATES

Age Started? _____

Age Stopped? _____

Amount/Frequency? _____

How Administered? _____

TRANQUILIZERS

Age Started? _____

Age Stopped? _____

Amount/Frequency? _____

How Administered? _____

INHALANTS

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

OVER THE COUNTER

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

PRESCRIPTION

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

METHADONE

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

CAFFEINE

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

NICOTINE

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

OTHER

Age Started? _____
Age Stopped? _____
Amount/Frequency? _____
How Administered? _____

List other compulsive problems (e.g. food, relationships, work, sex, etc.):

Do you believe you're addicted to alcohol or drugs? Yes No Unsure

Please explain: _____

How many times have you made serious attempts to stay sober/clean? Circle your answer:
None (0) One (1) Two (2) Three (3) Four (4) Five (5) More than five (6+)

What's the longest period of time you've been able to stay sober/clean? Circle your answer:
I've never tried long-term abstinence (0) Less than four weeks (-4) Four weeks (4) Six weeks (6)
Twelve weeks or more (12+)

How many times have you been admitted for detoxification from alcohol and/or drugs?

Circle your answer:

None (0) One (1) Two (2) Three (3) Four (4) Five (5) More than five (6+)

Recovery Programs

List the recovery programs in which you have been:

Facility:	City/State:	in-patient or out:		Dates:	Treatment
		(circle)			Completed
		in	out		<input type="checkbox"/> yes <input type="checkbox"/> no
		in	out		<input type="checkbox"/> yes <input type="checkbox"/> no
		in	out		<input type="checkbox"/> yes <input type="checkbox"/> no
		in	out		<input type="checkbox"/> yes <input type="checkbox"/> no

What has been most helpful in your past recovery attempts? Circle the letters:

a. Twelve-Step Program b. Church / Religion c. Friends d. Family e. Other

Do you currently have a Twelve-Step Sponsor? Yes No

If yes, Name: _____

Phone: _____

Briefly, what do you think has been missing in your past recovery attempts? _____

When you were most actively involved in your recovery? _____

How many recovery group (A.A., N.A., etc.) meetings did you attend during an average week?

Choose the statement that best describes how strongly you believe that you are addicted:

Totally convinced Mostly convinced Partially convinced Not convinced

Are you currently in recovery and experiencing pain, or having a hard time staying abstinent?

- Yes, and I think I might relapse soon.
- Yes, but I'm not in any immediate danger of relapse. I just want to lower my risk.
- No, I'm not experiencing any pain or trouble functioning and I'm not worried about the immediate risk of relapse.

Legal Status

Are you currently involved in any of the following legal matters? Yes No If yes, which?

- Probation Parole Divorce Proceedings Civil Proceedings Child care custody
 Drinking driver program Assault charges Other _____

Do you have a court appearance pending? Yes No If yes, when / where? _____

How much time have you spent in: Prison: _____ Jail: _____

List all prior convictions:

Conviction: _____ Date(s): _____ Time Served: _____

Conviction:	Date(s):	Time Served:

Parole / Probation Officer's Name: _____ Phone: _____

How often do you report? _____

Developmental History

Specific life events and traumas

- _____
- _____
- _____
- _____
- _____

Medical History

Height: _____ Weight: _____ Date / year of last physical: _____

Currently over / under weight? Yes No (+) (-)

Have you ever had control problems with food? Yes No If Yes, Explain:

Describe past and present physical health (include hospitalizations, and major accidents or illnesses): _____

Number of pregnancies _____: Live Births _____ Miscarriages _____ Abortions _____

We require residents to do 10-15 hours' worth of chores weekly. Is there any reason you would not be able to participate in the chore system? Yes No If Yes, Explain: _____

Are you currently under the care of: Physician Psychiatrist / Psychologist Therapist
Other? _____

If so, may we contact them? Yes No

Doctor: _____ Address: _____
Phone # _____ Diagnosis: _____
Prescribed Medications: _____

Doctor: _____ Address: _____
Phone # _____ Diagnosis: _____
Prescribed Medications: _____

Doctor: _____ Address: _____
Phone # _____ Diagnosis: _____
Prescribed Medications: _____

Have you ever had a psychological evaluation? Yes or No If yes, what year? _____
What were the results/diagnosis? _____

If so, who was the Psychiatrist who administered the test? _____

Describe any family history of mental illness, alcohol / drug abuse, etc.

Medications

Prescription Medications you are currently taking & Dosage:	Purpose:	Prescribing Doctor:	Doctor's Phone #

Please list any non-prescription medications you are currently taking :

Do you have allergies to penicillin, other antibiotics, aspirin, codeine, morphine, bee stings, or any other drugs, or food, etc.?

List allergies and types of reactions you have. _____

Date of last TB test: _____ Result: Pos. Neg.

Date of last AIDS test: _____ Result: Pos. Neg.

Date of last Hepatitis test: _____ Result: Pos. Neg.

General Medical Symptom

Please check any current medical concerns you have

_____ trouble sleeping
_____ loss of appetite
_____ eye/vision problems

_____ frequent headaches/ pains
_____ allergies
_____ blood in stool
_____ tremors

_____ high blood pressure
_____ rapid weight gain/loss
_____ diarrhea/ constipation

_____ sexual problems
_____ stomach problems/ ulcers
_____ liver problems
_____ diabetes

Other Symptoms

Circle the numbers of the following withdrawal symptoms that you are currently experiencing:

- 1.** Confusion **2.** Memory difficulty **3.** Mood swings **4.** Clumsiness **5.** Obsessions, thoughts or urges to use
6. Sleep disturbance a) too much b) too little **7.** Anxiety, or panic attacks **8.** Depression **9.** Stress
10. Suicidal thoughts

How many suicide attempts have you made? _____ Dates? _____ What method have you used?
(example: pills, alcohol, weapons, cutting self) _____

Do you have health/medical insurance? No Yes: Type: _____

Relationships

Describe your relationship with your family of origin? (mother, father, siblings) _____

What is your current relationship with your family? (husband, ex, children) Explain: _____

Do you have current friends you can count on and are healthy? If so, whom? _____

Are you currently involved in a romantic relationship? Yes No
If yes describe your relationship with your significant other: _____

Have you ever had a problem with pornography, fantasy, chronic masturbation or prostitution? Yes No
 Explain: _____

Child Information

Do you have any children living with you? YES NO

List all of your children: Check the last box if the child would be living w/ you at WCC:

Name of child (Last, First)	DOB	Gender	SS#	Father's Name	Custody?	WCC?

Would any of your children not currently living with you be joining you at CWC at a later time? _____
 If yes, please explain circumstances and estimated time they would be joining you: _____

If you are pregnant, how many months? _____ What is the due date? _____

Do your children have health/medical insurance? No Yes, Type: _____

Is the father involved with the children? Yes No Is he safe? Yes No

Do your children have a healthy relationship with their father? Yes No

Do your children have a healthy relationship with each other? Yes No

If you answered NO to any of these questions, please elaborate: _____

School-Age Children

Child	School your child attends?	How long at current school?	grade	Does your child enjoy school?	How does your child get to school?

Do any of your children have health concerns or physical limitations? Yes No

If yes, please elaborate: _____

Do any of your children have behavioral challenges we should be aware of? Yes No

If yes, please elaborate: _____

What is your child/children's response to being separated from you? _____

Are any of your children on medications? Yes No If yes, please elaborate: _____

***Be prepared to provide up-to-date immunization records for each child living with you**

Spiritual Background

Did you attend church or participate in a religious activity as a child? Yes No

If yes, how many years? _____ How often? Seldom Occasionally Regularly

Denomination: _____ Were you baptized? Yes No

Other information about your childhood experiences with Church, religion, or God? _____

What is your current relationship with God? _____

Current trust level with God (Rate between 0-5, 0 being the lowest and 5 the highest): _____

Are you currently attending church? Yes No If yes, please give the following:

Name of church: _____

Pastor's name: _____

How are you involved (Bible studies, children's ministry etc.)?: _____

Describe your current spiritual beliefs: _____

What part does God play in your life / recovery plan? _____

What recent changes have you had in your religious life (if any)? _____

Employment History

List previous employment:

List your ambitions:

What are your hobbies?

Education

Highest grade level completed: _____ Do you have a GED or diploma? _____ Year completed / attained: _____

List any schooling or special training you have: _____

Recovery

What is the major problem that caused you to seek help at this time? _____

How is the problem related to your addictions? _____

What do you need to do differently this time for your recovery to be successful? _____

Goals

Write a description of your short and long-term goals, and what you will need to reach them: _____

REFERENCES- Please list 3 personal references below.

1. Name _____

Phone Number _____

Email _____

2. Name _____

Phone Number _____

Email _____

3. Name _____

Phone Number _____

Email _____

I certify that the information provided in this application is true and correct.

Signature: _____

Printed Name: _____

Date: _____