Name: _____

Date: _____

Resident Intake Questionnaire

Path of Grace, Inc. - Crown of Beauty

1. Name: _____
2. Phone Number: _____
3. Age: _____
4. Contact other than yourself:
   Name: _____ Number: _____
   Name: _____ Number: _____
5. Where are you currently living: _____
6. Minor Children/Ages: _____
7. Who has your children: _____
8. Do you have any open court cases related to your children? (If yes, explain)
   _____
9. Are you pregnant: YES or NO
10. Are you Gay or Bisexual: _____
11. What is your current relationship status: _____
12. What Substances are you currently using and frequency:
    _____
13. How long have you struggled with drugs or alcohol: _____
14. When was your last use of drugs or alcohol? What was it?
    _____
15. What are your motivating factors for seeking treatment?
    _____
16. Have you ever attempted or completed Treatment before? When and Where:
    _____
17. What is your current financial situation: _____
18. What is your work history: _____
    _____
19. What is your family and home life like: _____
    _____
20. Do any of your immediate family members or anyone in your household use drugs or alcohol: (Explain)
    _____
21. Do you have any pending charges or court dates: (List Dates, County, Judge, Attorney, contact info) _____
    _____
22. Are you on probation? (County, Officer, Contact Info)
    _____
23. What are your beliefs spiritually: _____

24. Do you currently suffer from, or have you ever suffered from any medical conditions? (Such as...diabetes, high blood pressure, heart complications, seizures, Etc.)

_____

_____

25. Do you have HIV or HEP C (If yes, Explain): _____
26. Are you experiencing any dental problems or tooth pain: _____
27. Have you ever been diagnosed with any of the following mental disorders:

Anxiety	Y/N	OCD	Y/N
Depression	Y/N	Personality Disorders	Y/N
Bipolar (Type 1 or 2)	Y/N	Mood Disorders	Y/N
PTSD	Y/N	Paranoia	Y/N
Eating Disorders	Y/N	Schizophrenia	Y/N

*OR ANY OTHER MENTAL DISORDERS NOT LISTED/EXPLAIN: (Dual Diagnosis)

_____

_____

28. What medications are you currently prescribed to?
29. What psych medications have you been prescribed to in the past?
30. Have you experienced any of the following symptoms: feelings of paranoia or fear, mood swings, hearing voices, anxiety or panic attacks, periods of insomnia:

_____

31. Do you have any symptoms or behavioral patterns we should be made aware of:

_____

32. Have you ever had suicidal or homicidal thoughts? If so, elaborate:

_____

33. Have you ever had any suicide attempts? If so, elaborate:

_____

34. Have you ever self-harmed or self-mutilated? (Such as, cutting, pulling out hair, etc.)

_____

35. Do you have any physical limitations? Certain physical movements or activities you are unable to do: _____
36. Will you be able to meet the $800 entry fee? Do you have someone that can help meet the payment or make scheduled payments: _____
37. Are you currently on food stamps? If not, is there a reason you wouldn't qualify? Residents who are unable to receive food stamps are required to make a $200 monthly donation to cover cost of food. _____

NOTES/COMMENTS:

_____

_____

_____

_____

Resident Medication Record

Resident Name: _____

Allergies: _____

Date of Birth: ___/___/___

Medication Name/Mg:	Medication Treats (condition):	Medication Frequency:

Medication Changes:

Medication Name/Mg:	Changes:	Date:	Int.

Resident Signature: _____ *Date:* ___/___/___

Witness Signature: _____ *Date:* ___/___/___

Important things to discuss about our program

*Length of program is a minimum of 16 months to 2 years.

*Court ordered residents must complete a minimum of 18 months

*Must refrain from ANY RELATIONSHIP while in the program.

*Zero contact with men other than immediate family

*During the first 30 days you will not be allowed any contact with family.

At 30 days- write to and receive mail from approved family

At 90 days-House phone calls once daily with approved family

Home visits with approved family every other weekend (rotating 24-48)

At 6 months- may have cell phone to keep in contact with approved family

At 7 months-may use internet/social media

*We are a FAITH BASED program, we keep biblical beliefs and believe in the Holy Spirit moving and working in our lives. We attend several different churches of different denominations. Many of them are *spirit filled

*Dress appropriately, no breast, behinds, or midriffs showing, can not dress like a man

*Smoking/Vaping is allowed outside only. Not in homes or vehicles.

*Will be required to do OR participate in the following:

-work 5 days a week in the thrift store -daily chores

-participate in group therapy once a week -individual therapy 1 to 2 times a month

-AA once a week -Bible study once a week

-church services on Sunday -special church services periodically

*Get a sponsor and begin working the 12 steps

*Working in the thrift store is not a paying job, it is done as part of your recovery.

*After 7 months, we will begin a savings plan for you.

-16 months/$3,700 -18 months/$4,800 24 months/$8,100