PATH OF GRACE WOMEN'S RECOVERY HOME

APPLICATION

DATE:_____

NAME:_____ **DOB:**_____
AGE:_____

PHONE NUMBER:_____

FAMILY CONTACT AND PHONE NUMBER:_____

WHERE ARE YOU FROM?

_____

WHAT IS YOUR DRUG OF CHOICE?

_____

ARE YOU PRESCRIBED ANY MEDICATION?

_____

IF YES, PLEASE LIST ALL MEDICICATION:

_____
_____
_____
_____

HAVE YOU EVER BEEN DIAGNOSED WITH BIPOLAR, DEPRESSION, PTSD, OR ANY OTHER DISORDERS BY A PHYSICIAN?_____ **IF YES, PLEASE EXPLAIN:**

_____
_____
_____
_____

DO YOU HAVE ANY PHYSIAL LIMITATIONS?

_____

IF YES, PLEASE EXPLAIN:_____
_____
_____

DO YOU HAVE HIV OR HEP-C?

_____

ARE YOU IN A RELATIONSHIP? YES OR NO

IF YES PLEASE EXPLAIN THE HISTORY:_____

_____

_____

_____

_____

ARE YOU GAY, BISEXUAL, OR STRAIGHT?

_____

HOW OFTEN DO YOU DRINK OR USE?

_____

_____

_____

_____

DO YOU HAVE CHILDREN?

_____

IF SO, HOW MANY?

_____

LIST NAMES AND AGES OF EACH CHILD:

_____

_____

_____

_____

IF THE CHILDREN ARE MINORS, WHERE AND WITH WHOM ARE THE LIVING?

_____

_____

_____

_____

IS DCF INVOLVED WITH YOUR CHILDREN?_____ **IF SO, EXPLAIN:**

_____

_____

_____

_____

DO YOU HAVE ANY COURT CASES OR ON ANY TYPE OF PROBATION?

_____

IF YES, PLEASE EXPLAIN:

_____

_____
_____
_____
_____

WHAT IS YOUR WORK HISTORY?

_____
_____
_____
_____

WHAT IS YOUR FAITH IN GOD?

_____
_____
_____
_____

WHY ARE YOU REACHING OUT FOR HELP AT THIS TIME?

_____
_____
_____
_____
_____

WHO REFERRED YOU TO US OR HOW DID YOU HEAR ABOUT THE PROGRAM?

_____
_____
_____
_____