the damascus house

Damascus House for Women Application

Please fill out every field and ensure you sign all the proper fields

Name *

First Name Last Name

Cell Phone Number *

Please enter a valid phone number.

Home Phone Number (if applicable)

Please enter a valid phone number.

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Driver's License Number *

Is your driver's license suspended? *

- ○ Yes
- ○ No

Explain: *

Date of Birth *

Month Day Year

Age *

Weight *

Height *

Hair Color *

Eye Color *

Instagram Handle *

Facebook Account *

Marital Status *

MARRIAGE AND FAMILY INFORMATION

Name of Spouse/Significant Other *

First Name Last Name

Spouse/Significant Other Phone Number *

Please enter a valid phone number.

Spouse's/Significant Other Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Spouse's/Significant Other Occupation *

Spouse's/Significant Other Age *

Do you have children? *

- ○ Yes
- ○ No

INFORMATION ABOUT CHILDREN

Please fill in all fields for each of your children

	Name	Age	DOB	Male/Female	Custody
Child 1					
Child 2					
Child 3					
Child 4					

What arrangements are being made for your children while you are at The Damascus House for Women? *

Education (last year completed): *

Other training (list the type and years completed): *

Who referred you to The Damascus House For Women? *

HEALTH INFORMATION

Rate your health:

- ○ Very Good
- ○ Good
- ○ Average
- ○ Declining
- ○ Other

Explain *

Weight Changes:

○ Lost

- ◯ Gained
- ◯ Neither

Do you consider your eating habits normal? *

- ◯ Yes
- ◯ No

Explain *

Are you on a special diet? *

- ◯ Yes
- ◯ No

Explain *

Do you eat meat? *

- ◯ Yes
- ◯ No

Do you have any medically verifiable food allergies? *

- ◯ Yes
- ◯ No

Explain *

Do you have any medically verifiable disabilities? *

- ◯ Yes
- ◯ No

Explain *

Date of last medical examination: *

List an physical limitation you may have as indicated by a physician *

Have you had any past surgeries or medical hospitalizations? *

- ○ Yes
- ○ No

List all past surgeries or medical hospitalizations including reason and date: *

Do you take any prescription medications? *

- ○ Yes
- ○ No

Prescription History

	Name	Dosage	For What Reason	How long
Prescription 1				
Prescription 2				
Prescription 3				
Prescription 4				

Which of the following substances have you experimented with, past or current? *

- ☐ Alcohol
- ☐ Crank
- ☐ Crystal Meth
- ☐ Marijuana
- ☐ Spice
- ☐ Hallucinogenic (Acid, LSD, etc)
- ☐ Amphetamines (Uppers)
- ☐ Barbiturates (Downers)
- ☐ Meth Amphetamines
- ☐ Morphine
- ☐ Opiates
- ☐ Heroin

- [ ] Inhalants
- [ ] Crack
- [ ] Tabacco
- [ ] Ecstacy
- [ ] Fentanyl
- [ ]

Preferred Drugs:

	Name of Drug	Frequency of Use	Date of Last Use
Drug Name			
Drug Name			
Drug Name			
Drug Name			

Have you ever experienced a life-altering, traumatic event, that still affects you? *

- ○ Yes
- ○ No

Explain *

Have you recently suffered the loss of someone close to you? *

- ○ Yes
- ○ No

Explain *

Have you ever been tested for an STD? *

- ○ Yes
- ○ No

Please provide month and year of when you were tested *

What was the result of your STD test? *

Have you ever been tested for HEP-C? *

- ○ Yes
- ○ No

Please provide month and year of when you were tested *

What was the result of your HEP-C test? *

Have you ever been tested for HIV/AIDS *

- ○ Yes
- ○ No

Please provide month and year of when you were tested *

What was the result of your HIV/AIDS test? *

Are you currently pregnant? *

- ○ Yes
- ○ No

Do you have any learning disabilities (reading or writing)? *

- ○ Yes
- ○ No

Explain *

SPIRITUAL BACKGROUND

Do you believe in God? *

- ○ Yes
- ○ No
- ○ Uncertain

Are you saved? *

- ○ Yes
- ○ No
- ○ Not sure what you mean

PERSONALITY INFORMATION

Have you ever had any psychotherapy or counseling before? *

- ○ Yes
- ○ No

Exlpain *

If yes, list counselor or therapist and dates you were in counseling: *

What was the outcome? *

Have you ever been in a drug or alcohol program? *

- ○ Yes
- ○ No

Recovery Program History

	Date of Entry	Program Name	City/State	Reason for Leaving	Date of Discharge
Facility 1					
Facility 2					
Facility 3					

Facility 4

CHECK ANY OF THE FOLLOWING WORDS WHICH BEST DESCRIBE YOU NOW: *

- ☐ Active
- ☐ Ambitious
- ☐ Self-confident
- ☐ Persistent
- ☐ Nervous
- ☐ Hardworking
- ☐ Impatient
- ☐ Impulsive
- ☐ Calm
- ☐ Moody
- ☐ Often-blue
- ☐ Excitable
- ☐ Imaginative
- ☐ Serious
- ☐ Easy-going
- ☐ Shy
- ☐ Good natured
- ☐ Introvert
- ☐ Extrovert
- ☐ Likeable
- ☐ Leader
- ☐ Quiet
- ☐ Submissive
- ☐ Lonely
- ☐ Self-Conscience
- ☐ Sensitive

Have you ever felt like people were watching you? *

- ○ Yes
- ○ No

Explain *

Have you ever had hallucinations? *

- ○ Yes
- ○ No

Explain *

Are you afraid of being in a car? *

- ○ Yes
- ○ No

Explain

Do you have problems sleeping? *

- ○ Yes
- ○ No

Explain

Have you ever tried to commit suicide? *

- ○ Yes
- ○ No

Why?

Have you ever received psychiatric care or been in a psychiatric hospital? *

- ○ Yes
- ○ No

Psychiatric Hospitalization History

	Date of Entry	Program Name	City/State	Reason for Leaving	Date of Discharge
Facility 1					
Facility 2					
Facility 3					
Facility 4					

Are you on any type of government or financial assistance, such as Welfare, SNAP or SSI? *

- ○ Yes
- ○ No

What type? *

Is there any other information we should know? *

I, undersigned, agree that all information is correct:

Date *

Month Day Year