



Application Mosaic Recovery Center

GENERAL

Today's Date: _____

Name:

First	Middle	Last	Date Of Birth
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Present Address:

Street	City/State	Zip
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How long at this address? _____ **Phone#:** _____ **County:** _____

Emergency Contact:

Name	Relationship	Phone
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1. PERSONAL

Age: _____ **Sex:** _____ **Weight:** _____ **Height:** _____ **Eye Color:** _____

Social Security Number: _____

Race: Black White Hispanic American Indian Asian or Pacific Islander Other

Are you an American Citizen? Yes No

Do you have a valid driver's license? Yes No **DL Number:** _____

What State?: _____

Served in branch of military? Yes No **What Type of Discharge?** _____

Do you have any Reserve or Military obligations at this time? _____

High School Diploma? Yes No **Highest Grade Completed?** _____

Have you ever been homeless before? Yes No

If Yes, what were the circumstances that caused you to become homeless?

Why are you here? _____

3. DRUG HISTORY

Have you ever used drugs or alcohol? Yes No What is your drug of choice? _____

Do you consider yourself addicted? Yes No

Explain: _____

Why did you experiment with drugs? _____

I depend on drugs (circle all that apply)

To cope with life To be "in" with the crowd For Pleasure

To escape reality Other

Longest Period Clean? _____

Have you ever been in any other type of program before? Yes No

How many non-religious programs? _____ How many religious programs? _____

FREQUENCY OF USE

Please use the following codes on the tables below:

- | | |
|-----------------------------|--------------------|
| 1. No use in the past month | 4. 3-6 times daily |
| 2. 1-3 times per month | 5. daily |
| 3. 1-2 times per week | |

Substance	Specify Substance Used	Age First Used	Date Last Used	How Long Used	Frequency of Use
Alcohol					
Amphetamines					
THC					
Cocaine					
Hallucinogens(PCP)					
Inhalants					
Oxycodone					
Opiates					
Meth					
Benzos					
Tobacco					
Gravel					
Bath Salts					
Subutec					
Suboxon					
Specify Others					

Did your parents use? Yes No Did they use in front of you as a child? Yes No

Do they use now? Yes No Did they condone your using? Yes No

Explain: _____

4. LEGAL STATUS

Have you ever been arrested? Yes No How many times? _____

Date	Charges	Convicted(y/n)	Sentence	Time Served

Do you have any felony charges? Yes No

Have you ever been convicted of a sex crime? ? Yes No

(Falsifying this question will result in immediate termination from the program, and you may be legally responsible for any consequences that may occur due to your falsification)

If Yes for what? _____

What pending charges? _____ Court Date: _____

Have you ever been on proation? Yes No

Are you curently on probation? Yes No How Long/Time Remaining? _____

How do you report? In Person By Mail Phone How Often? _____

Name of probation officer: _____ Phone#: _____

Adress: _____

City: _____ State: _____ Zip: _____

Have you ever been in prison? Yes No When? _____ Where? _____

Name of Lawyer: _____ Phone#: _____

Adress: _____

City: _____ State: _____ Zip: _____

Did you come from jail? Yes No

Are you required by the courts to complete this program? Yes No

If Yes, list the city Judge Name, Phone & Charges: _____

5. EMPLOYMENT

Do you have a job? Yes No

Name of Employer: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Have you lost jobs due to drinking/using? Yes No How Many? _____

Have you ever missed work or put off work because of drinking/using drugs? Yes No

If Yes, Explain: _____

Does someone contribute to your financial support in any way? Yes No

If Yes, How Much/Often: _____

6. FINANCIAL STATUS

Are you receiving welfare, unemployment compensation, disability payments, workman's comp, alimony, VA benefits, or other income? Yes No

Explain(how much): _____

Do you have outstanding debts? (list below)

Owed To	Amount	Address	Phone	Payments

7. THE PRESENTING PROBLEM

What is the presenting problem in your life, as you see it? (Explain in your own words why you want our help)

What are you greatest needs, in order of priority? _____

8. SPECIAL CONDITIONS/CONFIDENTIALITY ISSUES

Have you ever thought about ending your life or the life of someone else? Yes No

If Yes, when? _____ Describe the incident: _____

Have you ever tried to end your own life or someone else's? Yes No

If Yes, when? _____ Describe the incident: _____

Have you ever been involved in the occult? _____

Have you ever been associated with a gang or gang related activity? Yes No

Have you ever been abused? Sexually? Yes No Physically? Yes No

Emotionally? Yes No

If so when did the abuse occur? _____ Did you report it? Yes No

Did you receive any form of treatment or counseling? Yes No

List people you were close to that have passed away: _____

9. SPIRITUAL

Do you believe in God? Yes No Uncertain If Yes, what has that belief done for you, how has it changed you? _____

Have you ever committed your life to God? Yes No

Date/Place: _____

How often do you attend church? Never Sometimes Regularly

Denomination Preference: Baptist Pentacostal Methodist Lutheran

FreeWill Baptist Catholic Church of God Church of Christ 7th Day Ad Morman

Are you a member of any church/religion? Yes No Which One? _____

Explain your need of God: _____

What is your standing with Him now (i.e.: good, bad, no relationship at all etc.)

Is there any information that The Mosaic Center needs to know so we can serve you better? _____

What do you plan to do after you graduate TMRC? _____

10. MEDICAL

Rate your general health: Excellent Good Fair Poor

Do you have any long-standing health issues that would prevent you from working?

Yes No If Yes Explain: _____

Do you have any major concerns about your health?

Yes No If Yes Explain: _____

List any communicable diseases: _____

List any medical problems or handicaps: _____

Do you have insurance? (Medicare, Medicaid, BCBS, etc.) _____

Medications	Dose	Rx Date	Quantity	Physician	Reason Prescribed

List below any medications that you are currently taking

List any medication(s) you should be taking: (Prescribed) _____

Are any of the medications a narcotic?: _____

Has your addiction caused medical problems?

Yes No If Yes Explain: _____

Do you have a doctor? Yes No

If yes list name, city of practice and phone #: _____

Date of last physical: _____

Have you had any treatment for mental illness? Yes No If Yes, When? _____

Where: _____ Diagnosis: _____

11. OTHER

Do you have SS Card: Yes No Birth Certificate: Yes No State ID: Yes No

Insurance Card: Yes No (Please give copies to intake personnel)

Why do you think you have an addiction problem? _____

Are you willing to spend 3 to 12 months in Christian Recovery? Yes No

Do you understand that we are a Christian based recovery program and Christ is the answer to your problems? Yes No