Hepzibah House Resident Application

PERSONAL INFORMATION

Full Legal Name: ____ Date of Birth: __________________

Alias or Nicknames: __________________________________ Social Security Number: ______________________

Phone: ____ Safe to leave messages? Yes _____ No _____

Mailing Address: ______________________________ City________________________ State ____ Zip ________

Describe your current living situation ____

Single ____ Cohabiting _____ Married _____ Separated _____ Divorced _____ Widowed _______

US Citizen: Yes _____ No _____ If not, country of birth: ____

Race: ____________________ Gender: M F Sexual Preference: __________________________________

Children? Yes _____ No _____ If yes, what is/are their sex/es and ages? _______________________________

Where do they live and with whom? ____

Who has custody of them? ____

TRAFFICKING/COMMERCIAL SEXUAL EXPLOITATION HISTORY

Do you consider yourself a trafficking survivor? Yes _____ No _____

Briefly describe your trafficking experience. ____

____

____

EDUCATION AND EMPLOYMENT

Are you currently employed? Yes ______ No _____ If yes, where? ____________________________________

How many hours per week? ____ Description of responsibilities ____

Are you in school? Yes _____ No _____ If yes, where? ____

Do you have a high school diploma? Yes _____ No _____ GED? Yes _____ No_____

If no, what was the highest grade you completed: ____________ Interested in GED? Yes _____ No _____

List any other education/ degrees/certifications: ____

LEGAL HISTORY

Have you been charged with any misdemeanors? Yes_____ No _____ If yes, note the charge and status.

____:

Have you been charged with any felonies? Yes _____ No _____ If yes, note the charge and status.

____

Are you currently on probation or parole? Yes_____No_____ If yes, for what charge/s? ____________________

Probation officers name and contact information: ____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid, Fentanol, Suboxone					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER:(specify)________________________ ________________________________ ________________________________					Yes □ No □

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

____

____

____

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Strength & number of pills per day	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PSYCHIATRIC HISTORY

Do you have a mental health diagnosis? Yes _____ No _____ What is it? ______________________________

Outpatient treatment/Name of therapist:________________________________ Dates: ______________________

Psychiatrist (for medication):____ Dates: __________________

What medications have you taken in the past?____

Have you ever been hospitalized for emotional or behavioral reasons? Yes _____ No____

If yes, give the name of the hospital/s and the date/s of treatment:

____

____

Have you ever received psychological testing? Yes _____ No _____ If so, give the name of the psychologist and the reason and date of testing.

____

Have you ever been a resident of a therapeutic program? Yes _____ No _____ If yes, please list the name/s and dates of participation.

____

_____ **I consent to a background check.**

_____ **I consent to allow HH to contact any physicians, therapist, programs or other professionals who have been involved in my care.**

_____ **I have read the description of the Hepzibah House program and agree to abide by all program rules.**

Signed ____ Date: ______________________