



Day Program Application

Date _____
 Name _____
 Street Address _____
 City, State, Zip _____
 Phone number where messages can be left _____
 Email _____
 Marital Status _____
 Are you employed? Yes No
 Attending school? Yes No
 Religious preference and church affiliation _____

| | |
|----------------------------|--------------------|
| For Office Use Only | App Recd _____ |
| Intake Staff | Facilitator |
| Call _____ | Call _____ |
| Intake _____ | Actl Start _____ |
| Sched Strt _____ | Session _____ |

Social Security #: XXX-XX-_____
 Date of Birth _____ Age _____

Ages of your children _____
 Employer _____
 School _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Medical Information

Allergies: Drug (list) _____
 Food (list) _____
 Other (list) _____
 None known

Please list *physical health* issues and diagnoses. _____

Please list *mental health* issues and diagnoses. _____

Current Concerns

Please check any that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety, nervousness | <input type="checkbox"/> Sadness, tearfulness | <input type="checkbox"/> Legal concerns |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Anger out of control | <input type="checkbox"/> Family conflict |
| <input type="checkbox"/> Alcohol or drug problems | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Poor self-esteem | <input type="checkbox"/> Hearing voices/seeing things | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Other (describe) _____ | | |

How long have you been experiencing the problem(s)? _____

What have you done to address the problem(s)? _____

Personal Goals

Please list one or more goals that you would like to accomplish during this program.

