



OverComers In Christ Outreach Ministries, Inc. Admission Record

Client Name: _____

Date Enrolled: _____

For Office Use Only

(Applicant fill out information below completely and honestly.)

Client Name: _____ Nickname: _____

AGE: _____ SSN: _____ - _____ - _____ Date of Birth: ____/____/____ Race: _____

Weight: _____ lbs Height: _____ Hair Color: _____ Eye Color: _____ Gender(M/F) _____

Tattoos' or Scars (circle one): YES or NO If YES, describe tattoos/scars and location(s):

Home Address: _____

City: _____ State: _____ Zip: _____ Phone# _____

Do you have a VALID driver's license? YES or NO

Where did you sleep last night? _____

What is your occupation: _____

Physical Condition (circle one) POOR FAIR GOOD

Do you have income of any kind? (circle one) YES or NO If YES, please describe any and all sources and amounts: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City: _____

State: _____ ZIP: _____ Phone Number: _____

Education: (circle last year completed) 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5+

Military Service

Have you ever been in the military service? (circle one) YES or NO Branch _____

Highest rank held _____ Jobs held _____

Honorably discharged (circle one) YES or NO

Legal Information

Have you ever been arrested or in jail? (circle one) YES or NO

Number of times _____ When, where, and charges/convictions (City and State)?

Time served _____

Are you on supervision, probation, and/or parole? (circle one) If yes, please state and describe each one (cause and length of time) _____

Name your supervisor, parole or probation officer _____
Address _____
City _____ State _____ Zip _____ Phone# _____
Do you have any pending court cases? (circle one) YES or NO
If YES, give details of each one _____

Have you ever been convicted of a sexual offense? (circle one) YES or NO
If YES, describe the charge you were convicted with and where: _____

Religious Background

What is your denomination? _____
Are you a member of a church? (circle one) YES or NO
Church attendance per month: (circle one) 0 1 2 3 4 5 6 7 8 9 10 +

Church Name: _____ City: _____ State _____

Pastor's Name: _____ Phone Number: _____

Family History

Father's Name: _____ Living? _____ Deceased? _____
Occupation: _____ Denomination: _____
Attends Church? (circle one) YES or NO
Mother's Name: _____ Living? _____ Deceased? _____
Occupation: _____ Denomination: _____
Attends Church? (circle one) YES or NO
How many brothers and sisters do you have? Brothers _____ Sisters _____

Are there any addiction problems in your family? (circle one) YES or N. If YES, please briefly describe:

Have you ever been involved in any occult, cultic, New Age, or other non-Christian practices? (circle one) YES or NO
If YES, are you still involved in anyway with it now? (circle one) YES or NO Please explain briefly your involvement. _____

Have your parents, brother(s), sister(s), and/or grandparents ever been involved in any occult, cultic, New Age, or other non-Christian practices? (circle one) YES or NO
If YES, are they still involved in anyway with it now? (circle one) YES or NO Please explain briefly their involvement. _____

Health Information

Rate you physical health: (circle one) Great Good Fair Poor

Rate you mental health: (circle one) Great Good Fair Poor

List all of your present and past illnesses and/or handicaps:

Date of last medical exam: _____ Problem(s) noted by Doctor: _____

Your Doctor's Name: _____ Phone: _____

If you have a medical condition(s) that requires regular visits to your doctor and/or hospital, list the reasons and how often you need to be seen.

Are you presently taking medication? (circle one) YES or NO

List medication(s): _____

Prescribed by: _____

City _____ State _____ Zip _____ Phone _____

If accepted, can you get enough medication to complete the program?(circle one) YES NO

Have you ever used over the counter and/or prescription drugs for non-medical reasons': (circle one) YES or NO If YES, list all the drugs and approximate length of time of usage:

Have you ever been hospitalized for an emotional breakdown? (circle one) YES or NO

Where _____ How long _____ Discharge Date _____

Have you ever been hospitalized for a mental illness? (circle one) YES or NO

Where _____ How long _____ Discharge Date _____

Have you ever had any psychotherapy or counseling? (circle one) YES or NO

Counselor/Therapist _____ Dates _____

Circle all the health problems you have or have had in the past:

- | | | | |
|--------------|----------------|--------------|---------------|
| Tuberculosis | AIDS | STDs | Poor Eyesight |
| Hearing Loss | Colitis | Pneumonia | Leukemia |
| Bronchitis | Cirrhosis | Anemia | Toothache |
| Kidney | Glaucoma | Backache | Blackouts |
| Thyroid | Nausea | Ulcers | Epilepsy |
| Cancer | Mental Illness | Prostate | Arthritis |
| Diabetes | Dizziness | Hypoglycemia | Depression |

When was your last HIV test date: ____/____/____ Results: _____

I certify that the answers given in this application are true and complete to the best of my knowledge. I certify that I am of sound mind and I am of legal age to enter this agreement.

Applicant's Signature

Date

Printed Name

Witness

Date

Senior Staff Signature

Date