



Intake Form

Thank you for your interest in Restart Training Center Ministry, Inc's program services we offer. Please fill out the Intake Personal Inventory Form in its entirety. If, a line item does not apply to you please enter "not applicable" in the space provided.

If, you are applying for our residential program service your total fee is \$2250.00. Your initial intake fee of \$1000.00 is required along with the completed Intake Form (the intake fee is a part of the total \$2250.00 fee for our 6-month program). You can snail-mail your intake form along with your intake fee, fax it and snail-mail your intake fee, or drop both your intake form and fee in person to our program location. Please note a bed date will not be assigned or reserved for a client until the completed intake form and fee are both received from the client at our ministry.

PERSONAL INFORMATION INVENTORY

Please complete this inventory as carefully as possible. Answer each item that applies to you. All information you provide will be treated confidentially and will become party of your record. If you have a question about a particular area, please put a mark by it and ask your counselor when it is complete.

DEMOGRAPHIC INFORMATION

Name: _____ Date: _____

Home Address: _____

Phone (Home) _____ (Work) _____ (Cell) _____

S.S. #: _____ - _____ - _____ Sex: _____ Date of Birth: _____ Age: _____

E-Mail Address: _____

Occupation: _____ Hours Per Week: _____

Employed By: _____

Referred Here By: _____ Phone: _____

Referral's Address: _____

Emergency Contact: _____ Phone: _____

Contact's Address: _____

How did you hear about this counseling program? _____

MARRIAGE INFORMATION (Circle One)

- Single Engaged Married Separated
 Divorced Remarried Living Together Widowed

Please list your relationships below. List your children beginning with the oldest. (Place a check by the child's name if from a previous marriage.)

| Relationship | Name | Age | Grade or Occupation |
|--------------|-------|-------|---------------------|
| SPOUSE | _____ | _____ | _____ |
| EX-SPOUSE | _____ | _____ | _____ |
| CHILDREN | _____ | _____ | _____ |
| CHILDREN | _____ | _____ | _____ |
| CHILDREN | _____ | _____ | _____ |
| MOTHER | _____ | _____ | _____ |
| FATHER | _____ | _____ | _____ |

What Year Married?: _____ How Long Did you Date?: _____

How Did You Meet?: _____

Did Your Parents Approve of Your Marriage? _____ Spouse's Parents?: _____

Have You Ever Been Married Before? _____ Number of Divorces? _____ How Long Divorced? _____

FAMILY INFORMATION

Father Living? Yes ___ No ___ Mother Living? Yes ___ No ___ If so, where? _____

What kind of relationship do/did you have with your father? (Circle One)

Excellent Good Fair Poor Nonexistent

What kind of relationship do/did you have with your mother? (Circle One)

Excellent Good Fair Poor Nonexistent

Did anyone else have a key role in your upbringing? (If so, who and why):

How many children (siblings) are/were in your family? (Brothers and sisters) _____

What child are you by number? (Circle One)

- Oldest Second Third Fourth Fifth Sixth Youngest Other

EDUCATION

Highest Level/Grade of Education Completed:

- Not Complete HS Some College AA Degree
 College (Major: _____) Graduate (Major: _____)

How well did you do in elementary school? _____

How well did you do in HS? _____

How well did you do in College? _____

How well did you do in Graduate School? _____

RELIGION/FAITH

Religious Affiliation: _____ Church/Synagogue Name: _____

Circle Your Level of Church Activity: **Active** **Inactive**

Briefly describe how important your faith is to you: _____

Do you want a Christian counseling approach? Yes No

Do you want the counselor to pray with you? Yes No

HEALTH

Health Status: Excellent Good Average Poor Very Poor

Height: _____ Weight: _____ How you gained or lost any weight in last six months? (Circle One)
How Much? _____

Describe any medical problems you have that require medication or physical care: _____

Are you currently under a doctor's care? _____ (If yes, please describe) _____

Physician's name: _____ Address: _____

If you are currently taking any medication please complete below:

| Name of Medication | Dosage | Date Prescribed | By Who |
|---------------------------|---------------|------------------------|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Have you ever used drugs other than for medical purposes? _____
(If yes, what and when) _____

Please describe your use of alcoholic beverages: _____

- Never 1-4 Times Year 1-2 Times Month
- 1-2 Times Week 4 Times Week Daily

Please describe your use of your drug of abuse: _____

- Never 1-4 Times Year 1-2 Times Month
- 1-2 Times Week 4 Times Week Daily

What medical and emotional problems existed in your family in which you grew up? _____

Have you previously had inpatient therapy? Yes No When? _____

With Whom? _____ For How Long? _____

What Led to Your Relapse? _____

How you ever thought of or attempted to harm yourself before? _____

(If yes, please describe) _____

How you ever thought of or attempted to harm someone before? _____

(If yes, please describe) _____

Have you ever been abused before (psychologically; physically, verbally; or sexually)? _____

If yes, please describe) _____

Have you ever abused anyone before (psychologically; physically, verbally; or sexually)? _____

If yes, please describe) _____

PRESENTING PROBLEM (S)

In your own words, briefly describe the main problem that prompted you to seek counseling at this time:

How long have you faced the problem? _____

Have there been times when the problem got better or disappeared? Yes No

If so when? _____ What do you think helped? _____

Were there times when the problem was especially bad? Yes No

When? _____ What made it bad? _____

Are there other people who play a role in: Causing your problems? Helping your problem?

Briefly explain: _____

Please check any of the following that are currently troubling you.

Put **two** checks by those items that are most important. You may add any comments you would like:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion/Adoption | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Adjustment Problems | <input type="checkbox"/> Fear | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Anger/Temper | <input type="checkbox"/> Finances | <input type="checkbox"/> Rejection |
| <input type="checkbox"/> Anxiety (worry) | <input type="checkbox"/> Forgiveness | <input type="checkbox"/> Religious/Spiritual Issues |
| <input type="checkbox"/> Apathy (the "blahs") | <input type="checkbox"/> Frustration | <input type="checkbox"/> Repetitive Ideas |
| <input type="checkbox"/> Assertiveness | <input type="checkbox"/> Guilt | <input type="checkbox"/> School Problems |
| <input type="checkbox"/> Bitterness (Resentment) | <input type="checkbox"/> Health | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Change of Lifestyle | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Honesty | <input type="checkbox"/> Shy/Awkward |
| <input type="checkbox"/> Children (Discipline) | <input type="checkbox"/> Impotence | <input type="checkbox"/> Single Parenting |
| <input type="checkbox"/> Children (School) | <input type="checkbox"/> Inability To Relax | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Communication | <input type="checkbox"/> In-Laws | <input type="checkbox"/> Spouse Abuse |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Irritability | <input type="checkbox"/> Stomach/GI Disturbance |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Death of Loved One | <input type="checkbox"/> Loss of Interest | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Dependent on Others | <input type="checkbox"/> Loss of Pleasure | <input type="checkbox"/> Substance Use in Family |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lust | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Mother | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Marriage | <input type="checkbox"/> Troubling Memories |
| <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Memory Difficulty | <input type="checkbox"/> Troubling Habit |
| <input type="checkbox"/> Envy (Jealousy) | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Occupation Issue | <input type="checkbox"/> Underactivity |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Opposite Sex | <input type="checkbox"/> Unfairly Treated |
| <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Overactivity | <input type="checkbox"/> Unusual Experiences |
| <input type="checkbox"/> Family Violence | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Wish to Hurt Someone |
| <input type="checkbox"/> Father | <input type="checkbox"/> Pride | <input type="checkbox"/> Withdrawal |

Thank you for your interest in the Restart Training Center Ministry, Inc residential program service. **RTCM is a 6-month residential training center. Students are not allowed to have a job while at RTCM.** The intake forms need to be filled out **completely** and student handbook read and signed. Admission cannot be done until all this information is completed and returned to us.

Once **ALL** the above is sent to us, you will be placed on our waiting list. The waiting period may be just a couple days, weeks, or months. You must call the intake coordinator once a week to keep us informed of your desire to enter. This is a general application and consists of the basic requirements of the Restart Training Center Ministry, Inc.

Belongings Checklist:

- ___ 1 Bible
- ___ 1 set of linens for a twin bed (sheets)
- ___ 1 comforter
- ___ 1 pillow
- ___ 2 sets of dress clothes (this includes 2 button-up shirt, 1 polo-type shirt, 2 pairs of dress pants, 2 pairs of dress socks, dress shoes, 2 neckties)
- ___ Pair of work gloves
- ___ 5 sets of casual clothes
- ___ 2 sets of work clothes
- ___ 7 pair each underwear and socks
- ___ 2 towels
- ___ 2 washcloths
- ___ 1 pair shower shoes
- ___ 1 bath robe
- ___ 1 pair work boots
- ___ 1 pair sneakers / gym shoes

- Toiletries/Misc:
- ___ Toothbrush
 - ___ Toothpaste
 - ___ Deodorant
 - ___ Shaving Supplies
 - ___ Soap
 - ___ Shampoo
 - ___ Mouthwash (Non-alcoholic)
 - ___ Hangers
 - ___ Laundry Bag-**full-vent/heavy duty only**
 - ___ Writing paper / Notebooks
 - ___ Pens / Pencils / Highlighters
 - ___ Hand Sanitizer (non-alcoholic)
 - ___ Case of Toilet Paper
 - ___ Facial Tissue

*\$50 + USPS Personal Money recommended (cash ok)

___ **\$1000 Intake Fee (non-refundable)**
**certified check or money order only*

Do Not Bring:

- ___ Jewelry *(only a watch, wedding ring or a medical ID bracelet)
- ___ Medical, dental or legal/court appointments *(must be taken care of before you begin RTCM)
- ___ Cigarettes, chew, snuff, drugs, alcohol, nicotine withdrawing substances of any kind, etc.
- ___ Magazines, books or any literature *(only your Bible)
- ___ Radios, mp3 player, clock radios, alarm clocks, etc.
- ___ Guns, knives, scissors, any other sharp instruments, or any other weapon
- ___ Food, snacks, drinks, etc.
- ___ Nutritional supplements, vitamins, etc.
- ___ No aerosols of any kind (body spray, deodorant, hair spray, etc.)
- ___ No checkbooks, credit cards, debit cards, or ATM cards.

*All medications are to be announced to the Intake Coordinator or Director prior to your arrival at the Training Center.
No mind-altering or narcotic medications allowed! OTC medications may be provided by the center.