

\* Office Use Only

**His Place Men's Program**  
**1415 2<sup>nd</sup> Ave, Opelika AL 36801**  
**(334)749-2130 Office (334)203-1830 Fax**

**Letter Sent:** \_\_\_\_\_  
**Interview Date:** \_\_\_\_\_  
**Accept/Decline:** \_\_\_\_\_

This information is confidential. It will not be held against you or used to judge you in any way. Please answer **all** questions honestly and **completely, not doing so will result in a declined application**. After completing the application, please write a 5 page story of your life so that we may know how to best help you.

**Please be aware we are a spiritually based 12 month recovery program. We are faith based. Your room and board will be provided for through generous donations from people who care for you. While in our care you will be responsible for any medical or dental care needed. If you are serious in your desire to get help, please call us regularly to see if we have an opening available for you. Your contact with us will keep your application valid. If we do not hear from you we will only hold an application 30 days, after that you would have to reapply.**

If you are accepted into the program the following documents will be needed before/upon your arrival:

Medical Physical including pap and liver enzymes \_\_\_\_\_

Blood work Tests & Test  
Results:

TB: \_\_\_\_\_ HIV/AIDS: \_\_\_\_\_ Hepatitis A, B, & C: \_\_\_\_\_

Birth Certificate: \_\_\_\_\_ Social Security Card: \_\_\_\_\_ Valid Picture I.D. \_\_\_\_\_

Psychological Evaluation: \_\_\_\_\_

\*\*\*\*\* **No Psychopathic Drugs Are Allowed While In Program** \*\*\*\*\*

**Personal Information:**

**Application Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Hair: \_\_\_\_\_ Eyes: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_ Type: \_\_\_\_\_ Valid? \_\_\_\_\_

**Education:**

Highest Grade Completed: \_\_\_\_\_ Graduated/GED: Yes \_\_\_\_\_ No: \_\_\_\_\_

**Emergency Contact:**

Name &amp; Phone Number of Person to Contact in an Emergency: \_\_\_\_\_

What is their relationship to you? \_\_\_\_\_

**Marital Status:**

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Engaged: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_ Widowed: \_\_\_\_\_

Number of times married: \_\_\_\_\_ Years married each time: \_\_\_\_\_

Does your Wife support your decision to get help? \_\_\_\_\_

Wife's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Names of Children and Ages: \_\_\_\_\_

**Parents:**

Names of Living Parents: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's contact phone: \_\_\_\_\_ Mother's phone: \_\_\_\_\_

Father's E---mail: \_\_\_\_\_ Mother's E---mail: \_\_\_\_\_

Names of Deceased Parents: \_\_\_\_\_

When did they die? \_\_\_\_\_

How did they die? \_\_\_\_\_

**Siblings:**Names and **ages** of siblings including yourself **in the order of birth:** \_\_\_\_\_**Hobbies & Interests:** \_\_\_\_\_**Medical:**

Please request any and all medical/psychological information from previous health provider, physicians, and counselors and submit upon arrival. Physical: \_\_\_\_\_ Psych Evaluation: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Primary Health Insurance Carrier Name &amp; Number: \_\_\_\_\_

Physician's Name &amp; Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Allergies: Yes \_\_\_\_\_ No: \_\_\_\_\_ List of allergies: \_\_\_\_\_

Current Medical Problems – Please be complete & specific: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all past surgeries or medical hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications Currently Taking Prescribed and Non---Prescribed: \_\_\_\_\_

List any physical limitations you may have as indicated by a physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been to counseling / psychiatrist? Yes\_\_\_\_ No\_\_\_\_\_ How long? \_\_\_\_\_

Have you ever been the victim of physical abuse? Yes\_\_\_\_ No\_\_\_\_\_ How long? \_\_\_\_\_

Have you ever self---mutilated? Yes\_ No\_\_\_\_ If yes, how & how recent? \_\_\_\_\_

Have you ever been the victim of sexual abuse? Yes\_\_\_\_\_ No\_\_\_\_\_ As a child?\_\_\_\_ As an Adult?

Do you have or have you ever contracted a sexually transmitted disease? Yes \_\_\_\_\_ No \_\_\_\_\_

Which STD? \_\_\_\_\_ Date Contracted: \_\_\_\_\_ Treatment: \_\_\_\_\_

CurrentStatus: \_\_\_\_\_

Sexual Preference: Heterosexual \_\_\_\_\_ Homosexual \_\_\_\_\_ Bisexual \_\_\_\_\_

Have you ever been involved in a homosexual relationship? \_\_\_\_\_

**Diet:**

Are you on a special diet? Explain: \_\_\_\_\_

Do you have food allergies? \_\_\_\_\_

Have you ever been diagnosed with an eating disorder? Please explain: \_\_\_\_\_

**Legal Information:**

Probation Officer:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E---Mail: \_\_\_\_\_

Attorney:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E---Mail: \_\_\_\_\_

List ALL arrests and results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List pending court cases, dates and allegations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any outstanding warrants for your arrest: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Substance Abuse:

List All Alcohol & Drugs You Use or Have Used:

Drug: _____	How Often: _____	How Much: _____	Last Used: _____
Drug: _____	How Often: _____	How Much: _____	Last Used: _____
Drug: _____	How Often: _____	How Much: _____	Last Used: _____
Drug: _____	How Often: _____	How Much: _____	Last Used: _____
Drug: _____	How Often: _____	How Much: _____	Last Used: _____
Drug: _____	How Often: _____	How Much: _____	Last Used: _____

When was the last time you used drugs? \_\_\_\_\_ Alcohol?

How old were you when you first started using drugs? \_\_\_\_\_ Alcohol?

Do you use tobacco/smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_ When did you smoke last?

Please note His Place is a smoke free facility. Are you willing to quit? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been in an alcohol, drug, or detoxification program before? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list the facilities: \_\_\_\_\_

Was it a religious or non---religious program? \_\_\_\_\_

Explain how it helped or hindered your recovery? \_\_\_\_\_

How involved were your family in your recovery process? \_\_\_\_\_

How willing are they in being involved in it now? \_\_\_\_\_

### Spiritual:

What life controlling problems do you see in your life that you need or want to resolve? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you feel that you have a need for God? \_\_\_\_\_

Have you ever committed your life to God? \_\_\_\_\_

What is your present relationship with God like? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Do you read the Bible? \_\_\_\_\_  
Are you open to Biblical solutions to your problems? \_\_\_\_\_  
Are you a member of any church or specific religion? \_\_\_\_  
Type of Religion: \_\_\_\_\_ Denomination: \_\_\_\_\_

**Financial:**  
Explain current financial obligations: \_\_\_\_\_  
\_\_\_\_\_  
Amount of current income and sources: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain why we should take you into our recovery program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to see happen in your life while you are with us? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you ready for your life to be changed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How willing are you to do whatever it takes to make the change? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you want to tell us more about yourself, please feel free to share with us anything you may find important for us to know in order for us to better understand your circumstances: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Applicant’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**His Place Director:** \_\_\_\_\_ **Date:** \_\_\_\_\_