



POTENTIAL NEW MEMBER ASSESSMENT

Assessment Date: ___/___/___

PERSONAL INFORMATION

Client Name: _____ SSN: _____

Birthdate: ___/___/___ Age: _____ Sex: _____

Currently Living: _____

Phone #: _____ When are you looking to become a Member? ___/___/___

Please check the following: Single Adult: _____ OR Family: _____

Number of Kids (If Applicable): _____ Kid Age(s): _____

Relationship Status: Married ___ Divorced ___ Single ___ In a Relationship ___

If in a relationship please describe:

On a scale of 1 to 10 with 1 being poor health and 10 being great health- How would you rate your:

Physical health _____ Mental Health _____ Emotional Health _____ Spiritual Health _____

How many hours per week would you like to invest to improve your health in each area?

Physical health _____ Mental Health _____ Emotional Health _____ Spiritual Health _____

List 3 Good Habits

List 3 Bad Habits

How many hours of volunteer work do you currently do? _____

Where? _____

Which would you say best describes your thoughts:

_____ I know me. _____ I don't know me.

Describe any areas of your life that you see yourself as broken _____

Describe any areas of your life that you see yourself as healed or healing _____

Think of the worst thing you have ever done. Which best describes how you feel when you think of it?

___ Sad ___ No Feeling ___ Angry ___ I want to vomit ___ All of the above ___ None of the above

What is the best curfew? ___ 8 p.m. ___ No curfew ___ Midnight



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When was the last time you really got mad? _____
Why? _____

List 2 goals do you have for the next 30 days? _____

List 1 goals you have the next 6 months? _____

Which is worse: ___ Not signing out of the building when required ___ Breaking Curfew

When was the last time you attended church? _____

What passage of the Bible did the Pastor speak from? _____

How often would you like to be tested for drug or alcohol use? _____

How long do you think is reasonable for a resident to have to leave if they drop dirty for a UA?

What is the benefit of not ever cleaning your room? _____

What is worse- ___ Sex with someone you are not married to ___ Smoking in a non-smoking area?
Why? _____

Do you think it is reasonable to have to walk up 3 flights of stairs 3 times a day for 7 days a week? ___

Would you rather (circle one) wash dishes clean toilets

What is the Bible? _____

How did you find out about Hope Street? _____

In your own words, describe why you would NOT be a good fit to become a member at Hope Street Ministry: _____



414.445.5404
2522 West Capitol Drive
Milwaukee, WI 53206

Is there any other comments you think we should consider?

EMPLOYMENT INFORMATION

Currently Employed? _____ Full Time _____ Part Time _____ Income \$ _____ Freq. _____
Other Income Source _____ Monthly Income: _____





PERSONAL INFORMATION

Client Name: _____
Drivers License #: _____ Issuing State: _____

MEDICAL HISTORY & MAJOR HEALTH ISSUES

Medical History (check all that apply):

___ High Blood Pressure ___ Diabetes ___ Heart Disease ___ Gout ___ Back Problems
___ Respiratory Problems ___ Asthma ___ HIV/AIDS ___ Hepatitis (Type: _____)

Mental Health Issues: (Check all that apply):

___ Depression ___ Mental Illness ___ Suicidal Thoughts ___ Paranoia ___ Schizophrenia
___ Hallucinations ___ Hearing Voices ___ Seizures ___ Head Trauma Current

Medications and Dosage:

Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

EDUCATION

High School Diploma or GED: Yes ___ No ___ Last Grade Completed in School: _____
Can you read and write? ___ Yes ___ No Plans for furthering Education: ___ Yes ___ No

CRIMINAL HISTORY

Have you been convicted of a crime? Yes ___ No ___
If Yes, list convictions and crimes not sentenced of yet: _____

Are you currently incarcerated? Yes ___ No ___ If yes, what is your release date? _____

Registered Sex Offender? Yes ___ No ___

Currently on Probation or Parole: Yes ___ No ___

When will you be off supervision: _____

Terms of Supervision: _____

Agent Name: _____ Phone #: _____



ADDICTION HISTORY

Drug(s) of choice (check all that apply):

Alcohol Cocaine Heroin Marijuana Prescriptions Other _____

Age you began using: _____ Longest Period of sobriety: _____ Current length of sobriety: _____

Have you completed any treatment: _____ When? _____ Any other addictions: _____

Summary of drug abuse history:

REFERRAL SOURCE

Rescue Mission

Treatment Center- Specify _____

County

Church- Specify _____

Walk In

Resident Referral – Specify _____

Word of Mouth

Staff Referral – Specify _____

PAN

Community Corrections- Specify

Ministry - Specify _____

Other: _____

EMERGENCY CONTACTS

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

