



# POTENTIAL NEW MEMBER ASSESMENT

Assessment Date: \_\_\_/\_\_\_/\_\_\_

## PERSONAL INFORMATION

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

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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 \_\_\_\_\_

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 -or- 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: \_\_\_\_\_



Is there any other comments you think we should consider?

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**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

Mental Health Issues: (Check all that apply):

\_\_\_ Depression \_\_\_ Mental Illness \_\_\_ Suicidal Thoughts \_\_\_ Paranoia \_\_\_ Schizophrenia \_\_\_  
Hallucinations \_\_\_ Hearing Voices \_\_\_ Seizures \_\_\_ Head Trauma Current: \_\_\_\_\_

## MEDICATIONS & DOSAGE

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_  
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## 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: \_\_\_\_\_