Applicants Last Name: _____

PRE-ADMISSION ASSESSMENT

Please print legibly. It is important to fully complete this form. Any assessments not legible or fully completed will be returned without review.

Name: _____ Age:_____ DOB:_____ SS#_____

Phone #:_____Sobriety Date: _____Longest Sobriety: _____ When: _____

Photo ID: ____ Gender_____ Pronouns (circle): she/her/hers they/them/theirs other _____

Ethnic Background: Caucasian___ Black___ Hispanic___ Other _____

Marital Status: Single___ Married___Divorced___Separated___ Family Size: _____ Family Income: _____

Where have you been staying? _____Address: _____City/St_____ Zip Code:_____

(•) Own ( ) Friend ( ) Parent ( ) Homeless/Shelter ( ) Jail

# of Children: _____ Ages and gender: _____

Where are your children staying? _____ Do you have contact? _____

Do you have a DCS Case?_____ If yes, DCS contact info: _____

Do you receive: SNAP (Food Stamp) Benefits? _____ Do you receive TANF Benefits? _____

Medical Insurance

Do you have Medical Insurance? _____ If yes: Insurance Provider: _____

Insured Name: _____ Insureds D.O.B: _____

Group#: _____ Insurance ID#:_____ Payor ID#:_____

Benefit Verification Phone: _____ Claim Submission Phone: _____ Copy of Card: _____

Emergency Contact

Name: _____ Relationship: _____Phone:_____

Address:_____

Referral: Who told you about Dove House?

Name: _____ Organization: _____

How can Dove House help you? _____

Staff Notes:

STAFF USE ONLY

Assessment completed by: _____

Date Waitlisted: _____

Handbook provided: _____

Waitlist instructions provided: _____

Date Admitted: _____ CM: _____

Date removed from waitlist: _____

Reason Removed: _____

Applicants Last Name: _____

PRE-ADMISSION ASSESSMENT

ALCOHOL/DRUG USE HISTORY

Drug of **choice & age** of first use: **1st**_____**/Age**_____ **2nd**:_____**/Age**_____ 3rd:_____**/Age**_____

What is your current frequency of use? _____

How do you use? _____ Have you ever used or shared a needle? _____

Have you used any of the following: (check all that apply): Alcohol ☐ Heroin ☐ Marijuana ☐ Hallucinogens ☐
Crack ☐ Benzos ☐ Opiates ☐ Meth ☐ Cocaine ☐ Speed ☐ Synthetics ☐

Substance Abuse/Mental Health Treatment

Have you ever been diagnosed w/ a mental health disorder? _____ If yes, what was the diagnosis? _____

Were you actively using at time of diagnosis? _____ Have you ever had issues with an eating disorder? _____

If yes, what type of disorder? _____ When is the last time you engaged in eating disorder behaviors? _____

Date	Program Name	Type of Program	Length of Treatment	Outcome of Treatment

Family History of Substance Abuse

	Y	N	Notes
Mother	◯	◯	
Stepmother	◯	◯	
Father	◯	◯	
Stepfather	◯	◯	
Brother(s)	◯	◯	
Sister(s)	◯	◯	
Aunts/Uncles	◯	◯	
Cousins	◯	◯	
Grandparents	◯	◯	
Children	◯	◯	

Current Partner:

Name: _____

Address: _____

Phone #: _____

Length of relationship: _____

Substance Use? *:* _____

Former Relationships (5 Years back)			
Name	From	To	User?

Foster Care:

Have you ever been in foster care? _____ If Yes, how many times? _____ How old were you? _____

Physical/Emotional/Sexual Abuse History:

Have you been a victim of CHILDHOOD: Physical Abuse_____ Mental/Emotional/Abuse_____ Sexual Abuse _____

Have you been a victim of rape? _____ If yes, when _____

Domestic Violence

Are you currently fleeing a domestic violence situation? _____ Have you ever been in a domestic violence situation? _____

If yes, who was the perpetrator and when did this occur? _____

Suicidal Ideation

Have you ever attempted suicide? _____ # of attempts ____ When? _____ Method? _____

Do you currently have suicidal thoughts or feelings? _____

If yes, have you thought about how, when or where this would occur? _____

MEDICAL HISTORY & SCREENINGS

	DATE	(+,-)
HIV		
HEP		
TB		
STD'S		

Date of your last physical examination: _____

Physician's Name/Clinic: _____

Blood type: _____ Date of last Menstrual period: _____

Birth control: _____

Are you currently under a physician's care? _____ If yes, for what condition:_____

_____

Do you have any medical and/or physical issues that need to be addressed? _____If yes, what are they? _____

_____

Current Medications (include over the counter and prescription)

Name of Medication example: Lexapro	**Dosage/Frequency** example: 20mg/day	**Route** example: oral, inhaler, injection	**Reason for medication** example: depression

Add an attachment to the document if you take more than 5 medications.

PRE-ADMISSION ASSESSMENT

Currently, does your insurance cover your medication cost completely? _____

How much do you pay out of pocket for your medications monthly? _____

How do you plan to pay for medications while living at Dove House?

_____

Are you allergic to any food or medications? _____If yes, what are they? _____

Do you have a special diet?_____ If yes, please explain:_____

Do you have any physical limitations that would not permit you to climb stairs?_____

Check all that apply:

☐ Diabetes ☐ Hypertension (High Blood Pressure) ☐ Hyperlipidemia (High Cholesterol) ☐ Cancer

☐ Smoking ☐ Obesity ☐ Asthma ☐ COPOD

Have you ever experienced a Traumatic Brain Injury? _____

If yes, when did this occur? _____

If yes, what symptoms are you still experiencing? _____

_____

Adverse Childhood Experience Study (A.C.E.S)

Circle one answer and for each question. If yes, enter a 1 on the line. Total at the bottom

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down or humiliate you?
   Or
   Act in a way that made you afraid that you might be physically hurt…. ◯Yes ◯No _____

2. Did a parent or other adult in the household often or very often….
   Push, grab, slap or throw something at you?
   Or
   Ever hit you so hard that you had marks or were injured? …… ◯Yes ◯No _____

3. Did an adult or person at least 5 years older than you ever….
   Touch or fondle you or have you touch their body in a sexual way?
   Or
   Attempt to actually have oral, anal or vaginal intercourse with you? ◯Yes ◯No _____

4. Did you often or very often feel that….
   No one in your family loved you or thought you were important or special?
   Or
   Your family did not look out for each other, feel close to each other or support each other?
   ◯Yes ◯No _____

5. Did you often or very often feel that….
   You did not have enough to eat, had to wear dirty clothes, and had no one to protect you?
   Or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ◯Yes ◯No _____

6. Was your mother or stepmother…
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   Or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   ◯Yes ◯No _____

7. Were your parents ever separated or divorced? ◯Yes ◯No _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ◯Yes ◯No _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   ◯Yes ◯No _____
10. Did a household member go to jail? ◯Yes ◯No _____

Total _____

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement**:**

1. I believe that my mother loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.

Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.

Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.

Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.

Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.

Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of the 14 were circled "Definitely True" or "Probably True" _____

Of these circled, how many are still true? _____

Burn's Depression Checklist

PRE-ADMISSION ASSESSMENT

Read each statement. Answer according to how you are feeling today.

Instructions: Put an X to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		0=Not At all	1=Somewhat	2=Moderately	3=A lot	4= Extremely
Thoughts and Feelings						
1	Feeling sad or down/in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling depressed					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end our life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1-25 here					
	Total					

Total Score	Level of Depression
0-5	No Depression
6-10	Normal but unhappy
11-25	Mild depression
26-50	Moderate depression
51-75	Severe depression
76-100	Extreme depression

Applicants Last Name: _____

Legal History

PRE-ADMISSION ASSESSMENT

Criminal History		
Date	Charge	Resolution

Current Charge(s): _____ Action Needed: _____

If currently incarcerated, do you have a projected Release date from jail/Prison? Y N Date: _____

Probation/Parole/Case Manager: _____Agency: _____

Phone: _____ Address: _____

Have you ever prostituted? **Y N** If yes, when? _____

Did you work for someone else while prostituting? **Y N** If Yes, what was the first name of that person? _____

Education/Employment History and Income

Last grade completed: _____ Degree? _____ Do you have a trade or skill? _____

Are you able to work? _____ If no, why? _____

Work Experience: Most Recent First going back 5 years				
From	To	Company	Position	Why did you leave?

Military Service: Have you served in the Military? _____ If yes, when/what capacity? _____

Discharge Status: _____ Is an immediate family member in the military? _____

By completing and signing this application, I wish to be considered for admission to Dove Recovery House for Women at Summerlin Place. All information provided is true. I understand a 90-day commitment is expected at time of admittance. I authorize Dove House Staff to contact any references listed by me on this application. I am homeless or at risk of becoming homeless.

_____

Applicant Signature Date

_____

Staff Signature Date

DOVE
RECOVERY HOUSE FOR WOMEN

DOMESTIC VIOLENCE LETHALITY SCREENING

1. Has he/she ever used a weapon against you/threatened you with a weapon?
Yes ☐ No ☐
Comments:

2. Has he/she ever threatened to kill you or your children?
Yes ☐ No ☐
Comments:

3. Do you think he/she might try to kill you?
Yes ☐ No ☐
Comments:

*** A Yes to 1-3 should indicate a staffing with director's and likely a referral to a DV shelter. If the decision is made to admit, a safety plan necessary for survivor must be completed.**

4. Does he/she have a gun or can he/she get one easily?
Yes ☐ No ☐
Comments:

5. Has he/she ever tried to choke you?
Yes ☐ No ☐
Comments:

6. Is he/she violent or constantly jealous or does he/she control most of your daily activities?
Yes ☐ No ☐
Comments:

7. Does he/she follow or spy on you or leave threatening messages?
Yes ☐ No ☐
Comments:

8. Have you left him/her or separated after living together or being married?
Yes ☐ No ☐
Comments:

9. Is he/she unemployed?

Yes ☐ No ☐

Comments:

10. Has he/she ever tried to kill himself/herself?

Yes ☐ No ☐

Comments:

11. Do you have a child/children together?

Yes ☐ No ☐

Comments:

12. Do you have a child that he/she knows is not his/hers?

Yes ☐ No ☐

Comments:

13. Has he/she been physical toward the child(ren) in a way that concerns you?

Yes ☐ No ☐

Comments:

14. Does he/she have an alcohol/substance abuse problem?

Yes ☐ No ☐

Comments:

15. Has he/she interfered with a 911 call?

Yes ☐ No ☐

Comments:

16. Is there anything else that worries you about your safety?

Yes ☐ No ☐

Comments:

***Negative responses to 1-3, but atleast 4 positive responses to 4-16 should indicate a treatment plan necessity.**