



ASSESSMENT APPLICATION FORM

PART 1 OF 5:

BASIC INFORMATION

Given Names _____

Last Name _____

Street Address _____

City _____ State _____ Postcode _____

Home Phone _____ Mobile _____

Date of Birth _____ Marital Status _____

Are you of Aboriginal or Torres Strait origin? Yes No

SPOUSE'S DETAILS

Name _____

Street Address _____

City _____ State _____ Postcode _____

Home Phone _____ Mobile _____

How did you hear about us? _____

NEXT OF KIN DETAILS

Please note that it is policy that your next of kin will be notified on your exit from the program or in the case of misadventure.

Do you agree to this procedure?

Yes No

Next of Kin _____

Relationship _____ Home Phone _____

Business Hour Phone _____ Mobile _____

Address _____

City _____ State _____ Postcode _____

CHILDREN

Do you have any children?

Yes

No

Carer details

Name _____

Address _____

City _____ State _____ Postcode _____

Home Phone _____ Mobile _____

BENEFIT DETAILS

Type of benefit _____ Amount per fortnight \$ _____

Centrelink Ref No _____ Date of next payment: _____

PART 2 OF 5:**QUESTIONNAIRE****2.1 LIFE CONTROLLING ISSUES****Do you use drugs?**

Yes

No

If yes, what do you use and how often? _____

Do you drink alcohol in excess?

Yes

No

If yes, what do you use and how often? _____

Do you use prescription medications?

Yes

No

If yes, what medications do you use and how much? _____

How many years have you been drug or alcohol dependant? _____**Do you or have you ever had an eating disorder?**

Yes

No

If Yes, explain: _____

Do you or have you ever self harmed? Yes No

If Yes, explain: _____

Have you ever attempted self-harm with the intent to end your life? Yes No

If Yes, explain: _____

What other issues do you have that you need help with? _____

What other areas would you like to address while at Destiny Haven? _____

2.2 EMPLOYMENT HISTORY

What type of work have you done? _____

Do you have a current Job? Yes No

If yes, where do you work? _____

Do you have a current driver's licence? Yes No

Have you ever been in jail or been convicted of a crime or offence? Yes No

If yes, please give details _____

2.3 FINANCES

Are you in debt? Yes No

If yes give details as to whom the debt is owed, and how much you owe: _____

2.4 LEGAL MATTERS

Do you have to appear in court in the near future? Yes No

If yes, please give details _____

Would you require court support from Destiny Haven? Yes No

Are you aware that there could be a cost involved for Court support? Yes No

Are you in agreement to cover petrol cost for one of our team to support you in court?

Yes No

2.5 OTHER RELEVANT INFORMATION

Group therapy and education is part of our Training Centre Program. Do you agree to participate fully in this aspect of your recovery? Yes No

Do you agree to undertake personal counselling inside and outside the program if needed? Yes No

Do you agree to participate in the daily work program which is a requirement of each client? Yes No

Are you willing to follow all guidelines, and directives given by Destiny Haven staff? Yes No

Our programs are Christian based and formulated from a Christian worldview. Will you agree to take part in these and complete all homework as required? Yes No

Attending Church is part of the program, and attendance is compulsory. Are you willing to participate in this as part of the program?	Yes	No
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What is your religion? _____

Destiny Haven is a smoke free program. Do you agree to abide by this rule, knowing that smoking (even on days or weekends out) will incur immediate discharge?	Yes	No
--	-----	----

Destiny Haven's rules have been made for the good of every person in our community. Are you willing to abide by the program rules?	Yes	No
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Random drug testing is part of our program and clients may be asked to undertake these. Are you willing to undergo this as requested?	Yes	No
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Having read the Destiny Haven rules (Appendix A and B of this document) do you agree to abide by the rules set down for your involvement in the program?	Yes	No
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Extreme body piercings are not allowed in our program. Do you agree to remove extraneous piercings if requested? (e.g. lip, eyebrow, tongue)	Yes	No
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I declare that all answers and information I have given are true and correct and understand that if found to be otherwise I may be discharged from the program and facility.

Signed _____

Date _____

PART 3 OF 5:

FAMILY AND SIGNIFICANT OTHERS QUESTIONNAIRE

The purpose of this questionnaire is to try and establish the client's relationship to "significant" other people in their life. Unhealthy relationships between the client and significant others may be a contributing factor to relapse. By identifying the nature of relationships between significant others and the client "the extent to which this co-dependency has impaired the normal development and functioning of each individual" can be determined.

3.1 GENERAL QUESTIONS

Are you married or living with someone?

No / Married / Defacto

How long has this relationship existed? _____

How many times have you been married? _____

How many times have you "lived" with someone? _____

Do you have a series of short-lived relationships or long term relationships? Yes / No

Have you recently finished a relationship? Yes / No

How long ago? _____

What is the quality of your relationship with the following members of your family? (e.g. is it hostile, neutral, supportive, nurturing, close, loving, alienated?)

Mother (natural, foster, step)	
Father (natural, foster, step)	
Siblings (natural, foster, step)	
Other family figures (Grandparents, aunts, uncles, godparents)	

Spouse	
Children	

What is your position in the family hierarchy? (i.e. first/last born) _____

Were you considered special by either parent? _____ Yes / No

By which parent and in what ways were you considered special? _____

Do you have a history of either parent being away a lot as a result of work, illness, etc.?

Yes / No

Can you explain in more detail what this meant for you? _____

3.2 ADVERSE FAMILY CONDITIONS

Is there a history of any of the following conditions occurring in your family that you are aware of? (Go back 3-4 generations if you can and state the family member that the condition applies to)

1. Drug Abuse _____
2. Alcoholism _____
3. Emotional or physical violence _____
4. Incest or other unusual sexual behaviour, eg paedophilia _____
5. Suicide or attempted suicide? _____
6. Mental illness including agoraphobia, anorexia, etc. _____
7. Compulsive gambling _____
8. Compulsive promiscuity _____
9. Criminal behaviours _____
10. Compulsive television viewing _____
11. Workaholism _____
12. Excessive relocation/separation from parents _____
13. Long term illness in the family (physical or psychiatric) _____

14. Is there a history of severe living problems in your "spouse's" family? Yes / No
15. Describe your perception of these problems _____

3.3 FAMILY SITUATIONS

Explain the parenting situations in your upbringing, that is, was your family upbringing in a monogamous, heterosexual, nuclear family, or was there a variation from this and in what ways did the variation affect you? _____

3.4 SEPARATION

Have you lost someone close to you through any of the following, and who?

Death	Yes / No	_____
Murder	Yes / No	_____
Suicide	Yes / No	_____
Divorce	Yes / No	_____
Separation	Yes / No	_____
Incarceration	Yes / No	_____

As a child were you ever separated from your family due to

Illness	Yes / No	_____
Long periods of hospitalisation	Yes / No	_____
Institutionalisation (e.g. boarding)	Yes / No	_____

3.5 SOCIABILITY

Have you ever belonged to any social or institutional groups?

E.g. Church groups	Yes / No
Community groups	Yes / No
Political groups	Yes / No

Street gangs	Yes / No
Social clubs	Yes / No
Sports groups/clubs	Yes / No
Therapy groups	Yes / No
NA / AA	Yes / No

What is your general attitude towards group affiliations? _____

Do you prefer to spend most of your free time alone, with one person, or in a group? _____

Do you have any hobbies? What are they? _____

Are there other activities you would like to develop? _____

What are some of the areas that you think you will most struggle with in entering a residential program? _____

PART 4 OF 5:

AUTHORITY

4.1 CENTRELINK

I, _____

of _____

do hereby give permission for any information concerning my claim for Centrelink to be passed on to the Managers of Destiny Haven. I also give permission for the Destiny Haven Managers to give information in relation to this claim to Centrelink should I be accepted into the program.

Signed: _____

Witnessed: _____

Date: _____

4.2 PERSONAL

Information to be released:

I, _____ do hereby authorise the Managers of
Destiny Haven to release information regarding myself to the following: _____

Information to be withheld:

Please do not discuss any information regarding myself with the following:

Signed: _____

Witnessed: _____

Date: _____

PART 5 OF 5:

MEDICAL INFORMATION

PRIVATE AND CONFIDENTIAL

IMPORTANT

- You must undertake a full blood test within two weeks before being admitted into the Destiny Haven program. The written results must be brought with you on the day of admission.
- You are required to bring a doctor's clearance, declaring your ability to participate in physical activities including fitness training and gardening.
- You must ask your doctor's surgery for the correct form of release of your records so that our doctor has access to your medical information.
- Please take note that it is your responsibility to have your teeth checked prior to being admitted to the program. Any routine visit to a dentist will not be permitted within the first three months of commencement of our program. Only emergency dental treatment will be sought within the first three months.

5.1 MEDICAL DETAILS

Medicare No _____

CRN No _____

Doctor's Name _____ **Phone No** _____

Address _____

City _____ **State** _____ **Postcode** _____

Do you suffer from	Asthma	Yes / No
	Diabetes	Yes / No
	Epilepsy	Yes / No
	Heart problems	Yes / No
	High blood pressure	Yes / No
	Phobias _____	Yes / No
	Allergies _____	Yes / No

Do you have active HIV, Hepatitis B or Hepatitis C? Yes / No

Have you been tested recently? Yes / No

If yes, please give details _____

Are you aware that you may be required to have further blood tests during the program?

Yes / No

Have you ever been on medication?

Yes / No

If yes, please give details _____

Have you ever been addicted to medication?

Yes / No

If yes, please give details _____

Do you smoke cigarettes?

Yes / No

How many per day? _____

Do you have any illness at the present time

Yes / No

e.g. bronchitis, sinus problems – give details _____

Please note details of any other medical problems that you have _____

5.2 HISTORY

Have you ever been to a rehabilitation, recovery or residential program before? Yes / No

If yes, when, where and how long did you stay?

Program	Location	Length of Stay

Have you had contact with the mental health system?

Yes / No

If yes, please give details _____

Have you been admitted to a mental health facility?

Yes / No

How many times have you been admitted voluntarily?

How many times have you been admitted involuntarily?

When was your most recent admittance to a mental health facility and what was the reason for your admittance? _____

Have you seen a counsellor or psychologist before?

Yes / No

If yes, please list his or her details:

Name	
Phone	
Address	

For how long did you see this psychologist? _____

How did seeing this psychologist help? _____

5.3 OTHER HEALTH INFORMATION

Do you have any special considerations shown below? If yes, please give details.

Dietary	Yes / No	_____
Spiritual	Yes / No	_____
Emotional	Yes / No	_____
Physiological	Yes / No	_____
Behavioural Therapy	Yes / No	_____

Have you ever experienced any of the below? If yes, please give details.

Depression	Yes / No	_____
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Mood swings	Yes / No	_____
Violent outbursts	Yes / No	_____
Anxiety attacks	Yes / No	_____
Panic attacks	Yes / No	_____
Paranoia	Yes / No	_____
Hallucinations	Yes / No	_____
Drug Psychosis	Yes / No	_____
Liver damage	Yes / No	_____
Kidney damage	Yes / No	_____
Stomach ulcers	Yes / No	_____
Anorexia	Yes / No	_____
Bulimia/or other	Yes / No	_____
Do you have an addiction?	Yes / No	_____
Are you pregnant?	Yes / No	_____

5.4 CLIENT MEDICAL CONTRACT

I _____ agree to the following terms and understand that if I breach any part of this contract I will be discharged from the Destiny Haven program.

Diagnosed Illnesses _____

Prescribed Medication

Prescribed Medication	Dosage	Time to be Taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

6. _____

I understand that:

- My medication will be held in the office and dispensed by Staff of Destiny Haven.
- I must ensure that I have a repeat prescription of my medication at the time of arrival.
- Any alterations to the above must first be approved by Destiny Haven's consulting Doctor, in consultation with Destiny Haven's Management.

Client Signature _____

Date _____

5.5 AUTHORITY MEDICAL

CONSENT TO OBTAIN INFORMATION

I, _____

of _____

hereby give permission for the Managers of Destiny Haven Life Development Training Centre to obtain relevant information from medical practitioners, other agencies and/or medical health professionals specifically relevant to my management and treatment while a resident of Destiny Haven Life Development Training Centre.

CONSENT TO RELEASE INFORMATION

I, _____ hereby agree to undertake a full blood test prior to arriving at Destiny Haven and to bring the results with me on the date of my arrival into the program.

I agree to allow my medical practitioner to speak to the Management of Destiny Haven regarding any physical or mental problems I may have. I also agree to make arrangements to have my medical records sent to the local medical practitioner on my arrival at Destiny Haven.

Signed

Consent to obtain information

Signed

Consent to release information

Date

Witnessed by

Date

I HAVE READ THE PROGRAM RULES AS LISTED IN APPENDIX A AND APPENDIX B AND AGREE TO ABIDE BY THEM AS STATED.

Signed

Date
