WARRIORS CENTER **Online Application**

Thank you for your interest in the Warriors Center. Our program is designed to help people struggling with homelessness, substance abuse or other life controlling problems who desire a faith-based approach to recovery.

Campus Location: Memphis Olive Branch (Women's Center) Bolivar

Program Applying For: Long Term Recovery Program 28 Day Spiritual Boot Camp Out-Patient

First Name:_____ **SSN:** _____-_____-_____ ☐ **Sex:**

Middle Name:_____ ☐ Male

Last Name:_____ **DOB:** ____/____/____ **Age:** _____ Female

Current Address:

Street: _____ **Height:** _____ **Weight:** _____

City: _____ **Legal Resident Of:**

State: _____ Zip: _____ State: _____

Phone: _____ Email: _____ County: _____

Have You Previously Been in the Warriors Center Program? Yes No **When?** _____

Marital Status: Single Married Divorced Engaged Separated

Race: American Indian Asian Black Hispanic Multi Racial White Other

Do You Read And Write English At A 5th Grade Level or Above: Yes No

Do You Have A High School Diploma? Yes No **If No, Do You Have A GED?** Yes No

I Need Help With: (Check All That Apply) Alcohol Addiction Drug Addiction

Homelessness: Other: _____

Have You Ever Been Treated for Substance Abuse? Yes No How many times? _____

Prior Treatment Facility: (list the most recent treatment program you have been in)

Name of Facility: _____

Address: _____

City: _____ State: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

Did you complete the program? Yes No

PHYSICAL HEALTH

Medical History: (Check all that apply to your current and past conditions)

Asthma	Head Trauma/TBI	Respiratory Problems
Alcohol Abuse	Heart Condition	Seizures
Diabetes Type 1 Type 2	Hepatitis	STI/STD
Mental Illness	High Blood Pressure	Tuberculosis
Drug Abuse	HIV/AIDS	Other _____

Do you have any other current medical concerns?

_____

_____

Are you currently being treated by a doctor? Yes No

Are you pregnant? Yes No Due Date:____/____/_____

Non Mental Health Medications:

List all current non- mental health medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Are you being treated with prescribed narcotics? *(Applicants on prescribed narcotics will need to complete the regimen prior to admission or switch to non-narcotic pain medications.)* Yes No

If Yes, what medications?

_____

Are you allergic to any medications? Yes No If Yes, what medications?

_____

_____

_____

Substance Abuse

Do you have a problem with alcohol? Yes No Type: _____

Do you have a problem with drugs? Yes No Type: _____

Do you have a problem with prescription meds? Yes No Type: _____

Do you need detox? Yes No Type: _____

MENTAL HEALTH

Have you ever been treated for mental disorders? Yes No When: ____/____/____

Have you ever been treated by a psychiatrist/psychologist? Yes No Last Visit: ____/____/____

Mental Health History: (Check all that apply to your current and past conditions)

ADD / ADHD

Anger Problems

Anorexia

Anxiety Disorder

Bipolar Disorder

Brain Injury

Bulimia

Depression

Hallucinations

Hearing Voices

Homicidal Tendencies/Thoughts

Insomnia

Multiple Personalities

Paranoia

Personality Disorder

Physical Abuse

PTSD

Schizophrenia

Suicide Attempts

Suicide Thoughts

Have you thought about, or attempted suicide in the past 3 months? Yes No If yes, how long ago:

_____

Name of Primary Psychiatrist/Psychologist: _____

Address: _____

City: _____ State: _____

Phone: _____ Fax: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

Mental Health Medications Currently Taking:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		

SPECIAL NEEDS

Do you have any type of disability? Yes No Type: _____

Do you have any medical restrictions? Yes No Type: _____

Do you have any other type of special needs? Yes No Type: _____

Do you require a special diet?* Yes No Type: _____

FINANCIAL INFORMATION

Are you presently employed? Yes No If yes, what is your monthly income? _____

Do you receive any other income (SSI, disability, etc)? Yes No If yes, what is the monthly amount?

_____

Do you currently receive any government assistance? Yes No What type?

_____

Do you have type of medical insurance? Yes No If yes, please provide the following information:

Insurance Provider:_____ Member ID

Number:_____

City:_____ State:_____ Zip:_____ Phone: ( )____-_____

Do you have a case worker: Yes No If yes, please provide the following information:

Case Worker's Name: _____

Address:_____

City: _____State: _____Zip Code: _____

Phone: _____Fax: _____

EMERGENCY CONTACTS

Primary Contact Name: _____ Relationship:

_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____ Email:

_____

Secondary Contact Name: _____ Relationship:

_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____ Email: _____

LEGAL ISSUES

Are you currently on probation? Yes No State/County: _____

Are you currently on parole? Yes No State/County: _____

Do you currently have any court cases pending? Yes No State/County: _____

Do you currently have any outstanding warrants? Yes No State/County: _____

Have you ever been convicted of a violent crime? Yes No If yes, please list each conviction and date:

_____

_____

_____

_____

_____

Have you ever been convicted of a sex related crime: Yes No If yes, please list each conviction and date:

_____

_____

_____

Are you currently facing charges for a violent or sex related crime? Yes No If yes, please describe fully:

_____

_____

Are you required to register as a sexual or predatory offender? Yes No

Probation or Parole Officer's Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Attorney's Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

In your own words, tell us why you need help and why you want to come to the Warriors Center:

_____

_____

_____

_____

_____

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. Furthermore, I understand that the Warriors Center is a faith-based program and that I have made a free and independent choice to enroll. I understand that other program options are available to me and I have had an opportunity to request a referral.

_____ ____/____/____

Applicant's Signature Date

Voluntary Compliance with Faith Based Activities

Warriors Center is a faith-based program that is based upon Christian principles and practices. As such, Warriors Center is only an appropriate option for people desiring such a program and who are willing to commit to fully participate in it. If you do not want to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better meet your needs.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to Warriors Center, I agree to the following:

Yes No I will participate in daily devotions, Bible studies and chapels.

Yes No I will participate in the weekly church services and special events.

Yes No I will participate in lecture classes, individualized study courses, group counseling, individual counseling, and other program components that are based on Christian principles.

Yes No I will attend and serve in all scheduled outreaches.

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the Warriors Center program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

_____ ____/____/____

Applicant's Signature Date