

# APPLICATION FOR HARMONY MINISTRIES

## (Harmony and Shiloh Houses)

DATE \_\_\_\_\_

**PLEASE PRINT**

1. Client's Name: \_\_\_\_\_ Sin # \_\_\_\_\_  
 Care Card # \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Address: \_\_\_\_\_  
  
 Phone \_\_\_\_\_ (wk) \_\_\_\_\_ best time to call: \_\_\_\_\_  
  
 Marital Status: \_\_\_\_\_ single \_\_\_\_\_ engaged \_\_\_\_\_ married \_\_\_\_\_ widowed \_\_\_\_\_ divorced  
 \_\_\_\_\_ separated \_\_\_\_\_ common-law      how long \_\_\_\_\_ how many times \_\_\_\_\_  
 Education \_\_\_\_\_ Occupation \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Birth date \_\_\_\_\_ Sin # \_\_\_\_\_ Care Card \_\_\_\_\_  
  
 Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_  
 Ministry Worker \_\_\_\_\_ A/D worker \_\_\_\_\_ Other \_\_\_\_\_  
 Income source \_\_\_\_\_ Monthly Income \_\_\_\_\_ Phone \_\_\_\_\_

2. List name, birth date, sex, relationship of all children, and whether they live at home with you.

NAME	BIRTH DATE	SEX	RELATIONSHIP	AT HOME?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. State the nature of the problem in your own words;

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What is your most difficult relationship right now?

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What is your most difficult emotion right now?

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**4. CRISIS INFORMATION:**

Do you have any current suicidal thoughts feelings or actions?       yes       no

If yes please explain:

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Do you have any past problems with hospitalizations, or jailing for suicidal or assaultive behavior?

yes       no - If yes please explain:

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Do you experience any current threats of significant loss or harm (illness, divorce, custody, job loss etc.)?

yes       no - If yes please explain:

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Are you presently on probation, or parole?  yes       no. If yes please explain:

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Name of Parole/ Probation Officer: \_\_\_\_\_

Phone: \_\_\_\_\_

5. **MEDICAL INFORMATION:**

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you presently taking any medications? If yes, please list below:

MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_

Any problems with: \_\_\_ eating \_\_\_ sleeping \_\_\_ chronic pain \_\_\_ recent weight changes.

Describe any answers checked above:

Any other medical problems: \_\_\_\_\_

Have you or a family member ever been hospitalized for mental or emotional illness?

\_\_\_ yes \_\_\_ no - If yes, please explain dates, places, reason:

\_\_\_\_\_

6. **COMMON PROBLEM CHECKLIST.** FILL IN: 0 = none, 1 = mild, 2 = moderate, 3 = severe

- |                      |                    |                       |
|----------------------|--------------------|-----------------------|
| ___ marriage         | ___ divorce        | ___ premarital        |
| ___ work             | ___ weight control | ___ alcohol           |
| ___ sexual issues    | ___ singleness     | ___ family            |
| ___ grief/loss       | ___ anxiety        | ___ depression        |
| ___ other addictions | ___ mood swings    | ___ past hurts        |
| ___ children         | ___ intimacy       | ___ drugs             |
| ___ self-esteem      | ___ anger control  | ___ stress management |

If any others, please specify:

\_\_\_\_\_

7. Who referred you to us? (Name, relationship, and phone number(s))

\_\_\_\_\_  
\_\_\_\_\_

8. By signing this form, I agree to do assignments and homework. I am willing to risk making the changes suggested by staff. I will show up for scheduled appointments.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_\_\_\_

Client Signature: \_\_\_\_\_

Harmony Ministries Director: \_\_\_\_\_