**WOMEN AT THE WELL MINISTRIES OF PA**

**Admission Information Form:**

**General:**

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

Last First Middle

Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Names/Aliases:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City St. Zip

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

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone

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

City St. Zip

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone

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

City St. Zip

Driver’s License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Health Insurance: Y / N

Company Name/Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any outstanding debts?: Y / N How much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information:**

DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_

Hair Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthmarks/distinguishing marks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: Asian Black Hispanic Pacific Islander White

Do you live on your own?: Y / N

Marital Status: Single Married Separated Divorced Remarried Widowed

How long were/have been married:\_\_\_\_\_\_\_\_\_\_\_

Do you have issues with having healthy relationship?: Y /N

How many Children:\_\_\_\_\_\_\_\_ Ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Church background:

As a child: None Some Often

As an adult None Some Often

Family background: If applicable to your situation

Mother’s Name/Address/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name/Address/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Issues you feel need addressed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you an American citizen: Y / N Naturalized Native

Sexual Life: Heterosexual Bisexual Homosexual Trans-sexual

Have you ever had an abortion: Y / N

**Health Information**

Any health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you wear glasses/contact lens: Y/ N

Are you pregnant: Y / N

List surgeries/year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have a special diet requirement: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an eating disorder: Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: Y / N List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medications you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle what you have experienced

Scarlet fever Herpes Gonorrhea

Chicken pox Syphilis Diphtheria

Mumps Hepatitis Tuberculosis

Whooping cough Pneumonia Nervous bread-down

Typhoid fever Cancer Anemia

Circle any of the following that applies:

**HEAD/EYES/EARS**   **CARDIAC**

Severe headaches High blood pressure

Blurred vision Low blood pressure

Double vision Severe chest pain

Eye pain Racing heart

Watery eyes Shortness of breath

Hearing loss Swelling of ankles

Frequent sneezing Leg cramps

Hay-fever Rheumatic fever

Sinus problems Heart problems

**Respiratory Gynecology**

Persistent cough Frequent urination

Coughing up blood Excessive thirst

Resp. cont. Gyn. cont.

Asthma Blood in urine

Night sweats Frequent urination @ night

Wheezing Burning with urination

Loss of bladder control

**G.I.**  Staining during urination

Nausea Frequent kidney infections

Poor appetite Kidney stones

Stomach ulcer **Neuromuscular**

Vomiting blood Arthritis

Frequent indigestion Blackout spells

Stomach pain Convulsions

Yellow jaundice Backaches

Gas pain Fatigue

Diarrhea Dizziness

Hemorrhoids Excessive fatigue

Persistent weight gain Orthopedic problems

Excessive weight gain

**Integumentary Neuropsychiatric**

Excessively dry skin Nervous

Frequent sweating Depressed

Rashes Worry

Boils Trouble sleeping

Itching Excessive sleeping

Cry easily

**Personality Information and Mental Health History**

Circle what best describes you:

Active Ambitious Self-Confident Imaginative

Nervous Hardworking Impatient Persistent

Moody Often depressed Excitable Impulsive

Calm Serious Outgoing Shy

Good natured Withdrawn Stubborn Likable

Leader Quiet Sensitive Submissive

Self-conscious Lonely Worthless Follower

Easily influenced Valuable Happy Angry

Bitter Dissatisfied Easy-going Demanding

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt that people are watching you: Y / N

Do people’s faces seem distorted: Y / N

Do colors seem to bright: Y / N

Are you able to judge distances: Y / N

Have you ever had hallucinations when on drugs: Y / N

Are you afraid of riding in a car: Y / N

Do you have difficulty hearing: Y / N What:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you express your feelings: Y / N

Do you enjoy being with people: Y / N Being alone: Y / N

Do you have trouble sleeping: Y / N

Do you have suicidal tendencies: Y / N

What do you see when you look in a mirror:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had psychiatric care: Y / N If yes, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

End results: Good Fair Poor None

Other concerns you would like to list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**Drug History**

List drugs/alcohol:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Cont. drug list:

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

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

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

Did you use drugs as a coping mechanism: Y / N Why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have an relationship with God: Y / N

How do you perceive God: Loving Forgiving Cruel Other\_\_\_\_\_\_\_\_

**Legal Status**

Have you ever been incarcerated: Y / N How long:\_\_\_\_\_

Charges:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on probation/parole: Y / N How long:\_\_\_\_\_\_ Remainder:\_\_\_\_\_\_\_\_

How often do you need to report:\_\_\_\_\_\_\_\_ By: person mail phone

Probation officer’s name/address/phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Education/Employment**

Highest level of education:\_\_\_\_\_\_\_\_\_\_

Longest period of time you worked for the same employer:\_\_\_\_\_\_\_\_\_\_

Name of profession/trade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you have issues with people of authority: Y / N

Have you served in the military: Y / N How long:\_\_\_\_\_\_\_\_

Branch:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Truth**

I certify that all the information recorded here is accurate and true to the best of my knowledge and has been fully completed by me in my own hand. I understand that any false or incomplete information may result in disqualification of any application for entrance into the Women of the Well Ministries of PA.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_

If forms were physically completed by another person:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_

Relationship to applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Issues you would like to heal from:**

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**Goals or Expectations**

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**Hobbies or Activities of Interest**

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**Favorite Foods**

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