

Little Rock Compassion Center

Recovery Program

The Little Rock Compassion Center is committed to helping men and women not only be rehabilitated but be regenerated by the power of God through Jesus Christ. We believe that there is not true rehabilitation without true regeneration by God. We have a proven program, using a Biblical approach that helps the whole person by aiming at the root of the problem, not the fruit of the problem.

IDENTIFICATION INFORMATION

Name _____	Date _____
Home Address _____	City _____
State _____ Zip Code _____	Phone _____
Social Security Number _____	Citizenship _____
Age _____ Date of Birth _____	Marital Status _____ Race _____
Currently living with _____	Relationship _____
Spouse's Name _____	Address _____
Spouse's Occupation _____	Number of Children _____
Give a one-word description of your life right now _____	
If homeless, how long? _____	

EDUCATIONAL INFORMATION

Check the boxes that apply:

Highest grade completed _____

- Completed G.E.D. What year? _____
- Completed Community College
 - Courses in _____
 - Degree in _____
- Completed College
 - Courses in _____
 - Degree in _____

If you did not finish high school, please explain below

FAMILY HISTORY

How many brothers and sisters do you have? (Include half) Brother(s) _____ Sister(s) _____

Please list their names, ages and addresses (if known). Start with the oldest first.

Name	Age	Address
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

What number are you in the birth order? _____

Are your parents living or deceased? _____

If living, list their name, address and phone number below:

	Name	Address	Phone
Mother/Step-mother	_____	_____	_____
Father/Step-father	_____	_____	_____

EMPLOYMENT HISTORY

Place of employment: _____

Type of work: _____

Reason for leaving: _____

Skills:

MEDICAL HISTORY

Doctor's Name _____ Phone _____

Address _____ Zip Code _____

Medical Insurance Carrier: _____ Number _____

Date of last doctor visit _____ Reason _____

Have you ever used needles? ____ yes ____ no Number of sexual partners: _____

Homosexual activity? ____ yes ____ no AIDS test results _____ Date _____

Other S.T.D. tests _____ Treatment History _____

Have you been taking medication in the last year? ____ yes ____ no

Are you currently on medication? ____ yes ____ no

Medications currently taking _____

Have you ever had problems with: (check all that apply)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Constipation	<input type="checkbox"/> Upset Stomach	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excess Fatigue	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Mental Problems	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Digestive Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> DT's	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bad Back	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> VD or Herpes
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Open Sores
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> TB	<input type="checkbox"/> TB Test	<input type="checkbox"/> Chest X-ray
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Special Diet	<input type="checkbox"/> Other	

For each problem marked, please explain:

Criminal History

Charges Pending _____

Court _____ Judge _____ Court Date _____

On probation/parole _____ Date of Sentence _____

Probation/parole officer _____ Name _____

Address _____

Term of probation/parole _____ Ever violated? _____ Yes _____ No

Time Served

Date	City	Charge	Time Served	Facility Served

Attorney _____

Have you ever been arrested for:

Assault	Yes	No	Alcohol related	Yes	No
Robbery	Yes	No	Alcohol related	Yes	No
Criminal Sexual Conduct	Yes	No	Alcohol related	Yes	No

Do you have any monthly income? _____ Yes _____ No If Yes, How much? _____

Little Rock Compassion Center

3618 Roosevelt, Little Rock, AR 72204

(501) 296-9114

Fax (501) 664-6847

Release of Information

To whom it may concern:

I hereby authorize the Little Rock Compassion Center to secure Information from and/or release information to any person, corporation, society, organization, government agency, institution, or any other entity regarding my/our case history and/or my/our circumstances.

I also hereby authorize any person, corporation, society, organization, government agency, institution, or any other entity to release to Little Rock Compassion Center any information regarding my/our case history and/or my/our circumstances.

My/our case information will remain available indefinitely to the person(s) or agency (ies) indicated above.

A Photostat or fax copy of this shall be as valid as the original.

By Client: _____

Signature: _____ Date: _____

By Spouse (If applicable): _____

Signature of Spouse: _____ Date: _____