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)

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