Living Faith
MINISTRY

1401 E I-44 Service Rd
Oklahoma City, OK 73111

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Program Application

Date: _____ ODOC #:_____

Last Name: _____ First Name:_____ Middle Initial: _____

****

Personal History

Source of information: _____ Gender: ☐ M ☐ F

Date of Birth: _____ Age: _____ Social Security Number: _____

Name of the institution where you are/were incarcerated: _____

Case Manager: _____ Case Manager's Phone Number _____

Reason for Incarceration: _____

History surrounding the reason: _____

Current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated How Long?_____

How many times have you been divorced? _____

How many live-in relationships have you had? ____

How many children do you have? ____________

Children's Name	Age	Gender
______________________	______	☐ M ☐ F
______________________	______	☐ M ☐ F
______________________	______	☐ M ☐ F
______________________	______	☐ M ☐ F
______________________	______	☐ M ☐ F

Do you pay child support? ☐ Yes ☐ No If yes, how much? __________

Are payments current? ☐ Yes ☐ No

Do any of your children have problems in any of the following areas?

_____ Behavioral	_____ Mental Health	____ Emotional	____ Alcohol
_____ Drugs	_____ Physical	____ Educational	____ Other

What are your usual living arrangements (House/Apartment/Parents, Relatives)?

____

Father's name: ______________________________ His Age: ____________

His Occupation: __________________ His Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Relationship with your father: ☐ Excellent ☐ Good ☐ Fair ☐ Bad ☐ None

Mother's Name:______________________________ Her Age: ____________

Her Occupation: __________________ Her Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Relationship with your mother: ☐ Excellent ☐ Good ☐ Fair ☐ Bad ☐ None

Sibling's Name	Age	Gender	Relationship
____________	____	☐ M ☐ F	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None
____________	____	☐ M ☐ F	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None
____________	____	☐ M ☐ F	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None
____________	____	☐ M ☐ F	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None
____________	____	☐ M ☐ F	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None
____________	____	☐ M ☐ F	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ None

 Initial ________

Have you ever been physically, emotionally, or sexually abused by either of your parents?

☐ Yes ☐ No

Have you ever been physically, emotionally, or sexually abused by any of your siblings?

☐ Yes ☐ No

Military Experience: Branch of service:_____ How Long? _____

Type of discharge: ☐ Honorable ☐ General ☐ Dishonorable

Religious Affiliation: _____

(Personal Testimony must be submitted on separate sheet with application)

Personal Strengths: _____

_____

_____

Personal Weaknesses: _____

_____

_____

What do you like to do for recreation and during your leisure time?

_____

What are you expectations of this ministry? _____

Education

Highest grade completed: _____

Schools completed: ☐ Elementary ☐ Middle (Junior High) ☐ High School ☐ GED

☐ College ☐ Vo-Tech Major: _____

Number of credit hours:_____

What special training have you completed?

_____

_____

Difficulties encountered in school: _____

Employment

Occupation while incarcerated: _____

Last employer: _____

Length of time you were employed by this employer: _____

Type of work you usually perform? _____

Special skills or trade: _____

Medical History

Check all that apply?

☐ Headaches
☐ Bowel disturbances
☐ Feel tense
☐ Unable to relax
☐ Can't make decisions
☐ Over ambitious
☐ No appetite
☐ Alcoholism
☐ Drugs
☐ Feel lonely
☐ Don't like weekends
☐ Fainting spells
☐ Insomnia
☐ Tremors
☐ Unable to have a good time
☐ Inferiority feelings
☐ Dizziness
☐ Fatigue
☐ Feel panicky
☐ Sexual problems
☐ Can't keep a job
☐ Stomach trouble
☐ Take sedatives
☐ Suicidal Ideas
☐ Can't make friends
☐ Financial problems
☐ Heart palpitations
☐ Nightmares
☐ Depressed
☐ Shy with people
☐ Home conditions bad

Do you have any chronic medical problems? ☐ Yes ☐ No
If yes, describe the problem.

_____

_____

Are you taking any prescribed medication? ☐ Yes ☐ No
If yes, provide the following information:

Medication Name	Strength/Dosage	How long	Reason	Side Effects

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, answer the following:

Date Hospitalized	Where	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been diagnosed and/or treated for a sexually transmitted disease? ☐ Yes ☐ No

Have you ever been tested for HIV/AIDS? ☐ Yes ☐ No If yes, results? ☐ Positive ☐ Negative

Have you ever had any homosexual activity? ☐ Yes ☐ No

Mental Health History:

Have you ever been treated for an emotional/mental health problem? ☐ Yes ☐ No
If you answered yes, When: _____ Where: _____
Diagnosis: _____ Name of physician: _____

Has anyone in your family ever been treated for an emotional/mental health problem?
☐ Yes ☐ No If yes, Who:_____ When:_____

Where: _____

Diagnosis: _____ Name of physician: _____

Have you experienced any of the following? (Check all that apply)

Depression	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Anxiety or Tension	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Hallucination (excluding drugs)	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Trouble Understanding	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Trouble Concentrating/Remembering	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Trouble Controlling Violent Behavior (Including periods of rage or violence)	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Thoughts of Suicide	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild
Attempted Suicide	☐ past 30 days	☐ Lifetime	☐ Serious	☐ Moderate	☐ Mild

If marked attempted suicide: When: _____ Where:_____
Method:_____ Drugs involved? ☐ Yes ☐ No

Homicidal thoughts and history: Explain.

_____

_____

Has medication ever been prescribed for any psychological/emotional problem? ☐ Yes ☐ No

Name of Physician: _____

Domestic Violence/Sexual Assault

Have you ever had feelings of uncontrollable rage? ☐ Yes ☐ No

Have you had any thoughts about harming others? ☐ Yes ☐ No

Have you ever had trouble controlling your impulses? ☐ Yes ☐ No

As an adult, have you been involved in fights? ☐ Yes ☐ No

Have you ever been arrested for fighting or for any other violent behavior? ☐ Yes ☐ No

If you answered Yes to any of the above questions, complete the following:

1. What were the circumstances of the violent act? _____
2. When did they occur? _____
3. Who was involved? _____
4. How did you feel about doing this? _____
5. Did the behavior involve substance abuse? ☐ Yes ☐ No
6. What was the effect on the victim? _____
7. What happened to you as a result of this act? _____
8. Were you arrested? ☐ Yes ☐ No How much time did you serve? _____

Have you ever been accused of rape or a sexual crime? ☐ Yes ☐ No

Have you ever been accused of domestic violence? ☐ Yes ☐ No

Have you ever had a Victim's Protective Order against you? ☐ Yes ☐ No

Legal Criminal Record

At what age were you first arrested? _____ Reason? _____

How many times in your life have you been arrested and charged with the following offenses?

	No. of Arrests	Date(s)
Public Drunkenness	_____	_____
DUI	_____	_____
DWI	_____	_____
APC	_____	_____
DUS	_____	_____
Shoplifting/ Vandalism/ Theft	_____	_____
Parole/ Probation Violation	_____	_____
Drug Charges	_____	_____
Forgery	_____	_____
Weapons Offense	_____	_____
Larceny	_____	_____
Burglary	_____	_____
Breaking & Entering	_____	_____
Robbery	_____	_____
Assault	_____	_____
Arson	_____	_____
Rape/ Sex Related Crimes	_____	_____
Homicide/ Manslaughter	_____	_____
Prostitution	_____	_____
Contempt of Court	_____	_____
Disorderly Conduct/ Vagrance	_____	_____
Major Driving Violations	_____	_____
Other: _____	_____	_____
_____	_____	_____

Have you engaged in illegal activities for profit? ☐ Yes ☐ No

Applicant's explanation of Legal Problems:_____
_____
_____
_____

Gang History

Gang Affiliation/ Status _____ Age when joined_____ Age when left_____

Motivation for joining _____ Motivation for leaving _____

Type violence with gang _____

Sexual offenses with gang _____

Substance Abuse History

Substance	Age First Used	Date First Used	Frequency	How used
Alcohol	_____	_____	_____	
Alcohol to intoxication	_____	_____	_____	
Heroin	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Methadone	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Painkillers	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Sleeping Pills	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Valium, Librium, Zanax	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Cocaine/Crack	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Crank/Methamphetamine	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
THC (Marijuana)	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Hallucinogens	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Inhalants	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
PCP	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
More than 1 at a time	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
Other Substances:				
_____	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral
_____	_____	_____	_____	☐IV ☐Snort ☐Smoke ☐Oral

Drug of choice? _____

Have you ever experienced DT's? ☐ Yes ☐ No Drug overdose? ☐ Yes ☐ No

Where do you usually drink or use drugs? _____

Do you ever drink or use drugs alone? ☐ Yes ☐ No

Have you ever drank or used drugs more than you intended? ☐ Yes ☐ No

Have you ever been treated for alcohol/drug abuse? ☐ Yes ☐ No

1. When: _____ Where: _____

   Did you complete the program? ☐ Yes ☐ No Length of treatment: _____

2. When:_____ Where: _____

   Did you complete the program? ☐ Yes ☐ No Length of treatment: _____

Program Participation

What programs have you completed while incarcerated?

_____

_____

_____

_____

I certify that the information provided in this application is complete and accurate to the best of my knowledge.

_____ _____

Signature Date