



CONVERTING
H E A R T S
m i n i s t r i e s

Assessment Application

APPLICANT NAME (print)	DATE
E-MAIL ADDRESS (print)	

APPLICANT NAME (print)	DATE
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INSTRUCTIONS: Fill in all items on this application. For questions with multiple choice answers, circle the answer(s) which apply. For questions which do not apply to you write N/A. Mail the completed application directly to Converting Hearts Ministries.

SECTION I - PERSONAL DATA

STATE YOUR REASON FOR APPLYING TO CHM

STREET ADDRESS

CITY STATE ZIP

HOME PHONE	WORK PHONE	CELL PHONE	AGE	U.S. CITIZEN? Y / N	DRUG OF CHOICE
DOB	HEIGHT	WEIGHT	SOCIAL SECURITY #	SPEAK ENGLISH? Y / N	LAST USED
PREVIOUS REHAB EXPERIENCE? Y / N	# OF PREVIOUS PROGRAMS	NAME OF LAST PROGRAM			DATE OF LAST PROGRAM

SECTION II - MARITAL DATA

MARITAL STATUS

SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOWED
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SPOUSE NAME # OF CHILDREN SPOUSE AGE SPOUSE CELL PHONE SPOUSE WORK PHONE

SPOUSE STREET ADDRESS

CITY STATE ZIP

SECTION III - RELIGIOUS INFORMATION

RELIGIOUS AFFILIATION ATTENDED CHURCH IN PAST YEAR?
Y / N PASTOR NAME ARE YOU BORN AGAIN?
Y / N

CHURCH NAME CHURCH PHONE PASTOR PHONE

SECTION IV - LEGAL & MISCELLANEOUS

PRIOR MILITARY SERVICE? Y / N	SERVICE DATE	SEXUALLY ACTIVE WITH OTHER THAN SPOUSE? Y / N
ANY PAST/PRESENT HOMOSEXUAL ACTIVITY? Y / N	EVER BEEN ACCUSED OF CHILD/SEXUAL ABUSE? IF YES, EXPLAIN. Y / N	
EVER BEEN ARRESTED? IF YES, EXPLAIN. Y / N		
ANY OPEN/PENDING LEGAL CASES/SITUATIONS? IF YES, EXPLAIN. Y / N		
CURRENTLY ON PROBATION/PAROLE? IF YES, EXPLAIN. Y / N		
PROBATION/PAROLE OFFICER NAME	PROBATION/PAROLE OFFICER PHONE	TIME REMAINING ON PROBATION/PAROLE
LAWYER NAME		LAWYER PHONE

APPLICANT NAME (print)	DATE
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SECTION V - PARENTAL DATA

FATHER NAME	CAUSE OF DEATH (IF DECEASED)
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ADDRESS	CITY	STATE	ZIP
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MOTHER NAME	CAUSE OF DEATH (IF DECEASED)
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ADDRESS	CITY	STATE	ZIP
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STEP-FATHER NAME	CAUSE OF DEATH (IF DECEASED)
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ADDRESS	CITY	STATE	ZIP
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STEP-MOTHER	CAUSE OF DEATH (IF DECEASED)
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NAME ADDRESS	CITY	STATE	ZIP
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SECTION VI - EMERGENCY CONTACTS

CONTACT 1 NAME	RELATIONSHIP TO YOU	DAY PHONE	EVENING PHONE	CELL PHONE
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ADDRESS	CITY	STATE	ZIP
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CONTACT 2 NAME	RELATIONSHIP TO YOU	DAY PHONE	EVENING PHONE	CELL PHONE
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ADDRESS	CITY	STATE	ZIP
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SECTION VII - EMPLOYMENT & EDUCATION

CURRENTLY EMPLOYED? IF YES, STATE WHERE EMPLOYED.
 Y / N

IF UNEMPLOYED, IS UNEMPLOYMENT RELATED TO SUBSTANCE ABUSE/ADDICTION? STATE CURRENT/PRIOR OCCUPATION
 Y / N

LIST SPECIAL JOB TRAINING OR SKILLS

LAST FULL GRADE COMPLETED	LIST DEGREES/CERTIFICATIONS	DO YOU WISH TO ATTAIN G.E.D.? Y / N
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SECTION VIII - MEDICAL HISTORY

PAST DISEASES (CIRCLE ANY YOU HAVE EVER HAD)

MUMPS	SCARLET FEVER	HEART DISEASE
MEASLES	RHEUMATIC FEVER	DIABETES
WHOOPING COUGH	CHICKEN POX	DISCHARGING EARS
ASTHMA	PNEUMONIA	SYPHILIS
HAY FEVER	POLIO	GONORRHEA
DIPHThERIA	CONVULSIONS	HERPES

APPLICANT NAME (print)

DATE

SECTION VIII - MEDICAL HISTORY *CONTINUED*

RECENT DISABILITIES (CIRCLE ANY YOU HAVE HAD IN PAST YEAR)

4 OR MORE COLDS YEARLY

FAINTING SPELLS

HEARING DIFFICULTY

FREQUENT SORE THROAT

ABDOMINAL PAINS

TIRE EASILY

POOR VISION

FREQUENT URINATION

BREATH SHORTNESS

FREQUENT LEG PAINS

ALLERGY

HERNIA (RUPTURE)

DIZZINESS

PERSISTENT COUGH

RINGWORM

FREQUENT STIES

SPEECH DIFFICULTY

NOSE BLEEDING

DENTAL DEFECTS

CRIPPLING CONDITIONS

RINGING OF EARS

HEART CONDITION

TRAUMA

SEIZURES

OTHER _____

RECENT WEIGHT GAIN/LOSS? LBS GAINED/LOST

Y / N

EVER ATTEMPT SUICIDE? DATE

Y / N

EVER TESTED FOR TUBERCULOSIS? DATE

Y / N

HAD TETANUS SHOT WITHIN LAST 5 YEARS?

Y / N

ANY REASON TO BELIEVE YOU MAY HAVE HIV/HEP B?

Y / N

ANY REASON TO BELIEVE YOU HAVE AIDS/?

Y / N

LIST NAME, DOSAGE AND AMOUNT TAKEN DAILY OF ANY CURRENTLY PRESCRIBED MEDICATIONS?

LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC.

EVER BEEN DIAGNOSED WITH A PSYCHIATRIC DISORDER?

Y / N

EVER HAD ANY EMOTIONAL UPSETS WHICH REQUIRED A DOCTOR OR PROFESSIONAL COUNSELOR? IF YES, EXPLAIN.

Y / N

EXPLAIN ANY OTHER MEDICAL ISSUES THAT WE SHOULD BE AWARE OF.

DO YOU HAVE MEDICAL INSURANCE?

Y / N

NAME OF INSURANCE COMPANY

NAME OF INSURED

POLICY NUMBER

GROUP NUMBER

DOCTOR NAME

ADDRESS

CITY

STATE

ZIP

DOCTOR PHONE

SECTION IX - FINANCIAL RESOURCES

CIRCLE ANY ITEMS WHICH APPLY TO YOU

ELIGIBLE FOR UNEMPLOYMENT

ELIGIBLE FOR HOUSING INCOME FROM SOCIAL SERVICES

ELIGIBLE FOR TEMPORARY DISABILITY

CURRENTLY COLLECTING SSI

CURRENTLY RECEIVING ANY FUNDING FROM SOCIAL SERVICES WHICH IS NOT LISTED ABOVE?

Y / N

DO YOU RECEIVE ANY OTHER INCOME? IF YES, EXPLAIN.

Y / N

ANY OTHER RESOURCES (IRA, PENSION, SAVINGS/CHECKING ACCOUNTS, 401(K), ETC.)? IF YES, EXPLAIN.

Y / N

APPLICANT NAME (print)

DATE

SECTION XI - LEGAL CONSENTS AND CERTIFICATIONS

INITIAL EACH STATEMENT AFTER YOU HAVE FULLY READ AND UNDERSTOOD THAT STATEMENT

ENTER INITIALS	CONSENT AND CERTIFICATION STATEMENTS
	1. I AGREE THAT I WILL HOLD HARMLESS AND NOT BRING SUIT AGAINST CONVERTING HEARTS MINISTRIES, INC. OR ITS' AGENTS OR EMPLOYEES FOR ANY INJURY, HARM OR OTHER DANGERS WHETHER CAUSED BY ITS' AGENTS, EMPLOYEES OR BY THIRD PARTIES.
	2. I UNDERSTAND THAT CONVERTING HEARTS MINISTRIES, INC. MAY BE USING MY TESTIMONY (WRITTEN AND/OR VERBAL), PHOTO, VIDEO (IMAGES), AND/OR AUDIO (VOICE), OF ME FOR ITS MINISTRY USE. I UNDERSTAND THAT CONVERTING HEARTS MINISTRIES, INC. WILL BE USING THESE BOTH IN PRIVATE AND PUBLIC (I.E. NEWSLETTER, WEBSITE, STORYBOARD, ETC.). MY SIGNATURE STATES THAT I UNDERSTAND THAT ALL THE ABOVE MATERIAL IS THE PROPERTY OF CONVERTING HEARTS MINISTRIES, INC. AND I FREELY GIVE CONVERTING HEARTS MINISTRIES, INC. FULL RIGHTS OF IT'S USE.
	3. I FURTHER CONSENT THAT THE AUTHORITIES OF CONVERTING HEARTS MINISTRIES, INC MAY PROVIDE FOR EXAMINATION AND/OR DIAGNOSTIC PROCEDURES AND MAY PROVIDE EMERGENCY SURGERY, COUNSELING SERVICES AND/OR MEDICAL OR DENTAL TREATMENT OR ADMINISTRATION OF NECESSARY ANESTHETICS, WHEN IN THE OPINION OF ANY PHYSICIAN OR SURGEON OF GOOD STANDING SUCH EXAMINATION, DIAGNOSTIC OR MEDICAL TREATMENT IS NECESSARY FOR THE MENTAL OR PHYSICAL HEALTH OF THE ABOVE NAMED INDIVIDUAL.
	4. I HEREBY AUTHORIZE CONVERTING HEARTS MINISTRIES, INC. TO OBTAIN ANY MEDICAL RECORDS NECESSARY FOR THE SPECIFIC PURPOSE OF TREATMENT WHILE HERE. I UNDERSTAND THAT ANY OF THE RECORDS OBTAINED CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT AND I ALSO UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY ME, IN WRITING, AT ANY TIME. (I.E., HOSPITAL, PSYCHOSOCIAL, PSYCHIATRIC, PHYSICIAN, ETC.)
	5. CONVERTING HEARTS MINISTRIES, INC. HAS THE PERMISSION TO INTERACT AND/OR RELEASE ANY PERTINENT INFORMATION/PAPERWORK TO FAMILIES, PASTORS, PROBATION, PHYSICIANS, COURTS, AND ANY OTHER PROFESSIONALS THAT WE DEEM APPROPRIATE.
	6. WHILE AT ANY CHM FUNCTION OR OUT ON PASS CHM IS NOT LIABLE FOR MY ACTIONS. I AM SOLELY RESPONSIBLE TO ADHERE TO ALL STATE AND FEDERAL LAWS, AND ALL ASPECTS OF MY CHM COVENANT.
	7. I HAVING READ THE POLICIES AND PROCEDURES OF CONVERTING HEARTS MINISTRIES, INC. UNDERSTAND AND HAVE NO QUESTIONS REGARDING THE CONTENTS OF THIS PAPERWORK.
	8. I DO HEREBY CERTIFY THAT ALL THE RECORDED INFORMATION ON THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

BY SIGNING BELOW, I ACKNOWLEDGE THE FOLLOWING IN REGARD TO THE STATEMENTS IN SECTION XI:

- I HAVE FULLY READ EACH OF THE STATEMENTS.
- ANY QUESTIONS I HAD REGARDING THE STATEMENTS HAVE BEEN FULLY ANSWERED.
- I HAVE A FULL UNDERSTANDING OF EACH STATEMENT.
- MY INITIALS BY A STATEMENT INDICATE MY AGREEMENT TO THAT STATEMENT.

SIGNATURE

DATE

APPLICANT NAME (print)

DATE

SECTION XII - TREATMENT GOALS

ON A SEPARATE SHEET OF PAPER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. WHAT IS THE MAIN PROBLEM, AS YOU SEE IT? WHAT BRINGS YOU HERE?
2. WHAT HAVE YOU DONE ABOUT IT?
3. WHAT CAN WE DO? WHAT ARE YOUR EXPECTATIONS IN COMING HERE?
4. IS THERE ANY OTHER INFORMATION WE SHOULD HAVE?

CIRCLE YOUR TREATMENT GOALS

ADDICTION

ANGER

DIVORCE

DEPRESSION

DISCIPLINE

HATE

FORGIVENESS

GOSSIP

LYING

LAZINESS

LISTENER

SOCIAL SKILLS

SELFISHNESS

SELF WORTH

PATIENCE

WORRY

SENSITIVITY

BITTERNESS

HOMOSEXUALITY

COMMUNICATION

FAITH

LUST

ANXIETY

GRATITUDE

TEMPER

CONTROL

MANIPULATION

TRUST

FEAR

SUBMISSION

HEALTHY BOUNDARIES

OTHER _____

Client ID# _____
 Change Assessment Scale (URICA) :
 Drug Version

Date: ____/____/____
 Assessment Point: _____

EACH STATEMENT BELOW DESCRIBES A HOW A PERSON MIGHT FEEL WHEN STARTING THERAPY OR APPROACHING PROBLEMS IN THEIR LIVES. PLEASE INDICATE THE EXTENT TO WHICH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR WOULD LIKE TO FEEL. FOR ALL STATEMENTS THAT REFER TO YOUR "PROBLEM", ANSWER IN TERMS OF PROBLEMS RELATED TO YOUR DRUG USE. THE WORDS "HERE" AND "THIS PLACE" REFER TO YOUR TREATMENT FACILITY.

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS IN THE QUESTIONNAIRE:

- 1=Strongly Disagree
- 2=Disagree
- 3=Undecided
- 4=Agree
- 5=Strongly Agree

CIRCLE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Data Entry
1) As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5	
2) I think I might be ready for some self-improvement.	1	2	3	4	5	
3) I am doing something about the problems that had been bothering me.	1	2	3	4	5	
4) It might be worthwhile to work on my problem.	1	2	3	4	5	
5) I'm not the problem one. It doesn't make much sense for me to consider changing.	1	2	3	4	5	
6) It worries me that I might slip back on a problem I have already changed, so I am looking for help.	1	2	3	4	5	
7) I am finally doing some work on my problem.	1	2	3	4	5	
8) I've been thinking that I might want to change something about myself.	1	2	3	4	5	
9) I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.	1	2	3	4	5	

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Data Entry
10) At times my problem is difficult, but I'm working on it.	1	2	3	4	5	
11) Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5	
12) I'm hoping that I will be able to understand myself better.	1	2	3	4	5	
13) I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5	
14) I am really working hard to change.	1	2	3	4	5	
15) I have a problem and I really think I should work on it.	1	2	3	4	5	
16) I'm not following through with what I had already changed as well as I had hoped, and I want to prevent a relapse of the problem.	1	2	3	4	5	
17) Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5	
18) I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5	
19) I wish I had more ideas on how to solve my problem.	1	2	3	4	5	
20) I have started working on my problem but I would like help.	1	2	3	4	5	
21) Maybe someone or something will be able to help me.	1	2	3	4	5	
22) I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5	
23) I may be part of the problem, but I don't really think I am.	1	2	3	4	5	
24) I hope that someone will have some good advice for me.	1	2	3	4	5	

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Data Entry
25) Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5	
26) All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5	
27) I'm struggling to prevent myself from having a relapse of my problem.	1	2	3	4	5	
28) It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5	
29) I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5	
30) I am actively working on my problem.	1	2	3	4	5	
31) I would rather cope with my faults than try to change them.	1	2	3	4	5	
32) After all I had done to try and change my problem, every now and then it comes back to haunt me.	1	2	3	4	5	

Drug Abstinence Self-efficacy Scale

Client ID# _____

Date: ____/____/____

Assessment Point: _____

LISTED BELOW ARE A NUMBER OF SITUATIONS THAT LEAD PEOPLE TO ENGAGE IN THEIR ADDICTION. WE WOULD LIKE TO KNOW HOW CONFIDENT YOU ARE THAT YOU WOULD NOT ENGAGE IN YOUR ADDICTION IN EACH SITUATION.

CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR FEELINGS OF CONFIDENCE TO NOT ENGAGE IN YOUR ADDICTION IN EACH SITUATION DURING THE PAST WEEK ACCORDING TO THE FOLLOWING SCALE:

- 1=Not at all confident
- 2=Not very confident
- 3=Moderately confident
- 4=Very confident
- 5=Extremely confident

Situation	Confident not to engage in my addiction				
	Not at all	Not very	Moderately	Very	Extremely
1) When I am in agony because of stopping or withdrawing from my addiction.	1	2	3	4	5
2) When I have a headache.	1	2	3	4	5
3) When I am feeling depressed.	1	2	3	4	5
4) When I am on vacation and want to relax.	1	2	3	4	5
5) When I am concerned about someone.	1	2	3	4	5
6) When I am worried.	1	2	3	4	5
7) When I have the temptation to engage in my addiction.	1	2	3	4	5
8) When I have the opportunity to engage in my addiction in a social situation.	1	2	3	4	5
9) When I dream about my addiction.	1	2	3	4	5
10) When I want to test my will power over my addiction.	1	2	3	4	5

Situation	Confident not to engage in my addiction				
	Not at all	Not very	Moderately	Very	Extremely
11) When I am feeling a physical need or craving for my addiction.	1	2	3	4	5
12) When I am physically tired.	1	2	3	4	5
13) When I am experiencing some physical pain or injury.	1	2	3	4	5
14) When I feel like blowing up because of frustration.	1	2	3	4	5
15) When I see others engaging in my addiction at a bar or a party.	1	2	3	4	5
16) When I sense everything is going wrong for me.	1	2	3	4	5
17) When people I used to engage in my addiction with encourage me to engage again.	1	2	3	4	5
18) When I am feeling angry inside.	1	2	3	4	5
19) When I experience an urge or impulse to engage that catches me unprepared.	1	2	3	4	5
20) When I am excited or celebrating with others.	1	2	3	4	5



P.O. Box 524 | Creedmoor, NC 27522
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Required Documents for Acceptance into Converting Hearts Resident Ministry

- Completed Application for Assessment
 - Criminal Background Check – State Level
 - The following bloodwork must be done prior to admission:
 - HIV/AIDS
 - TB/PPD (Tuberculosis Skin Test),
 - HEP-C/HCV (Hepatitis C Test)
- These tests must have been completed within the past 90 days from date of assessment. Local Lab that provides testing for all 3*
- Any previous psychiatric evaluations must be released to Converting Hearts Ministries.
 - Legal Paperwork (*If pending charges or on probation, documentation must be provided to verify this.*)
 - Signed Financial Agreement
 - Residential Handbook for Converting Hearts Ministries (*Will be given to you upon acceptance into the program and must be brought with you upon your date of check-in.*)

Paperwork can be turned in on your date of check-in, can be e-mailed to

info@convertinghearts.org

or mailed to:

Converting Hearts Ministries
Attn: Office Personnel
PO Box 524
Creedmoor, NC 27522