The mission of the Glory House is helping people claim their lives with Christian compassion, resources and support.

4000 S. West Avenue • PO Box 88145 Sioux Falls, SD 57109-8145 • Phone (605) 332-3273 • Fax (605) 332-6410

Application for Services

Name: _____ Social Security #: _____ Date of Birth: _____

Home Address: _____ County: _____
(street, city, state, zip code)

Phone#: _____*Race or Ethnic Origin: _____*Gender: _____Male _____Female

Emergency Contact:

Name: _____ Phone #: _____

Address: _____

Relationship to above person: _____

Referral Source (circle one): Self Admit, Parole, Court Services, IMT, Drug Court, Treatment Center, Attorney

Referred by: _____ Probation/Parole ID #: _____

*Glory House does not discriminate based on race, color, gender, age, religion, national origin, marital status, political belief, mental or physical handicap. Government funding agencies require this information for statistical purposes only.

SUBSTANCE USE TREATMENT HISTORY:

Please answer the following regarding your treatment history.	Yes	No
Have you ever had a previous treatment for addiction?		
Have you ever attended a 12 step meeting?		
Have you ever stayed in a halfway house?		
Have you worked with a sponsor?		
Do you feel you have or have had a problem with alcohol?		
Do you feel you have or have had a problem with drugs?		
What is your longest period of sobriety from alcohol?		
What is your longest period of sobriety from drugs?		

Please explain any "yes" answers: _____

_____

_____

ALCOHOL:

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your alcohol use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your use caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others? (driving under the influence, fights, self harm)		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (anxiety, nausea, headaches, shaking, insomnia)		
Have you used any substance to avoid withdrawal symptoms?		

MARIJUANA/SYNTHETIC CANNABINOIDS (K2):

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your marijuana use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your used caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (irritability, restlessness, insomnia)		
Have you used any substance to avoid withdrawal symptoms?		

COCAINE:

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your cocaine use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your used caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (restlessness, slowed thinking, unpleasant dreams)		
Have you used any substance to avoid withdrawal symptoms?		

HALLUCINOGENS (LSD, DMT, GHB, PCP, mushrooms, bath salts):

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your hallucinogen use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your used caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		

HEROIN/OPIATES (Morphine, Oxycodone, Hydrocodone, Fentanyl):

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your opiate use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your used caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (muscle aches, nausea, sweating, diarrhea)		
Have you used any substance to avoid withdrawal symptoms?		

INHALANTS:

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your inhalant use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your used caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		

NICOTINE:

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your nicotine use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your used caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (headaches, difficulty concentrating, irritability)		
Have you used any substance to avoid withdrawal symptoms?		

AMPHETAMINE/METH/OTHER STIMULANTS (Adderall, MDMA, Ritalin):

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your amphetamine use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your use caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (decreased appetite, muscle pain, fatigue, anxiety)		
Have you used any substance to avoid withdrawal symptoms?		

SEDATIVES (Clonazepam, Ambien, Ativan, Valium, Xanax, DXM):

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

Please answer the following regarding your sedative use.	Yes	No
Have you used more or for longer periods than intended?		
Have you tried to control your use or quit?		
Have you spent the majority of your time using?		
Have you experienced cravings?		
Has your use caused problems at work, school or home?		
Has your use caused problems in your relationships?		
Have you given up activities you used to enjoy?		
Has your use been dangerous to yourself or others?		
Have you experienced physical or mental health problems due to your use?		
Have you had to use more of the substance to experience the same effects?		
Have you experienced less of an effect with continued use of the same amount?		
Have you experienced withdrawal symptoms? (sweating, nausea, shaking, restlessness)		
Have you used any substance to avoid withdrawal symptoms?		

OTC MEDICATIONS:

Age of first use	Date of last use	When using this substance what type, how much and how often did you use?
Method of use		

GAMBLING HISTORY:

Please answer the following regarding your gambling.	Yes	No
Have you gambled with increasing amounts of money?		
Have you felt restless or irritable when trying to control gambling?		
Have you tried to quit or control gambling?		
Have you felt preoccupied with gambling?		
Have you gambled to deal with strong emotions?		
Have you gambled the next day to win back your losses?		
Have you lied about gambling?		
Have you had relationship, work or school problems?		
Have you relied on others to help you financially due to gambling?		
Do you feel you have a problem with gambling?		
What forms of gambling do you participate in?		
How much do you spend on gambling per month?		

How old were you when you started gambling?
How much gambling related debt do you have?
How often do you gamble?
What is the most you have won?
What is the most you have lost?
When was the last time you gambled?

Please explain any "yes" answers: _____

_____

_____

PHYSICAL AND MEDICAL:

Please answer the following regarding your physical health.	Yes	No
Do you have any present health problems?		
Do you have any allergies?		
Do you have any disabilities?		
Have you had any serious health problems, injuries or illnesses in the past?		
Do you have a family history of medical problems?		
Do you have any communicable diseases?		
Do you take any medications for medical problems?		
Do you have health insurance?		
Do you have any health problems due to substance use?		
Do you have any eating problems or special diets?		
Do you have problems sleeping?		
Do you do anything to stay healthy?		
My current health is (circle one): Excellent Good Fair Poor		

Please explain any "yes" answers: _____

_____

_____

PSYCHOLOGICAL HISTORY:

Please answer the following regarding your mental health.	Yes	No
Have you been diagnosed with a mental health disorder?		
Have you had counseling for a mental health disorder?		
Have you been prescribed medication for a mental health disorder?		
Have you ever had psychiatric hospitalizations?		
Do you ever feel sad, down or depressed?		
Do you ever feel fearful, anxious or nervous?		
Do you have feelings of uncontrollable anger, rage or violence?		
Have you ever been physically, emotionally or sexually abused?		
Have you experienced any trauma?		

Do you or have you had thoughts of suicide?		
Do you or have you had thoughts of harming others?		
Have you been in unhealthy relationships?		
Have you ever attempted suicide?		
Have you experienced problems with weight or diet issues?		
What do you do to cope with strong emotions?		
My coping skills are (circle one): Excellent Good Fair Poor		
My current mental health is (circle one): Excellent Good Fair Poor		

Please explain any "yes" answers: _____

_____

_____

EDUCATION:

Please answer the following regarding your education.	Yes	No
Do you have a high school diploma or GED?		
Were you ever suspended or expelled?		
Did you ever have problems with classmates or teachers?		
Did you experience any problems in school due to substance use?		
Do you have any learning problems?		
Did you participate in an alternative school?		
Did you experience any problems in school?		
Have you attended college?		
Do you have plans to further your education?		
What was your favorite subject?		
What is your highest education level?		
What type of grades did you receive? (circle one): Mostly A's Mostly B's Mostly C's Failing		

Please explain any "yes" answers: _____

_____

_____

VOCATIONAL:

Please answer the following regarding your vocational history.	Yes	No
Are you employed?		
Do you need assistance finding employment?		
Have you experienced any problems in the workplace?		
Have you ever had problems with co-workers or supervisors?		
Have you ever been fired?		
Have you had problems at work due to substance use?		
Have you ever used before or during work?		
Were you in the military?		
Are you a war veteran?		

Do you have any vocational training?		
How many months have you worked in the last year?		
What is your ideal employment?		
List your job skills:		
When have you felt successful in employment?		

Please explain any "yes" answers: _____

_____

_____

List past three jobs, starting with most recent:

Employer	City and State	Dates Employed	Reason for Leaving

FINANCIAL:

Please answer the following regarding your financial history.	Yes	No
Do you have any income?		
Do you have difficulty managing your money?		
Do you owe child support?		
Do you owe fines, court costs or restitution?		
Do you have any other debt?		
Do you have any financial concerns?		
Have you ever filed bankruptcy?		
Do you or anyone in your home receive government assistance?		
Has there been a time when you felt financially secure?		
How much did you spend on substance use per week?		
How did you fund your use? (selling drugs, stealing, borrowing, going without)		
What was your gross income in the past 12 months?		
How will you pay for services?		

Please explain any "yes" answers: _____

_____

_____

LEGAL HISTORY:

Please answer the following regarding your legal history.	Yes	No
Were you ever arrested as a juvenile?		
Have you committed crimes under the influence of drugs or alcohol?		
Have you previously been on parole/probation?		
Have you successfully completed parole/probation?		
Did you receive any disciplinary actions while incarcerated?		

Do you have any pending charges?		
Age of first arrest?		
How many times have you been to prison?		
How long were you incarcerated for?		
What is your current charge or conviction?		
What are your previous convictions?		
How long are you on probation/parole for?		
How do you feel about your legal situation?		

Please explain any "yes" answers: _____

_____

_____

SOCIAL:

Please answer the following regarding your legal history.	Yes	No
Do you have friends that use alcohol/drugs?		
Do you have friends that encourage substance use?		
Do you have friends that discourage substance use?		
Do you have friends that you trust?		
Do you have difficulty trusting others?		
Have you lost friends due to substance use?		
Have you been involved in a gang?		
Do you participate in any organized activities?		
How many friends do you have that do not have a criminal record?		
What are your talents?		
What do you do for fun?		
What percentage of your time was centered on drug and alcohol related activities?		

Please explain any "yes" answers: _____

_____

_____

FAMILY:

Please answer the following regarding your family history.	Yes	No
Were your parents regularly employed?		
Do your family members support you?		
Are you close with your family members?		
Do you have family members with a criminal record?		
Do you have family members with substance abuse problems?		
Did you experience unhappiness as a child?		
Did you have any significant problems as a child?		
Did you ever run away from home?		
Do you have any concerns about your family relationships?		
Father's Name and Occupation		

Mother's Name and Occupation					
Parent's Marital Status (circle one):	Never Married	Married	Separated	Divorced	Widowed
Step Parents Names					
Siblings Ages and Genders					
Children Ages and Genders					
Marital Status (circle one):	Never Married	Married	Separated	Divorced	Widowed

Please explain any "yes" answers: _____

_____

_____

SPIRITUAL:

Please answer the following regarding your spiritual history.	Yes	No
Do you believe in a Higher Power? (example God or Tunkashila)		
Do you have concerns about your beliefs?		
Have you lost faith in a Higher Power?		
Have you lost your dreams/goals?		
Are you discouraged about the future?		
Have there been any changes to your beliefs?		
What is your spiritual preference?		
When was the last time you attended a spiritual event/church		
Were you required to attend as a child?		
What lifts your spirit?		
What are your strengths?		
What are your weaknesses?		
What goal would you like while in Glory House services?		

Please explain any "yes" answers: _____

_____

_____

I _____, acknowledge that I have completed this application to the best of my abilities. I understand this is confidential information that is used for placement in to treatment services.

_____ _____
Applicant Signature Date

_____ _____
Witness Signature Date

Revised: 6/95
Revised: 10/02
Revised: 3/04
Revised: 12/12
Revised: 10/19