

**MALACHI HOUSE INTERNATIONAL  
DREAM CENTER VETERAN HOUSING PROGRAM  
INFORMATION FORM**

**(Please Print)**

Date:										
<b>RESIDENT'S INFORMATION</b>										
Resident's Last Name:			First:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (circle one)	
Spouse's Name:							<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Insurance Name:				Policy Number:			Birth Date:	Age:	Sex:	
							/ /		<input type="checkbox"/> M	<input type="checkbox"/> F
Street Address:				Social Security No.:			Home No.: ( )			
							Cell No.: ( )			
P.O. Box:			City:			State:		Zip Code:		
Children Name:				DOB/Age:			Name of School			
Children Name:				DOB/Age:						
Children Name:				DOB/Age:						
Children Name:				DOB/Age:						
Occupation:			Employer:				Employer's Phone No.:			
			Employer's Address:				( )			
<b>COUNSELING</b>										
SESSION GOALS				PLEASE CHECK BOX		REMARKS				
1. Housing/Transportation				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
2. Case Management				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
3. Substance Abuse Services				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
4. Life Skills/Self-Esteem				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
5. Clinical Counseling for Adults				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
6. Group Counseling–Anger Management				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
7. Holistic Counseling (body, soul and spirit)				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
8. Clinical Counseling for Children				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
9. Job Skills Training				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
10. Financial Counseling				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
11. Employability Training				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
12. Social Services/Social Security Resources				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
				<input type="checkbox"/> Yes	<input type="checkbox"/> No					
<b>IN CASE OF EMERGENCY</b>										
Name of Local Friend or Relative (Not Living at Same Address):					Relationship to Resident:		Home Phone No.:		Work Phone No.:	
							( )		( )	
Resident/Guardian signature							Date			

**MALACHI HOUSE INTERNATIONAL DREAM CENTER  
HOUSING PROJECT PROGRAM  
PRESCREENING FORM FOR VETERANS (CONTINUED)**

**I. Current Problems:**

	<u>YES</u>	<u>NO</u>
Financial	_____	_____
Unit (Job)	_____	_____
Child Care	_____	_____
Recent Move	_____	_____
Pending Move	_____	_____
Loneliness/Isolation	_____	_____
Medical	_____	_____
Family Disagreements	_____	_____
Deaths in the Family	_____	_____
Explain any yes answer: _____		
_____		
_____		
_____		
_____		

**II. History of Violence in the Family, if any:**

	<u>YES</u>	<u>NO</u>
1. Did you witness abuse as a child?	_____	_____
2. Were you abused as a child?	_____	_____
3. If you were abused, how?		
a. Physically	_____	_____
b. Sexually	_____	_____
c. Emotionally	_____	_____
d. Needs neglected	_____	_____

**MALACHI HOUSE INTERNATIONAL DREAM CENTER  
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PRESCREENING FORM FOR VETERANS (CONTINUED)**

4. Have you had any previous involvement with the Family Advocacy Program or the Child Protective Services?

Explain any yes answer: \_\_\_\_\_

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**III. Substance Use/Abuse:**

YES

NO

A. In the current family does anyone use/abuse alcohol/drugs?

\_\_\_\_\_

\_\_\_\_\_

Explain any yes answer: \_\_\_\_\_

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B. In the families of origin did anyone use/abuse alcohol/drugs?

\_\_\_\_\_

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Explain any yes answer: \_\_\_\_\_

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**IV. History of Mental Illness (Include Suicide and Homicide Attempts):**

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V. **Answer the following questions relating to your children (if applicable):**

- |   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. Do any of these children have medical problems?                | _____      | _____     |
| 2. Are any of these children difficult or exceptional in any way? | _____      | _____     |
| 3. Are there any present special problems?                        | _____      | _____     |

Explain any yes answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How is discipline administered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. How are problems solved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. How are emotions/feelings handled in the family? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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7. How is spare time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VI. Experience with counseling, if any:**

	<u>YES</u>	<u>NO</u>
Ministers'	_____	_____
Alcohol/Drug	_____	_____
School Counselors	_____	_____
Marriage and Family Counseling	_____	_____
Social Work Service	_____	_____
Community Mental Health	_____	_____
Court Mandated Counseling	_____	_____

Explain any yes answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

