Restart Training Center Ministry, Inc.

"Loving People To Spiritual Renewal"

Intake Form

2019

To Whom It May Concern:

Restart Training Center is a faith-based minimum six-month long men's full residential recovery support program. We are located on an Amish minister's 90-acre farm at 2324 Leaman Road in Lancaster, Pennsylvania. We have 12 beds available at our facility. We have four single male intern staff that live on the property with our client's (students as we call them) at our program who supervise them 24 hours a day, seven days per week. We escort/supervise our clients at all venues they are required to participate in by us, the Court, and/or their probation/parole officer. Our students are not allowed to be on narcotic or psychotropic medications during their entire six-month stay here.

The following services are offered to the client's while they are completing the initial six months in our program: (1) weekly individual counseling; 2) weekly group counseling; 3) attendance at two 12-Step recovery support groups in the community at large; 4) weekly community service at a local nonprofit where our client's help assemble boxes of food to be dispersed throughout the Susquehanna region and beyond; 5) 25 hours or more weekly of life-skills and spiritual class instruction on many subjects (e.g., anger management, emotional intelligence, addiction recovery, PTSD, etc.); 6) 3-6 hours weekly gym/recreation time at the local YMCA in West Lampeter where we have a membership; 7) 6-12 hours of relationship counseling with our client and his spouse/girlfriend, children or other family members; 8) Transportation to/from required medical or legal appointments; 9) Weekly attendance at corporate worship services; and 10) Vocational training through local businesses when available.

Our lead counselor Mr. Samuel Mwangi is ICADC and is the former lead counselor for The Naaman Center office located in Quarryville, PA and the CEO of Community Care & Addiction Recovery Services located in Leola, PA. Pastor Jaime Santiago has a master's in LPC and worked as a part-time contracted therapist at The Naaman Center Vine Street Lancaster, PA location. Pastor Jaime Santiago is a recovered person of addiction for over 31 years, never relapsed and graduated from Teen Challenge in 1991 after completing their one-year residential program.

Sincerely Yours,

Rev. J. Jaime Santiago

Pastor J. Jaime Santiago, MA

Executive Director – Restart Training Center Ministry, Inc.

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Thank you for your interest in services offered by Restart Training Center Ministry, Inc's program. Please fill out the Intake Personal Inventory Form in its entirety. If a line item does not apply to you, please enter "not applicable" in the space provided.

If you are applying for our residential program service the tuition is $2250.00 for the six-month program and is non-refundable. You can snail-mail your intake form along with your intake fee, fax it and snail-mail your intake fee, or drop off both your intake form and fee in person to our program location. Please note a bed date will not be assigned or reserved for a client until the completed intake form and fee are both received from the client at our ministry.

PERSONAL INFORMATION INVENTORY

Please complete this inventory as carefully as possible. Answer each item that applies to you. All information you provide will be treated confidentially and will become part of your record. If you have a question about a particular area, please put a mark by it and ask your counselor when it is complete.

DEMOGRAPHIC INFORMATION

Name: _____ Date: _____

Home Address: _____

_____

Phone (Home) _____ (Work) _____ (Cell) _____

S.S. #: _____-_____-_____ Sex: _____ Date of Birth: _____ Age: _____

E-Mail Address: _____

Occupation: _____ Hours Per Week: _____

Employed By: _____

Referred Here By: _____ Phone: _____

Referral's Address: _____

Emergency Contact: _____ Phone: _____

Contact's Address: _____

How did you hear about this counseling program? _____

_____

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MARRIAGE INFORMATION *(CHECK ONE)*

☐ Single	☐ Engaged	☐ Married	☐ Separated
☐ Divorced	☐ Remarried	☐ Living Together	☐ Widowed

Please list your relationships below. List your children beginning with the oldest. (Place a check by the child's name if from a previous marriage.)

Relationship	Name	Age	Grade or Occupation
SPOUSE			
EX-SPOUSE			
CHILDREN			
CHILDREN			
CHILDREN			
MOTHER			
FATHER			

What Year Married?: _____ How Long Did you Date?: _____

How Did You Meet?: _____

Did Your Parents Approve of Your Marriage? _____ Spouse's Parents?: _____

Have You Ever Been Married Before? _____ Number of Divorces? _____ How Long Divorced? _____

FAMILY INFORMATION

Father Living? Yes____ No____ Mother Living? Yes____ No ____ If so, where? _____

What kind of relationship do/did you have with your father? *(Circle One)*

Excellent Good Fair Poor Nonexistent

What kind of relationship do/did you have with your mother? *(Circle One)*

Excellent Good Fair Poor Nonexistent

Did anyone else have a key role in your upbringing? (If so, who and why):

_____

_____

How many children (siblings) are/were in your family? (Brothers and sisters) _____

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What child are you by number? *(Circle One)*

☐ **Oldest** ☐ **Second** ☐ **Third** ☐ **Fourth** ☐ **Fifth** ☐ **Sixth** ☐ **Youngest** ☐ **Other**

EDUCATION

Highest Level/Grade of Education Completed:

☐ **Not Complete** ☐ **HS** ☐ **Some College** ☐ **AA Degree**

☐ **College (Major: _____)** ☐ **Graduate (Major: _____)**

How well did you do in elementary school? _____

How well did you do in HS? _____

How well did you do in College? _____

How well did you do in Graduate School? _____

RELIGION/FAITH

Religious Affiliation: _____ Church/Synagogue Name: _____

Circle Your Level of Church Activity: **Active** **Inactive**

Briefly describe how important your faith is to you: _____

_____

Do you want a Christian counseling approach? ☐ Yes ☐ No

Do you want the counselor to pray with you? ☐ Yes ☐ No

HEALTH

Health Status: ☐ **Excellent** ☐ **Good** ☐ **Average** ☐ **Poor** ☐ **Very Poor**

Height: _____ Weight: _____ How you gained or lost any weight in last six months? *(Circle One)*

Gained **Lost** How Much? _____

Describe any medical problems you have that require medication or physical care: _____

_____

_____

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Are you currently under a doctor's care? _____ (If yes, please describe) _____

_____

Physician's name: _____ Address: _____

_____

If you are currently taking any medication please complete below:

Name of Medication	**Dosage**	**Date Prescribed**	**By Who**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever used drugs other than for medical purposes? _____

(If yes, what and when) _____

_____

Please describe your use of alcoholic beverages: _____

☐ **Never** ☐ **1-4 Times a Year** ☐ **1-2 Times a Month**

☐ **1-2 Times a Week** ☐ **4 Times a Week** ☐ **Daily**

Please describe your use of your drug of abuse: _____

☐ **Never** ☐ **1-4 a Times Year** ☐ **1-2 Times a Month**

☐ **1-2 Times a Week** ☐ **4 Times a Week** ☐ **Daily**

What medical and emotional problems existed in your family in which you grew up? _____

_____

Have you previously had inpatient therapy? ☐ **Yes** ☐ **No** When? _____

With Whom? _____ For How Long? _____

What Led to Your Relapse? _____

_____

How you ever thought of or attempted to harm yourself before? _____

(If yes, please describe) _____

_____

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How you ever thought of or attempted to harm someone before? _____

(If yes, please describe) _____

_____

Have you ever been abused before (psychologically; physically, verbally; or sexually)? _____

If yes, please describe) _____

_____

Have you ever abused anyone before (psychologically; physically, verbally; or sexually)? _____

If yes, please describe) _____

_____

PRESENTING PROBLEM (S)

In your own words, briefly describe the main problem that prompted you to seek counseling at this time: _____

_____

_____

How long have you faced the problem? _____

Have there been times when the problem got better or disappeared? ☐ Yes ☐ No

If so when? _____ What do you think helped? _____

_____

Were there times when the problem was especially bad? ☐ Yes ☐ No

When? _____ What made it bad? _____

_____

Are there other people who play a role in: ☐ Causing your problems? ☐ Helping your problem?

Briefly explain: _____

_____

_____

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Please check any of the following that are currently troubling you. Put **two** checks by those items that are most important. You may add any comments you would like.

_____ Abortion/Adoption
_____ Adjustment Problems
_____ Anger/Temper
_____ Anxiety (worry)
_____ Apathy (the "blahs")
_____ Assertiveness
_____ Bitterness (Resentment)
_____ Breathing Difficulty
_____ Change of Lifestyle
_____ Child Abuse
_____ Children (Discipline)
_____ Children (School)
_____ Communication
_____ Concentration
_____ Confusion
_____ Death of Loved One
_____ Dependent on Others
_____ Depression
_____ Divorce
_____ Dizziness
_____ Eating Problems
_____ Envy (Jealousy)
_____ Exhaustion
_____ Failure
_____ Family Conflict
_____ Family Violence
_____ Father
_____ Fatigue
_____ Fear
_____ Finances
_____ Forgiveness
_____ Frustration
_____ Guilt
_____ Health
_____ Headaches
_____ Homosexuality
_____ Honesty
_____ Impotence
_____ Inability To Relax
_____ In-Laws
_____ Irritability
_____ Loneliness
_____ Loss of Interest
_____ Loss of Pleasure
_____ Lust
_____ Mother
_____ Marriage
_____ Memory Difficulty
_____ Muscle Tension
_____ Occupation Issue
_____Opposite Sex
_____ Overactivity
_____ Perfectionism
_____ Pride
_____ Rape
_____ Rebellion
_____ Rejection
_____ Religious/Spiritual Issues
_____ Repetitive Ideas
_____ School Problems
_____ Separation
_____ Sex
_____ Sexual Abuse
_____ Shy/Awkward
_____ Single Parenting
_____ Sleep Problems
_____ Spouse Abuse
_____ Stomach/GI Disturbance
_____ Stress
_____ Substance Use
_____ Substance Use in Family
_____ Suicidal Thoughts
_____ Suspiciousness
_____ Troubling Memories
_____ Troubling Habit
_____ Trust
_____ Underactivity
_____ Unfairly Treated
_____ Unusual Experiences
_____ Wish to Hurt Someone
_____ Withdrawal

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Thank you for your interest in the Restart Training Center Ministry, Inc residential program service. **RTCM is a 6-month residential training center. Students are not allowed to have a job while at RTCM**. The intake forms need to be filled out **completely** and student handbook read and signed. Admission cannot be done until all this information is completed and returned to us.

Once **ALL** the above is sent to us, you will be placed on our waiting list. The waiting period may be just a couple days, weeks, or months. You must call the intake coordinator once a week to keep us informed of your desire to enter. This is a general application and consists of the basic requirements of the Restart Training Center Ministry, Inc.

Belongings Checklist:

_____ 1 Bible

_____ 1 set of linens for a twin bed (sheets)

_____ 1 comforter

_____ 1 pillow

_____ 2 sets of dress clothes (this includes 2 button-up shirt, 1 polo-type shirt, 2 pairs of dress pants, 2 pairs of dress socks, dress shoes, 2 neckties)

_____ Pair of work gloves

_____ 5 sets of casual clothes

_____ 2 sets of work clothes

_____ 7 pair each underwear and socks

_____ 2 towels

_____ 2 washcloths

_____ 1 pair shower shoes

_____ 1 bath robe

_____ 1 pair work boots

_____ 1 pair sneakers / gym shoes

Toiletries/Misc:

_____ Toothbrush

_____ Toothbrush

_____ Deodorant

_____ Shaving Supplies

_____ Soap

_____ Shampoo

_____ Mouthwash (Non-alcoholic)

_____ Hangers

_____ Laundry Bag-**full-vent/heavy duty only**

_____ Writing paper / Notebooks

_____ Pens / Pencils / Highlighers

_____ Hand Sanitizer (non-alcoholic)

_____ Case of Toilet Paper

_____ Facial Tissue

*$50 + USPS Personal Money recommended (cash ok)

_____ **$1000 Intake Fee (non-refundable)**

**certified check or money order only*

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Do Not Bring:

_____ Jewelry *(only a watch, wedding ring or a medical ID bracelet)

_____ Medical, dental or legal/court appointments *(must be taken care of before you begin RTCM)

_____ Cigarettes, chew, snuff, drugs, alcohol, nicotine withdrawing substances of any kind, etc.

_____ Magazines, books or any literature *(only your Bible)

_____ Radios, mp3 player, clock radios, alarm clocks, etc.

_____ Guns, knives, scissors, any other sharp instruments, or any other weapon

_____ Food, snacks, drinks, etc.

_____ Nutritional supplements, vitamins, etc.

_____ No aerosols of any kind (body spray, deodorant, hair spray, etc.)

_____ No checkbooks, credit cards, debit cards, or ATM cards.

*All medications are to be announced to the Intake Coordinator or Director prior to your arrival at the Training Center. **NO PSYCHOTROPIC OR NARCOTIC MEDICATIONS OF ANY KIND ALLOWED IN THIS FACILITY!** OTC medications may be provided by the center.