



## Intake Form

2020

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,

A handwritten signature in black ink that reads "Rev. J. Jaime Santiago".

Pastor J. Jaime Santiago, MA

*Executive Director – Restart Training Center Ministry, Inc.*



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? \_\_\_\_\_  
\_\_\_\_\_



**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) \_\_\_\_\_



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: \_\_\_\_\_



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) \_\_\_\_\_



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: \_\_\_\_\_



**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.

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



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 / Highlighters
- \_\_\_ Hand Sanitizer (non-alcoholic)
- \_\_\_ Case of Toilet Paper
- \_\_\_ Facial Tissue

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

\_\_\_ **\$2250 Intake Fee (non-refundable)**  
*\*certified check or money order only*





**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.