



13535 County Road 413

Dexter, Mo. 63841

Phone: 573-891-1192

info@nbdexter.com

29:11

PLEASE PRINT

Application

Today's Date

PERSONAL INFORMATION

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ SS# _____

Single

Married

Please place an X in the appropriate box that describes the above address

Permanent Address

Temporary Address

Treatment Facility

Jail/Prison

Other

If other, please explain : _____

Release Date: _____

IPO Name: _____

DOC# _____

JEREMIAH HOUSE

Do you have any pending legal cases?

YES

NO

If yes, place an **X** the box of all that apply:

Traffic Violations

Civil Involvements

Criminal involvements

If you answered yes to any of the above, please complete the

Do following:

Date: _____ **Charge:** _____

Status of Violation/Involvement:

PROBATION AND PAROLE INFORMATION:

Name: _____ **Location:** _____

Phone Number: _____

How long have you been or were you on probation/parole: _____

What reason were you or are you on probation _____

EDUCATION INFORMATION:

What is the highest grade you have completed? _____

If you did not graduate, do you want to receive your G.E.D.? _____

SPIRITUAL INFORMATION:

you have any religious or spiritual affiliations? _____

If yes, what: _____

Are you presently attending church? YES NO

Have you in the past? YES NO

How often? _____

Please describe your relationship with God or your Higher Power:

Primary "Drug of Choice": _____

Secondary: _____

Have there ever been incidents of overdose, withdrawal or adverse reaction to drugs or alcohol? YES or NO

If yes, please describe: _____

List any substance abuse treatment programs you have attended:

LEGAL HISTORY (ASSOCIATED WITH CHEMICAL USE/ALCOHOL)

DATE	CHARGE	AGE	LOCATION	USE INVOLVEMENT

MEDICAL INFORMATION:

Physicians Name: _____

Address: _____

City: _____ State _____ Zip _____

Specialty: _____ Office Phone: _____

If you have more than one physician, please list all the same information as above for each physician on another sheet of paper and attach it to the last page of this application.

Have you ever required Psychiatric counseling? ___ If yes, please explain in detail.

Please List All Medication Both **Prescribed** and **Over-the-Counter** That You Take

Medication Name	Physicians Name	Dosage Amount	When Taken	Medication Reason