Star of the North Maternity Home
Applicant Questionnaire

FULL NAME: __________________ BIRTHDATE: ___________________
AGE:_______

Due Date or DOB of Infant:___________________

Where do you live right now?_______________________________________

CURRENT LIFE SITUATION:
____Single (never married)
____Married—how long?_________
____Domestic partner- how long?_________
____Divorced—what year_________
____Widowed—what year_________
____Other

Do you have other children (not including the infant above)?

Do they live with you? _____ Age(s)? _____

Have you ever had or now have CPS involvement?

Education level:
____Left school in the ____th grade
____High School graduate
____Completed GED
____Trade school/apprenticeship
____College graduate

Are you currently employed?

Are you on disability (SSI)? or have any disability needs?

Are there any cultural or spiritual beliefs that you would like us to be aware of? No

Do you have any legal issues? (felonies, misdemeanors, jail or prison time)

Are you currently on probation or parole? (If yes, please provide contact information)

PHYSICAL HEALTH:

Please choose 0–10 scale, which can best represent your health status today (0 means the worst and 10 means the best).________

Allergies: ______________Medications ________________Food _________Envrionmental

Do you wear glasses? ____ Yes _____No

Have you had an eye exam in the last 12 months? (If so who and where)

Have you seen a dentist in the last 12 months? (If so who and where)

Do you have a primary care provider? If yes, who and contact information)

Do you have an OB provider? (Who, contact information)

Do you have any current health issues? (Check those that apply, explain if checked)

____Asthma or respiratory ailments
____Diabetes
____Heart problems
____Headaches
____Seizures
____Constipation
____Urination
____Diarrhea
____Nausea/vomiting
____Ulcers or digestive issues
____Hepatitis/AIDS
____STD's __________________
____Hearing loss
____Arthritis
____Pneunomia
____Pregnancy health issues (bleeding, cramping, nausea
____Other

Is there anything else you would like us to know about your health or family health history?

Current Medications/(include Opioid treatment if applicable) prescribed by who?:

Past Medications/Effects:

MENTAL HEALTH SYMPTOMS (Please check all that apply):

____Depression
____Sleep problems
____Appetite
____Concentration problems
____Memory problems
____Low motivation
____Reduced interest/enjoyment
____Self-criticism/guilt
____Crying spells
____Suicidal thoughts
____Self injurious behaviors
____Mood swings
____Too much energy
____Racing thoughts
____Irritability
___Anger management problems
____Thoughts of harming others
____Seeing/hearing/smelling/feeling things that are not really there
____Paranoia
___Relationship problems
____Hyperactivity
____Aggressive behaviors/history of physical aggression/threatening others
____Stealing
____Running away
____Lying
____Vomiting after eating
____Self starving
____Severe overeating episodes
____Anxiety/worry
____Anxiety around other people
____Panic attacks
____Fast or unusual heartbeat
____Phobias/fears
____Obsessions (unwanted thoughts)
____Compulsions (unwanted behavior)
____Nightmares
____Flashbacks
____Gambling
____Sexual problems or identity/concerns/issues
____Other problems or concerns:

___Have you had a Diagnostic Assessment within the past year? (When/where?)

FAMILY MENTAL HEALTH HISTORY:

___Depression
___Anxiety
___Bipolar
___Schizophrenia
___Alcohol/Drugs
___ADHD
___Learning Disabilities
___Eating Disorders
___Tics/Tourette's
___Dementia
___Suicide

TRAUMA EXPOSURE:
Have you ever experienced physical, sexual or emotional abuse or neglect at any time in your life?
____No
____Yes (How old were you?) child (by whom) parents
Have you experienced any other traumatic event during your life?
____No
____Yes (describe) parents fighting and using substances
Have you witnessed traumatic events?
____No
____Yes (describe)

How do your trauma experiences affect you today?
Got me started on drugs.

RISK ASSESSMENT:
Have you ever tried to end your life?
____No
____Yes—When?___________how_______________?

Have you ever harmed yourself (cutting, burning, etc.)?

CURRENT MENTAL HEALTH SERVICES:

___Psychiatric Care (When/where?)____
___Counseling/Therapy (When/where?))____
___Psychiatric Hospitalizations (When/where?)_____________________________________
___Psychological Testing (When/where?))____
___ Case Manager/Social Worker (/Name/Agency))____________________________
___ARHMS Worker (Name/Agency?))____

SUBSTANCE USE HISTORY:

______Are you on a Rule 25 (voluntary or involuntary)

Have drugs or alcohol been a problem for you (check all that apply)?
_____ Alcohol _________________Date Last Used
_____ Heroin _________________Date Last Used
_____ Marijuana_________________Date Last Used
_____ Meth_________________Date Last Used
_____ Opioids_________________Date Last Used
_____ Cocaine_________________Date Last Used
_____ Crack_________________Date Last Used
_____Ssmoke/vape tobacco?
_____ Other ____

PAST AND CURRENT CHEMICAL DEPENDENCY SERVICES:
Have you ever had any substance use treatment? If yes, when and where?

___Inpatient Treatment (When/where?)
___Partial Hospitalization Treatment (When/where?)
___Outpatient Treatment (When/where?)

When was your last negative UA? (Where and when) ___not clean at present___________________

SOCIAL HISTORY:

Where were you born and raised?

Do you have siblings, parents?

Do you describe your childhood as happy or stressful?

How is your current relationship with your family?

Have you ever been in foster care? (how long, how many families)?

PLEASE BRING A COPY TO YOUR NEXT INTERVIEW OF THE FOLLOWING DOCUMENTS:

1) Photo ID - Drivers License and/or SS Card
2) Current Diagnostic Assessment (within 12 months) or most recent
3) Rule 25 (if applicable)
4) Current Court Order or Legal Documents (i.e Probation or Parole conditions)
5) Bring a copy of your medical insurance card
6) Bring Completed SON Applicant Questionnaire
7) Bring Completed & Signed Background Check Form