



## INTAKE APPLICATION- Please Print

### INFORMATION IN THIS APPLICATION IS CONFIDENTIAL

*Doors to Freedom exists to provide a safe place for survivors of sex trafficking to experience a transformed life. We have a residential facility where we will help you to start a new life, guiding you through your education, building life skills, and caring for your basic, social, and spiritual needs. We are not a medical, addictions rehab, or mental health facility, but we will help you to get needed care through other community resources.*

Any information on this application will not be held against you or used to judge you. Doors to Freedom staff simply needs to know the facts about you and where you are in life right now. You do have an option not to answer questions you don't feel ready to answer or don't know the answer. We will not be able to thoroughly help you if you are not completely honest when you answer the questions below. This information is confidential

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
First Middle Last

LEGAL ADDRESS: \_\_\_\_\_  
Street City State Zip code

YOUR AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_ HAIR COLOR: \_\_\_\_\_

DO YOU HAVE ANY SCARS OR TATTOOS? Y / N If yes, describe: \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

ARE YOU A US CITIZEN: Y / N If NO, please indicate country of citizenship: \_\_\_\_\_

NAME(S) OF CUSTODIAL PARENT(S)/GUARDIAN(S): \_\_\_\_\_

RELATIONSHIP TO RESIDENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

REFERRAL SOURCE - (see page 2 for additional information)

\_\_\_\_ DSS \_\_\_\_ DJJ \_\_\_\_ Law Enforcement: \_\_\_\_\_ Other: \_\_\_\_\_

## LEGAL INFORMATION

DATE COMPLETED:

DO YOU HAVE ANY PENDING LEGAL ISSUES? Y / N If yes, please list below. Include court appearances, charges pending, etc. (Use the back of the page if necessary.)

LIST YOUR PAST CONVICTIONS: (Use the back of the page if necessary.)

Date	Charge	Conviction	Sentence	Time Served

LAW ENFORCEMENT INVOLVED IN YOUR TRAFFICKING CASE? Y / N

OFFICER: \_\_\_\_\_ COUNTY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

LAW ENFORCEMENT BRANCH: \_\_\_\_\_

IS THERE CURRENTLY LEGAL ACTION AGAINST YOUR PIMP/TRAFFICKER/PERPETRATOR(S)? Y / N

EXPLAIN: \_\_\_\_\_

NAME OF YOUR PIMP AND OTHERS INVOLVED: \_\_\_\_\_

IS YOUR TRAFFICKER/PIMP CURRENTLY IN CUSTODY? Y / N IF YES, WHERE: \_\_\_\_\_

IF NO, DO YOU KNOW WHERE YOUR TRAFFICKER/PIMP CURRENTLY IS? (IF YES, WHERE?) \_\_\_\_\_

ATTORNEY OR LEGAL REPRESENTATIVE NAME: \_\_\_\_\_

AGENCY: : \_\_\_\_\_ E-MAIL: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

City

State

Zip code

GUARDIAN AD LITEM NAME: \_\_\_\_\_

AGENCY: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PROBATION OFFICER NAME: \_\_\_\_\_ COUNTY: \_\_\_\_\_

How often do you report? \_\_\_\_\_ In person or through the mail? \_\_\_\_\_ Cost? \_\_\_\_\_

AGENCY: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

City

State

Zip code

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DSS WORKER NAME: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DJJ OFFICER NAME: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

***Doors to Freedom is NOT a medical facility.***

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION, OVER-THE-COUNTER MEDICATION, OR ANY USING ANY ILLEGAL DRUG? Y / N                      If yes, list what medication or drug, dosage, date of last use.

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DOES THE MEDICATION SEEM TO HELP? Y / N

DO YOU HAVE A HISTORY OF DRUG/ALCOHOL ABUSE OR ADDICTION? If so, describe \_\_\_\_\_

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HAVE YOU EVER BEEN DIAGNOSED WITH ANY MEDICAL CONDITION? If so, what? \_\_\_\_\_

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Have you ever experienced:

Migraines     HIV/AIDS     Tourette's     Abortion     Epilepsy/Seizures  
 Hearing Loss     Vision Issues     UTI     Miscarriage     Kidney Stones  
 Heart Disease     Diabetes     Asthma     Tuberculosis     High Blood Pressure  
 STI/STD     Hepatitis A - pos. or neg. / B - pos. or neg. / C - pos. or neg.

HAVE YOU HAD A COUGH THAT HAS PERSISTED FOR MORE THAN 3 WEEKS \_\_\_\_\_ YES \_\_\_\_\_ NO?

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST 30 DAYS:

night sweats     chronic fatigue     unexplained weight loss     bloody phlegm

DO YOU HAVE ANY ALLERGIES? If so, what? (medications, foods, household products, outdoor, pet, cosmetic, etc.) \_\_\_\_\_

WHAT IS THE ANTICIPATED ALLERGIC REACTION? \_\_\_\_\_

WHAT SHOULD BE DONE IN THE EVENT OF ALLERGIC REACTION? \_\_\_\_\_

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DO YOU REQUIRE AN EPIPEN? Y / N

WHEN WAS YOUR LAST VISIT TO A DOCTOR? \_\_\_\_\_ DENTIST? \_\_\_\_\_

VISION? \_\_\_\_\_

PREVIOUS/CURRENT DOCTOR: \_\_\_\_\_ OFFICE: \_\_\_\_\_

PREVIOUS/CURRENT DENTIST: \_\_\_\_\_ OFFICE: \_\_\_\_\_

PREVIOUS/CURRENT OBGYN: \_\_\_\_\_ OFFICE: \_\_\_\_\_

PREVIOUS/CURRENT EYE DOCTOR: \_\_\_\_\_ OFFICE: \_\_\_\_\_

PREVIOUS/CURRENT SPECIALIST: \_\_\_\_\_ OFFICE: \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED? Y / N

IF YES, STATE REASON: \_\_\_\_\_

HAVE YOU EVER BEEN TREATED FOR A SEXUALLY TRANSMITTED DISEASE? Y / N

WHEN WAS YOUR LAST TB TEST? \_\_\_\_\_

WHEN WAS YOUR LAST MENSTRUAL CYCLE: \_\_\_\_\_

ARE YOU PREGNANT? Y / N

IS THERE A POSSIBILITY THAT YOU COULD BE PREGNANT? Y / N

IF YES: HAS A DOCTOR CONFIRMED YOUR PREGNANCY? Y / N

Approximate due date: \_\_\_\_\_

DO YOU KNOW WHO THE BIRTH FATHER IS? Y / N

IF SO, IS HE AWARE? Y / N

DO YOU HAVE ANY CURRENT/PREVIOUS MENTAL HEALTH DIAGNOSES OR ISSUES (depression, anxiety, panic attacks, etc.)? Y / N

IF YES, SPECIFY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER HAD A SEVERE EMOTIONAL UPSET? Y / N

If YES, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER CONSIDERED SUICIDE? Y / N ARE YOU CURRENTLY SUICIDAL? Y / N

HAVE YOU EVER INTENTIONALLY HARMED YOURSELF? Y / N

ARE YOU CURRENTLY HARMING YOURSELF? Y / N

PREVIOUS/CURRENT THERAPIST/COUNSELOR: \_\_\_\_\_ OFFICE: \_\_\_\_\_

PREVIOUS/CURRENT PSYCHIATRIST: \_\_\_\_\_ OFFICE: \_\_\_\_\_

OTHER MENTAL HEALTH PROFESSIONAL: \_\_\_\_\_ OFFICE: \_\_\_\_\_

Have you ever been diagnosed with any of the following

The following list of infections that require medical clearance prior to admission:

- |   |  |
|---|--|
| <input type="checkbox"/> Pharyngeal Diphtheria                                      | <input type="checkbox"/> MRSA-respiratory infections                                 |
| <input type="checkbox"/> Influenza, known or suspected                              | <input type="checkbox"/> Methicillin/oxacillin resistant Staph aureus                |
| <input type="checkbox"/> Neisseria meningitidis (meningococcal), known or suspected | <input type="checkbox"/> (MRSA)-Skin infections                                      |
| <input type="checkbox"/> Meningococcal pneumonia                                    | <input type="checkbox"/> Vancomycin resistant enterococcus (VRE)                     |
| <input type="checkbox"/> Meningococemia   | <input type="checkbox"/> Cutaneous Diphtheria  |
| <input type="checkbox"/> Mumps (infectious parotitis)                               | <input type="checkbox"/> Ebola viral hemorrhagic fever                               |
| <input type="checkbox"/> Mycoplasma pneumonia                                       | <input type="checkbox"/> Lassa fever   |
| <input type="checkbox"/> Pertusis (whooping cough)                                  | <input type="checkbox"/> Marburg Virus disease                                       |
| <input type="checkbox"/> Pneumonic plague   | <input type="checkbox"/> E coli 0157:h7 in a diapered or incontinent patient         |
| <input type="checkbox"/> Adenovirus pneumonia                                       | <input type="checkbox"/> Disseminated or severe primary mucocutaneous Herpes simplex |
| <input type="checkbox"/> Rubella  | <input type="checkbox"/> Impetigo  |
|   | <input type="checkbox"/> Adenovirus pneumonia  |

FAMILY HISTORY

DATE COMPLETED

NAME OF BIOLOGICAL MOTHER, IF DIFFERENT THAN GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip Code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

NAME OF BIOLOGICAL FATHER, IF DIFFERENT THAN GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip Code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

List all immediate family: (Step-Parent(s), Spouse, Boyfriend, Sister(s), Brother(s), Half-Sibling(s), Step-Sibling(s), Adoptive Sibling(s), and Children) - Continue on back if needed.

NAME	RELATIONSHIP	AGE	RESIDENCE

ARE YOU AN EMANCIPATED MINOR? Y / N

ARE YOU CURRENTLY IN CONTACT WITH YOUR FATHER AND/OR MOTHER? \_\_\_\_\_

HOW OFTEN DO YOU SEE/COMMUNICATE WITH THEM? \_\_\_\_\_

PARENTS' MARITAL STATUS: (circle one) Divorced Separated Remarried Living Together  
Married (How long? \_\_\_\_\_) Other: \_\_\_\_\_

HAVE PARENTAL RIGHTS BEEN TERMINATED FOR YOUR FATHER/MOTHER? Y / N

If YES, who? \_\_\_\_\_ When? \_\_\_\_\_

IS ANYONE ELSE LEGALLY RESTRICTED FROM SEEING YOU? Y / N

If YES, who? \_\_\_\_\_ Restrictions: \_\_\_\_\_

HOW LONG HAVE YOU BEEN AWAY FROM YOUR FAMILY? \_\_\_\_\_

DO YOU DESIRE TO BE REUNITED WITH YOUR FAMILY? Y / N Please explain. \_\_\_\_\_

WERE YOU RAISED BY ANYONE OTHER THAN YOUR BIOLOGICAL PARENTS? Y / N

If YES, please explain: \_\_\_\_\_

NAME: \_\_\_\_\_

First

Middle

Last

ADDRESS: \_\_\_\_\_

Street

City

State

Zip code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

YOUR MARITAL STATUS: (Circle one)

Single

Separated

Divorced

Living Together

Widowed

Married (How long? )

In a Relationship

HAVE YOU EVER BEEN MARRIED? Y / N

CURRENT SPOUSE/SIGNIFICANT OTHER, IF APPLICABLE:

NAME: \_\_\_\_\_

First

Middle

Last

ADDRESS: \_\_\_\_\_

Street

City

State

Zip Code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

IF YOU HAVE CHILDREN:

WHERE ARE THEY CURRENTLY LIVING? \_\_\_\_\_

WHO HAS CUSTODY? (Write name and relationship.) \_\_\_\_\_

CUSTODIAN'S CONTACT INFORMATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

City

State

Zip Code

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WHAT ARRANGEMENTS ARE BEING MADE FOR YOUR CHILDREN WHILE YOU ARE AT DOORS TO FREEDOM?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IS THERE ANY OTHER FAMILY INFORMATION YOU FEEL DOORS TO FREEDOM SHOULD BE AWARE OF?

If yes, describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EDUCATION HISTORY DATE COMPLETED:

LAST SCHOOL YOU ATTENDED: \_\_\_\_\_

HIGHEST GRADE COMPLETED: DATE LEFT/GRADUATED: \_\_\_\_\_

ARE YOU INTERESTED IN OBTAINING YOUR GED CERTIFICATE? Y / N YOUR HIGH SCHOOL DIPLOMA? Y / N

(Minors must participate in school while at Doors to Freedom.)

HAVE YOU EVER BEEN IN SPECIAL EDUCATION CLASSES? Y / N

If YES, please describe: \_\_\_\_\_

DO YOU CONSIDER YOURSELF A GOOD READER? Y / N A GOOD WRITER? Y / N

WHAT WAS YOUR FAVORITE SUBJECT IN SCHOOL? \_\_\_\_\_ YOUR LEAST FAVORITE SUBJECT? \_\_\_\_\_

LIST ANY IDENTIFIED EDUCATION-RELATED DIFFICULTIES

(including learning disabilities, reading comprehension problems, behavioral problems):

\_\_\_\_\_

EMPLOYMENT HISTORY DATE COMPLETED:

1. \_\_\_\_\_

Employer

Position

Dates

ADDRESS: \_\_\_\_\_

Street

City

State

Zip code

WORK PHONE: \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

2. \_\_\_\_\_

Employer

Position

Dates

ADDRESS: \_\_\_\_\_

Street

City

State

Zip code

WORK PHONE: \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

HAVE YOU EVER BEEN TERMINATED FROM A JOB? Y / N

If YES, please explain: \_\_\_\_\_

WHAT WOULD BE YOUR CAREER OF CHOICE?

\_\_\_\_\_

CURRENT FINANCIAL STATUS DATE COMPLETED:

DO YOU HAVE ANY OUTSTANDING DEBTS? Y / N

If YES, please explain: \_\_\_\_\_



**HAVE YOU MADE ARRANGEMENTS\* FOR THEIR PAYMENT WHILE YOU ARE AT DOORS TO FREEDOM? Y / N**

\*DOORS TO FREEDOM PROVIDES FOOD AND SHELTER, BUT WILL NOT BE RESPONSIBLE FOR ANY OUTSTANDING DEBT OR ACCRUED MEDICAL OR FINANCIAL EXPENSES WHILE LIVING IN OUR FACILITY.

**SOCIAL INTEREST**

**DATE COMPLETED:**

DO YOU HAVE A FACEBOOK ACCOUNT? Y / N

DO YOU HAVE A TWITTER ACCOUNT? Y / N

OTHER SOCIAL MEDIA ACCOUNT? Y / N If so, what? \_\_\_\_\_

DO YOU PLAY ANY RECREATIONAL SPORTS/ACTIVITIES? \_\_\_\_\_

ARE YOU A PART OF ANY CLUBS/ORGANIZATIONS? \_\_\_\_\_

LIST HOBBIES OR THINGS OF INTEREST: \_\_\_\_\_

FAVORITE TV SHOWS: \_\_\_\_\_

FAVORITE MOVIE: \_\_\_\_\_

FAVORITE BOOK: \_\_\_\_\_

**RELIGIOUS BACKGROUND/BELIEFS**

**DATE COMPLETED:**

IN WHAT RELIGION/DENOMINATION WERE YOU RAISED? (IF NONE, WRITE N/A) \_\_\_\_\_

HAVE YOU EVER WITNESSED OR BEEN INVOLVED WITH WITCHCRAFT/OCCULT ACTIVITIES?

(Satan worship, Ouija boards, levitation, rituals, séances, sacrifices, etc.)

HAVE YOU EVER BEEN INVOLVED IN ANY OF THESE ACTIVITIES: (Circle any that apply.)

Christian Science

Jehovah's Witness

Brotherhood

Mormonism

Kabbalah

New Age Movement

Eastern Religions

Scientology

Transcendental Meditation Rainbows

If so, write a brief explanation of your involvement: (Use the back of the page if necessary.)

**SEXUAL HISTORY**

**DATE COMPLETED:**

HAVE YOU EVER BEEN INVOLVED IN:

PROSTITUTION? Y / N

STRIPPING? Y / N

PORNOGRAPHY? Y / N

SAME SEX RELATIONSHIP? Y / N

SEXUALLY ASSAULTING ANOTHER PERSON? Y / N

HAVE YOU EVER EXPERIENCED:

RAPE/SEXUAL ASSAULT? Y / N

SEXUAL ABUSE? Y / N

SEXUAL HARASSMENT? Y / N

**VIOLENT BEHAVIOR**

**DATE COMPLETED:**

DO YOU HAVE A HISTORY OF VIOLENT BEHAVIOR? Y / N

VIOLENCE TOWARDS FAMILY? Y / N

VIOLENCE TOWARD PEERS? Y / N

VIOLENCE TOWARD STRANGERS? Y / N

VIOLENCE TOWARD ANIMALS? Y / N

SETTING FIRES? Y / N

DAMAGING PROPERTY? Y / N

THEFT? Y / N

Last episode: \_\_\_\_\_ Type of violent behavior: \_\_\_\_\_

PERSONAL INFORMATION	DATE COMPLETED:
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WHY DO YOU WANT TO COME TO DOORS TO FREEDOM? Please explain in at least 4 sentences.

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IN YOUR OPINION, WHAT KIND OF HELP DO YOU THINK YOU NEED?

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DESCRIBE YOUR GREATEST FEAR IN COMING TO DOORS TO FREEDOM:

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IS THERE ANY INFORMATION YOU FEEL LIKE DOORS TO FREEDOM SHOULD KNOW?

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DO YOU FEEL YOU WILL BE ABLE TO SUBMIT TO THE STAFF AND THE HOUSE RULES? Y / N

Why or Why Not?

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PLEASE RATE THE FOLLOWING ON A SCALE FROM 1-5, WITH 1 EASY AND 5 BEING EXTREMELY DIFFICULT:

While in this program, how easy will it be for you to:

EASY ----- HARD

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| • Discuss your personal issues with a counselor                 | 1 | 2 | 3 | 4 | 5 |
| • Accept personal responsibility                                | 1 | 2 | 3 | 4 | 5 |
| • Think seriously about things in your life that need to change | 1 | 2 | 3 | 4 | 5 |
| • Take action to solve personal problems                        | 1 | 2 | 3 | 4 | 5 |
| • Express your feelings   | 1 | 2 | 3 | 4 | 5 |
| • Be around other people (as opposed to being alone)            | 1 | 2 | 3 | 4 | 5 |
| • Get along with other people                                   | 1 | 2 | 3 | 4 | 5 |

Describe how you see yourself:

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WHAT WOULD YOU WANT SOMEONE TO KNOW ABOUT YOU?

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IN A RELATIONSHIP, WHAT'S THE MOST IMPORTANT CHARACTER TRAIT TO YOU, AND WHY?

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WHAT MAKES YOU FEEL GLAD? \_\_\_\_\_

WHAT MAKES YOU FEEL SAD? \_\_\_\_\_

WHAT MAKES YOU FEEL MAD? \_\_\_\_\_

WHAT, IF ANYTHING, \_\_ MAKES YOU WANT TO ARGUE/FIGHT? \_\_\_\_\_

WHAT, IF ANYTHING, MAKES YOU WANT TO RUN AWAY? \_\_\_\_\_

IS THERE ANYONE IN YOUR LIFE THAT MAKES YOU FEEL SUPPORTED? Y / N If yes, who? What does he/she do to make you feel supported? \_\_\_\_\_

LIST ANY OTHER PROGRAMS THAT YOU HAVE BEEN TO:

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WERE THE PROGRAMS SUCCESSFUL FOR YOU? WHY OR WHY NOT?

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By signing this I acknowledge that the information provided herein is accurate and true to the best of my knowledge. I also understand that any false or incomplete information may cause and result in disqualification from admittance into the program, or early dismissal from the program.

Print Name: \_\_\_\_\_

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_

\_\_\_\_\_  
DOORS TO FREEDOM INTAKE COORDINATOR

\_\_\_\_\_  
Date