# *The Lighthouse Foundation*

# *Client Application Form for*

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Name: ______________________________

Present Address: ______________________________

______________________________

Age: __________ D.O.B.: ____________________

Phone Number: ______________________________

Nationality: ______________________________

Contact Name: ______________________________

Address: ______________________________

______________________________

Contact Relationship: ______________________________

Phone Numbers: ______________________________

______________________________

Accommodation: Alone ❑ Spouse ❑ Parents ❑ Friends ❑ Other: ____________________

Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

Do you have any children? No ❑ Yes ❑ If yes, how many & age: ____________________

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N.I. No.: ______________________________

Employer: ______________________________

Termination Date: ______________________________

Benefits Claimed: ______________________________

Position: ______________________________

Previous Employer: ______________________________

Skills & Qualifications: ______________________________

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Do you Smoke? No ❑ Yes ❑ If yes, how many per day? ___________

Do you Drink? No ❑ Yes ❑ If yes, amount per day? _______________ Type of Alcohol: _________

Do you use drugs? No ❑ Yes ❑ If yes, what is your primary drug: ____________________

Daily Amount: ______________________________ Age Started: _______ Prescribed: No ❑ Yes ❑

Other drugs used: Amphetamines ❑ Cannabis ❑ Crack Cocaine ❑ Ecstasy ❑ LSD ❑ Heroin ❑
Methadone ❑ Temazepan ❑ Other: ______________________________

Have you received any previous treatment for Drug or Alcohol Abuse? No ❑ Yes ❑

If yes, with whom: ______________________________

Previous Drug Use *(drugs taken, age started, how used, etc.)*:

______________________________

______________________________

______________________________

______________________________

______________________________

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How would you describe your sexuality: ______________________________

Have you ever had an H.I.V test? No ❑ Yes ❑ If yes, what was the result: ____________

Do you have Hepatitis or any other related diseases? No ❑ Yes ❑ Don't Know ❑

Have you ever been prosecuted for a violent offence? No ❑ Yes ❑

Have you ever been prosecuted for a sexual offence? No ❑ Yes ❑

Do you have any outstanding court appearances? No ❑ Yes ❑

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Do you have a Social Worker, Probation Officer, Psychiatrist or other such person who has been regularly seeing you? No ❑ Yes ❑

If yes, please state the name of the person/s, their Job Title and a telephone number where they can be contacted: ______________________________

Doctors Name: ____________________

Address: ____________________

Telephone Number: ____________________

## *Lighthouse student agreement*

I agree that the information I have given on this form is to the best of my knowledge correct and I understand that any false or misleading statements may be sufficient grounds for cancelling any agreements made. I also herewith give lighthouse foundation permission to acquire any information concerning my medical history from my doctor, drug or alcohol worker or any other relevant agencies.

Signed: ____________________ Print Name: ____________________

Witnessed: ____________________ Print Name: ____________________

Date: ____________________