REGISTRATION

2020-2021 Season

Date: _____

NAME: _____

Phone Number:_____ **DOB:** _____

SS#: _____ **E-MAIL:**_____

Ethnicity (Please Circle):

White, African American, Hispanic, Asian or Pacific Islander, Native American or Native Alaskan

Marital Status: ___Single ___Married ___ Separated ___Divorced ___Widowed

If married where is your spouse staying: _____

Have you been a Guest of RITI in any previous year? Yes____ No____

Are you currently homeless? Yes___ No___

If yes, how long have you been homeless? _____

If no, where are you currently living? _____

Do you have ANY source of income (job, SSI, retirement, etc.)? Yes_____ No_____

Are you a Veteran? Yes_____ No_____

If yes are you eligible for or do you now receive VA benefits? Yes_____ No_____

If yes explain:

_____

_____

What is you highest level of education? _____

How long have you been in Lexington? _____

Is Lexington your home? _____ If not, where are you from? _____

Do you have friends or family in Lexington who would provide you a place to live if you would accept?

Yes ___ No___

If yes, please explain why you cannot accept. _____

Do you take any over-the-counter medicines? Yes No

If yes please list:

_____

Do you take any prescription medicines? Yes No

If yes please list:

_____

_____

Are you allergic to any medicines? Yes No

If yes please list:

_____

Are you allergic to any foods? Yes No

If yes please list:

_____

Please circle the word that best describes your general health:

Excellent Good Fair Poor

Please circle any of the following illnesses that you have had:

Diabetes	Heart Trouble	Kidney Trouble	Lung Trouble
High blood Pressure	Seizures	Cancer	Rheumatic Fever
Asthma	Thyroid Disorder	Nervous Disorder	Mental Disorder

In the following list, please circle “Yes” for each symptom that you have or have had in the past and provide a brief description. Please circle “No” for each symptom you do not have:

Bleeding No Yes Describe_____

Dizziness No Yes Describe_____

Fainting No Yes Describe_____

Chest Pain No Yes Describe_____

Vomit Blood No Yes Describe_____

Bloody Stool No Yes Describe_____

Seizures/convulsions No Yes Describe_____

Passing Out No Yes Describe_____

Suicidal Thoughts No Yes Describe_____

Hear Voices No Yes Describe_____

See things No Yes Describe_____

DRUG USE INFORMATION

Name: _____ Date: _____

Please indicate below if you have used the following drugs, even if a doctor prescribes them. If you have used the drug within the past month (past 30 days), indicate how many days during the month (from 1-30) that you have used it.

Drank Beer: _____

Drank hard liquor: _____

Used cocaine (coke, crack): _____

Used non-prescription narcotics (Codeine, morphine, dilaudid, Demerol, Percodan(Oxy), Darvon, hydromorphone, Methadone):

_____

Used upper (Amphetamine, no-doze, Ritalin, Methylphenidate, diet pills, Heroin, Methamphetamines):

_____

Used downers (Barbiturates, Phenobarbital, pentobarbital**,** Secobarbital or sleeping pills, synthetic marijuana, Serenity):

_____

Used relaxants (Valium, Librium, Meprobamate, Xanax):

_____

Please list any not mentioned above:

_____

Name: _____**Date:** _____

Please read each problem carefully and place a mark in the column that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Mark one column for each problem and do not skip any items.

How much were you distressed by:

	Never	**Sometimes**	**Often**
1) Thoughts of ending your life.	_____	_____	_____
2) Temper outburst that you could not control.	_____	_____	_____
3) Trouble getting your breath.	_____	_____	_____
4) Having urges to beat, injure or harm yourself or someone.	_____	_____	_____
5) Having urges to break or smash things.	_____	_____	_____
6) Spells of terror or panic.	_____	_____	_____

Reviewed and Documents Collected by:

The below is to be completed by Debbie Farinelli and a BOD Member only.

ID Provided: Yes or No

TB Test: ___/____/____

Hep A:___/____/____

Sex Offender Search: Yes or No

Background Check: Yes or No