ADMISSION APPLICATION
Saint Gianna's Maternity Home

Date of admission_____ **Please fill in *every* blank** on this form. Put "none" or "0" if nothing to report.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____Age____
Address: _____ SSN: _____-_____-_____
_____ Religious Preference: _____
Phone Number: _____ Race: _____
Emergency Contact Person/Next of Kin: _____
Address and phone number: _____
Who referred you / how did you hear about Saint Gianna's Maternity Home? _____

Previous shelters or residences in which you have lived:
Name: _____ Date: _____
Name: _____ Date: _____
Are you currently: single married separated divorced widowed

Reason that you are in need of Saint Gianna's Maternity Home?

CHILDREN

List name and age
1. _____
2. _____
3. _____

Do you have legal custody of each child? _____
Are the child's immunizations up to date? _____
Are there any health care needs or other concerns with your child? _____
If yes, please explain: _____

MEDICAL

Allergies: _____ Contagious diseases: _____
Current medications: _____
Due date: _____ Date of last physical/pre-natal appointment: _____
Doctor's name: _____ Doctor's phone #: _____
Name of Clinic/Hospital where you have been doctoring: _____

Have you had any problems with this pregnancy? _____
Do you have any other medical conditions that we need to be aware of? _____
If yes, please explain: _____

Medical Insurance Company: _____ Policy #: _____
Medical Assistance #: _____

EDUCATION

Last grade completed: _____ Name of school: _____
GED? Date obtained: _____
Past vocational/job training: _____
Are you currently attending school or a training program? Please explain. _____

REPRODUCTIVE HISTORY

Due date of this baby _____

How many times have you been pregnant? _____ How many live births? _____

Have you ever:

1. Experienced a miscarriage? _____
2. Had an unplanned pregnancy? _____
3. Experienced a loss or a traumatic event during pregnancy? _____
4. Terminated a pregnancy? _____
5. Placed a child for adoption? _____
6. Had a stillbirth? _____
7. Taken birth control pills or had an IUD? _____
8. Taken emergency contraceptives, such as the "morning after" pill? _____
9. Contracted a sexually transmitted disease? _____
10. Have you had your tubes tied or had any other reproductive surgery? _____
11. Experienced post partum depression? _____
12. Experienced any post partum psychosis related to post partum depression or post abortion trauma? _____

If you answered yes to any of the above question, please explain on the back of this form.

How is the child's father involved in this pregnancy? _____

FINANCIAL

Income Source (please circle):

	TANF	Food Stamps	WIC	Child Support	SSI	Employment
Amount Received:	_____	_____	_____	_____	_____	_____

DRUGS/ALCHOHOL/MENTAL HEALTH

Have you ever used?

Alcohol Marijuana Cocaine/Crack Heroin Meth/Crystal Other

Last time you used? _____

Have you ever had treatment or counseling for drug and/or alcohol abuse? _____

If so, when and where? _____

Have you ever been under the care of a psychiatrist? _____If so, please explain: _____

Have you ever been the victim of physical, sexual, or verbal abuse? _____

Have you ever been the victim of incest? _____

Have you ever lived in foster care? _____

Do you currently want to do any type of counseling or therapy? _____

Have you been involved with any cults, the occult, or witchcraft (wicca)? _____

LEGAL

Have you ever or are you currently on probation or parole or under court authority for any reason? ___

Do you have a criminal record? _____ Do you have any pending charges? _____

Do you have any prior convictions? _____

If yes to any of the above, please explain: _____

I hereby certify that the information contained in this application is true and correct. I understand that falsifying any information on this application is grounds for termination from Saint Gianna's Maternity Home.

Signed: _____ Date: _____

SGMH Staff: _____ Date: _____