



## MATTCH PROGRAM APPLICATION

(Medically Assisted Treatment & Therapeutic Counseling Heals)

This is an application for Voluntary Outpatient Opioid Services to be provided at NO COST to the applicant.

### 1. IDENTIFICATION

|                     |               |                     |
|---------------------|---------------|---------------------|
| NAME:(first)        | (middle init) | (last)              |
| DOB: ____/____/____ | Age: _____    | GENDER: MALE FEMALE |
| STREET ADDRESS:     |               |                     |
| CITY:               | Tennessee     | ZIP:                |

### 2. CONTACT

|                  |                          |     |    |
|------------------|--------------------------|-----|----|
| EMAIL ADDRESS:   | May we Email you?        | Yes | No |
| PRIMARY PHONE:   | May we call/text/lvg vm? | Yes | No |
| SECONDARY PHONE: | May we call/text/lvg vm? | Yes | No |

### 3. EMERGENCY CONTACT INFORMATION

|         |               |          |
|---------|---------------|----------|
| NAME:   | RELATIONSHIP: | PHONE:   |
| STREET: | CITY:         | ST: ZIP: |

### 4. PROFESSIONAL/EDUCATIONAL INFORMATION

|  |
|--|
| EMPLOYEMENT STATUS: ____ Employed ____ Self-Employed ____ Unemployed ____ Student ____ Retired   |
| EMPOLYER: _____ JOB TITLE: _____ LENGTH OF EMPLOYEMENT: _____  |
| HIGHEST LEVEL OF EDUCATION: ____ HS Withdrawal ____ HS Grad ____ Assoc's ____ Bachelor's<br>____ Master's ____ Doctorate ____ Specialized Training Area: _____ |

### 5. RELIGIOUS/SPRITUAL INFORMATION

|  |                                 |
|--|---------------------------------|
| Do you consider yourself to be religious?                                      | If yes, what is your faith?     |
| Do you consider yourself to be spiritual?                                      | Do you attend church regularly? |
| If so, where?  |                                 |
| Do you wish for your counseling experience to include a Christian perspective? |                                 |

### 6. MATCH PROGRAM REFERRAL

|   |
|---|
| How did you learn about the MATTCH Program? ____ Social Media ____ Newspaper/Print Media ____ Friend/Family<br>____ Church ____ Physician Referral (Name of referrant): _____ |
|---|

## SCORED PORTION OF MATTCH APPLICATION

### 7. HISTORY

| HOW LONG HAVE YOU BEEN USING OPIOIDS?     |  |
|---|--|
| <input type="checkbox"/> Less than 1 Year | <input type="checkbox"/> 3 to 5 Years      |
| <input type="checkbox"/> 1 to 3 Years     | <input type="checkbox"/> More than 5 Years |
| <b>SCORE:</b> _____                       |  |

### 8. MEDICATIONS

| PLEASE LIST ALL MEDICATIONS, DOSAGES, AND MEDICAL CONDITIONS |        |                         |
|--|--------|-------------------------|
| Name of Medication   | Dosage | Condition Being Treated |
|  |        |                         |
|  |        |                         |
|  |        |                         |
|  |        |                         |
|  |        |                         |
|  |        |                         |
| <b>SCORE:</b> _____  |        |                         |

### 9. PAST TREATMENT

| PLEASE PROVIDE DETAILS OF PAST TREATMENTS AND THEIR OUTCOMES |                          |                             |
|--|--------------------------|-----------------------------|
| Dates of Treatment   | Facility or Program Name | Outcome (Comp/Partial/None) |
|  |                          |                             |
|  |                          |                             |
|  |                          |                             |
| <b>SCORE:</b> _____  |                          |                             |

### 10. MOTIVATION/DETERMINATION

| HOW SERIOUS ARE YOU ABOUT OVERCOMING YOUR OPIOID ADDICTION? |                          |                             |
|---|--------------------------|-----------------------------|
| Minimal Motivation: 1-4                                     | Moderate Motivation: 5-7 | Significant Motivation 8-10 |
|   |                          |                             |
| <b>SCORE:</b> _____   |                          |                             |

### 11. MOTIVATING FACTORS

| LIST ALL FACTORS THAT MOTIVATED YOU TO APPLY FOR THE MATTCH PROGRAM |  |  |
|---|--|--|
|   |  |  |
|   |  |  |
|   |  |  |
|   |  |  |
| <b>SCORE:</b> _____   |  |  |

### 12. PERSONAL GOALS

| LIST ALL PERSONAL GOALS THAT ARE RELATED TO OVERCOMING YOUR ADDICTION |  |  |
|---|--|--|
| Goal 1:   |  |  |
| Goal 2:   |  |  |
| Goal 3:   |  |  |
| <b>SCORE:</b> _____   |  |  |



**13. LIFE CHANGES**

|  |  |
|--|--|
| LIST CHANGES YOU ARE WILLING TO MAKE IN YOUR LIFE TO SUPPORT YOUR RECOVERY |  |
| Change 1:  |  |
| Change 2:  |  |
| Change 3:  |  |
| <b>SCORE:</b> _____  |  |

**14. TRIGGERS AND COPING SKILLS**

|   |               |
|---|---------------|
| LIST YOUR TRIGGERS AND POTENTIAL WAYS OF COPING |               |
| Trigger 1:                                      | Coping Skill: |
| Trigger 2:                                      | Coping Skill: |
| Trigger 3:                                      | Coping Skill: |
| <b>SCORE:</b> _____                             |               |

**15. SUPPORT SYSTEM**

|  |  |  |
|--|--|--|
| LIST FAMILY, FRIENDS, & COMMUNITY ORGANIZATIONS THAT WILL BE A SUPPORT DURING RECOVERY |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| <b>SCORE:</b> _____  |  |  |

**16. WORK LIFE BALANCE**

|   |  |
|---|--|
| CURRENTLY EMPLOYED OR ATTENDING SCHOOL?   |  |
| HOW DO YOU PLAN TO BALANCE YOUR RESPONSIBILITIES WITH MATTCH AND YOUR RECOVERY PROCESS? |  |
| Plan 1:   |  |
| Plan 2:   |  |
| Plan 3:   |  |
| <b>SCORE:</b> _____   |  |

**17. PREVIOUS COUNSELING HISTORY**

|  |                        |  |
|--|------------------------|--|
| LIST ALL PREVIOUS COUNSELORS AND RATE YOUR COUNSELING EXPERIENCE |                        |  |
| Name of Counselor  | Beginning/Ending Dates | Rate Experience (0-10) <small>10 is BEST</small> |
|  |                        |  |
|  |                        |  |
|  |                        |  |
| <b>SCORE:</b> _____  |                        |  |

**18. COUNSELING PREFERENCES**

|  |       |             |       |
|--|-------|-------------|-------|
| INDICATE YOUR PREFERENCE AND WILLINGNES TO PARTICIPATE IN THE FOLLOWING: |       |             |       |
| Weekly Individual Counseling:  | Y / N | Preference: | Y / N |
| Monthly Family Counseling:   | Y / N | Preference: | Y / N |
| Group Sessions:  | Y / N | Preference: | Y / N |
| Celebrate Recovery/etc:  | Y / N | Preference: | Y / N |
| <b>SCORE:</b> _____  |       |             |       |



**19. COMMITMENT**

| ARE YOU WILLING TO PARTICIPATE IN THE FOLLOWING: |       |                                |               |
|--|-------|--------------------------------|---------------|
| Medical Appointments                             | Y / N | Drug Testing/Screening         | Y / N         |
| Taking Medications as Prescribed                 | Y / N | Attend all Counseling Sessions | Y / N         |
| Complete Assessments/Surveys                     | Y / N |                                |               |
|  |       |                                | <b>SCORE:</b> |

**20. PAST/PRESENT SOCIAL AND EMOTIONAL CHALLENGES**

| How is your current emotional health? | Poor | Unsatisfactory | Satisfactory | Good                          | Very good           |
|---------------------------------------|------|----------------|--------------|-------------------------------|---------------------|
| Abortion                              | Past | and/or         | Present      | Panic Attacks                 | Past and/or Present |
| Adoption                              | Past | and/or         | Present      | Paranoia/Overly Suspicious    | Past and/or Present |
| Alcohol/Drug Use                      | Past | and/or         | Present      | Poor Memory                   | Past and/or Present |
| Anxiety                               | Past | and/or         | Present      | Racing Thoughts               | Past and/or Present |
| Bedwetting                            | Past | and/or         | Present      | Rage/Anger                    | Past and/or Present |
| Body Image Issues                     | Past | and/or         | Present      | Repetitive Behaviors/Thoughts | Past and/or Present |
| Depression                            | Past | and/or         | Present      | Risky Behavior                | Past and/or Present |
| Eating Issues                         | Past | and/or         | Present      | Sexual Dysfunction            | Past and/or Present |
| Excitability                          | Past | and/or         | Present      | Sleep Disturbances            | Past and/or Present |
| Extreme Mood Shifts                   | Past | and/or         | Present      | Social Shyness                | Past and/or Present |
| Fatigue                               | Past | and/or         | Present      | Suicidal Attempts             | Past and/or Present |
| Guilt/Shame                           | Past | and/or         | Present      | Suicidal Thoughts             | Past and/or Present |
| Hallucinations                        | Past | and/or         | Present      | Stress                        | Past and/or Present |
| Harm to Self / Others / Animals       | Past | and/or         | Present      | Unexplained losses of time    | Past and/or Present |
| Headaches                             | Past | and/or         | Present      | Victim of Violence/Trauma     | Past and/or Present |
| Impulsivity                           | Past | and/or         | Present      | Worthlessness                 | Past and/or Present |
| Nightmares                            | Past | and/or         | Present      | Other:                        | Past and/or Present |

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

Client Score: \_\_\_\_\_

Program Approval: \_\_\_\_\_

