MENTAL HEALTH COACHING FORM

Resounding Minds Ministries

Recharging. Refocusing. Rededicating.

Mental Health Coaching Form

First & Last Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Email address: ______________________________

Does applicant have a disability of a long duration?

☐ Yes ☐ No

Is applicant currently or have they ever been diagnosed with any of the following?

Please circle your answer.

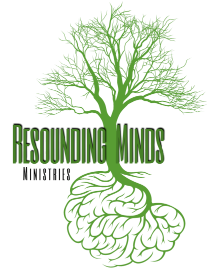
Mental Illness	YES	NO	CURRENTLY
Alcohol Abuse	YES	NO	CURRENTLY
Drug Abuse	YES	NO	CURRENTLY
Developmental Disability	YES	NO	CURRENTLY
Physical Disability	YES	NO	CURRENTLY

Does applicant have a history of any psychiatric conditions?

☐ Yes ☐ No

Please continue to next page.

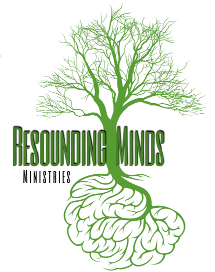
3418 Saint Elmo Ave., Chattanooga TN 37409 • resoundingmindsministries@gmail.com
www.resoundingmindsministries.org



If history of psychiatric conditions applicable, please check all that apply.

	Currently Experiences		History With If history is applicable, please give details of experience.
Homicidal Ideas/ Attempts	☐ Yes	☐ No	
Assaultive Behavior	☐ Yes	☐ No	
Delusions	☐ Yes	☐ No	
Severe Depression	☐ Yes	☐ No	
Severe Thought Disorder	☐ Yes	☐ No	
Cognitive Impairment	☐ Yes	☐ No	
Suicidal Ideas	☐ Yes	☐ No	
Suicidal Attempts	☐ Yes	☐ No	
Hallucinations	☐ Yes	☐ No	
Arson/Fire Setting	☐ Yes	☐ No	
Victim of Sexual Abuse/Assault	☐ Yes	☐ No	
Victim of Trauma	☐ Yes	☐ No	
Other (please specify)	☐ Yes	☐ No	

If applicable, please list any hospitalizations for these conditions.



Does applicant receive psychiatric care?

☐ Yes ☐ No

If yes, please list name, address, phone number of all psychiatric care providers.

Does applicant have a history of any substance abuse disorders?

☐ Yes ☐ No

If yes, please list drug(s) choice, frequency of use, approximate date of last use.

Does applicant have any current or past history of substance abuse treatment?

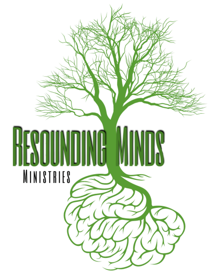
☐ Yes ☐ No

If yes, please list name, address and phone number of all substance abuse program providers.

Is applicant involved in any 12-step or other self-help recovery programs?

☐ Yes ☐ No

If yes, please list programs.



If applicant is substance free, for how long? ______________________________

Does applicant have a history of medical conditions?

☐ Yes ☐ No

If yes, please list conditions. If applicable, please list hospitalizations for these medical conditions.

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits.

______________________________ ______________________________

Signature of Applicant **Date Signed**

Please understand that applying for assistance does not mean that your application is approved. All applications are reviewed and are subject to the RMM approval guidelines.

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