

WORKING TOGETHER FOR CHANGE MINISTRIES, INC.



PRESENTS:

J.H.BOWMAN HOUSE OF HOPE

- **SAFE**
- **SOBER**
- **SUPPORTIVE**

**AFFORDABLE HOUSING FOR WOMEN TRANSITIONING
FROM HOMELESSNESS, JAIL, OR PRISON**

(\$100.00 WEEKLY or \$350.00 MONTHLY (to be paid on the 1st day of the
month) **Non-refundable \$100 to secure space**

**For more information, please call Donna K. Thompson:
405.209.6750 or obscprisonministry@yahoo.com**

HEALTH INFORMATION

Do you have or have you ever had any of the following problems? Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma or Emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Failure (water in the lungs) |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart attack/stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression or psychiatric problem |

Do you have any other medical problems not listed above? Please list:

I am currently taking the following medication (s) to treat the following condition(s):

Medication:

Condition:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:

Do you have health insurance?

Where do you go for medical care?

Do you have a personal physician? Y N

Physician Name:

Phone# ()

Physician Address:

In the next few months, I would like to address the following medical problems/concerns:

Is there anything else we should know about your health

NAME: _____