RESIDENTIAL PROGRAM APPLICATION
Personal Data

Confidential

PERSONAL DATA & INFORMATION:

Name:____
Last First M

Address:____
Street City State Zip Code

Social Security Number:__________________________ Birth Date:________________ Age:______________

Driver's License #: ________________________________ ☐ Valid ☐ Expired ☐ Suspended

If Suspended, Why?____

REFERRED BY:

Name: ____
Last **First**

RACE / ETHNIC BACKGROUND (Please Circle Only One)

☐ Caucasian ☐ Japanese ☐ Haitian
☐ Puerto Rican ☐ Cuban ☐ Filipino
☐ African American ☐ Chinese ☐ Asian
☐ American Indian ☐ Other

Are you an American Citizen: ☐ Yes ☐ No
If you answered No, please explain:_______________________________________
____

For the following questions please **check** the answer that applies:

Are your parents still living? Father: ☐ Yes ☐ No Mother: ☐ Yes ☐ No

Father's Name:____ Age:_______________

Mother's Name:____ Age:_______________

Are you adopted? ☐ Yes ☐ No

Were you raised by anyone other than your parents? ☐ Yes ☐ No

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If yes, please explain:____

____

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated

MILITARY SERVICE

Have you ever served in the U.S. Armed Forces? ☐Yes ☐No Explain:__________

If yes, Branch of Service:______________________________

MARITAL RELATIONSHIP

For the following questions please **check** the answer that applies:

Marital Status: ☐Single ☐ Married ☐Separated ☐Divorced ☐Remarried ☐Widowed

List your present living arrangement:

☐Living Alone ☐With Parents ☐With Spouse ☐With Others (non-relatives)

☐With Others (relatives, children) Other:__________________________

ACADEMIC

List the highest grade that you have completed:______________________________

OCCUPATIONAL

What is your vocational trade or profession, if any?____________________________

How many jobs have you held in the last two years?____________________________

THE PROBLEM

What is your main problem, as you see it?______________________________________

____

____

____

What have you done about it?______________________________________

____

____

____

What are your greatest needs in order of priority?__________________________

____

____

____

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Have you ever been in a treatment program?

Was it religious or non-religious?

In how many programs have you been enrolled?

Reason for Leaving

Have you ever been in a Teen Challenge program before? ☐Yes ☐No

When? Where

Why did you leave the program? (Check one)

☐Dismissed ☐I Chose to leave ☐Completed Program ☐Graduated

☐Other

Why do you wish to be admitted?

What are you expecting (believing) God to do in your life through the program?

Describe what you are willing to do, or what you think is required of you

What would you like to do after you leave Teen Challenge?

The undersigned student applicant fully acknowledges that the information provided herein is accurate and true to the best of his knowledge, and that the application form has been completed and filled out by student applicant in his own handwriting. Student applicant further understands that any false or incomplete information may cause and result in disqualification from admittance into the program, whether a student is just entering into or is in fact in the program.

Name Date

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LEGAL HISTORY

Are you legally mandated to participate in a Teen Challenge type program? ☐Yes ☐No

If yes, by whom? ☐Parole Board ☐ Probation ☐ Court ☐Other Explain: ____________________

____

If answer is Court, please county of origin:____

Are you currently or will you be under legal supervision? ☐Yes ☐No

Method of reporting: ☐Phone ☐Letter ☐In person Explain:_____________________________

How often do you report? ____________ How Long? __________ Time Remaining? __

Probation or Parole Officer's Name: ____

Agency: _____________________________________ Phone Number:__________________________

Address:____

Street City State Zip

Are any of the following pending against you? (please check the box that apply)

☐Arrest Warrant ☐Court Appearance ☐Criminal Charges ☐Sentencing

☐Other:__________________________

If you have checked any of above, please explain:____

____

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List all arrests and convictions:

Date	Charges	Conviction Yes or No	Sentence	Time in Jail	Were alcohol, drugs, or both involved?

Have you ever been in prison? ☐Yes ☐No

DATE	INSTITUTION
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PHYSICAL HEALTH

Please be advised that NETC is **NOT** a medical care facility; therefore, we do not provide clients with medication or onsite access to professional physical or mental healthcare providers.

MEDICAL HISTORY: (Check all that apply to your current past conditions)

☐Asthma ☐Drug Abuse ☐HIV/AIDS

☐Alcohol Abuse ☐Head Trauma/TBI ☐

Respiratory

☐Back Problems ☐Heart Condition ☐Seizures

☐Diabetes ☐Type 1 ☐Type 2 ☐Hepatitis ☐A ☐B ☐C ☐STI/STD

☐High Blood Pressure ☐

Tuberculosis

Do you have any current medical concerns? ☐Yes ☐No

If yes, please be specific:-

____

____

Are you currently being treated by a doctor? ☐Yes ☐No

Adm. Use Only

Name of primary Doctor:________________________________

Address:______________________________________

City:______________________ State:______ Zip:_______________

Phone:________________________ Fax:__________________________

Dates of treatment:_____/_____/_______ to _____/_____/______

Reason for

treatment:____

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Are you allergic to ANY medications (over the counter or prescribed?)

☐ Yes ☐ No

If yes, what

medications?____

____

____

Are you being treated with narcotics? (Applicants on prescribed narcotics will either have to complete the regimen prior to admissions to Teen Challenge or switch to non-narcotic pain medications.) ☐ Yes ☐ No

If yes, what are the

medications?____

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MENTAL HEALTH

Have you ever been treated for mental disorder(s)? ☐Yes ☐No

Have you ever been treated by a psychiatrist/psychologist? ☐Yes ☐No

Mental Health History: (Check all that apply to your current and past conditions)

☐ ADD/ADHD	☐Hallucinations	☐ Physical Abuse
☐ Anorexia	☐ Hearing Voices	☐ Rape
☐ Anxiety Disorder Disorder	☐ Homicidal Thoughts	☐ Schizoaffective
☐ Bipolar Disorder	☐ Insomnia	☐ Schizophrenia
☐ Bulimia	☐ Multiple Personalities	☐Sexual Abuse
☐ Depression	☐ Paranoia	☐Suicide Attempts
☐ Flashbacks	☐ Personality Disorder	☐ Suicide Thoughts

Have you thought about, or attempted suicide in the past 3 months? ☐ Yes ☐ No

If yes, how long ago?_________________________

Name of Primary Psychiatrist/Psychologist:____________________________________

Address:____

City:_______________ State:______ Zip:_________________

Phone:_____________________ Fax:______________________

Dates of treatment: ___/___/___ to ___/___/___

Reason for treatment: _______________________________

Adm. use only

Mental Health Medications Currently Taking:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

**Special dietary accommodations are usually unable to be accommodated.*
Please speak to your admissions rep to discuss your needs.

PERSONAL / FAMILY MEDICAL HISTORY

Please check the appropriate box for any family member that has experienced any of the following problems:

	Grandpa	Father	Mother	Spouse	Brother	Sister	Child
Drug Abuse							
Alcoholism							
Physical Problems							
Mental Health Problems							

When were your teeth last examined?____
Are you currently experiencing problems with your teeth? ☐Yes or ☐No
If yes, please explain:____
____

If you drink coffee, tea or smoke cigarettes, please list the amount you consume each day:

Cigarettes:________________________________ packs smoked per day
Coffee:____________________________________cups consumed per day
Tea:______________________________________cups consumed per day

List how often you used the following drugs **(Never, Once, Several Times, or Regularly)**

Alcohol		Glue	
Barbiturates (downers)		Tobacco	
Amphetamines (uppers)		Marijuana	
Heroin		Crack	
Cocaine		Crank(Methamphetamine)	
Hallucinogenics		Others (specify)	
Opium			

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INSURANCE INFORMATION FOR ANY FUTURE MEDICAL NEEDS

List your health insurance type: (please check the box that applies to you)

☐No health insurance ☐Other private insurance ☐Blue Cross/ Blue Shield

☐Medicaid ☐ Medicare ☐Other public funds_______________________________________

Insurance policy number:____

Company:____ Phone:______________________________

Do you have State insurance? ☐Yes or ☐No

If so, are you receiving food stamps with your State benefits? ☐Yes or ☐No … Amount____________

You receiving cash assisted with your State benefits? ☐Yes or ☐No … Amount___________________

Special Needs:

Do you any type of disability? ☐ Yes ☐ No

Type:______________

Do you have any chronic conditions? ☐ Yes ☐ No

Type:______________

Do you have any medical restrictions? ☐ Yes ☐ No

Type:______________

Do you have any other type of special needs? ☐ Yes ☐ No

Type:______________

Do you have any allergies? ☐ Yes ☐ No

Type:______________

Do you require a special diet?* ☐ Yes ☐ No

Type:______________

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