

Date _____

Name _____ Age _____
Last First Middle

Gender _____ Height _____ Weight _____ Eye Color _____

Social Security # _____ Birth Date _____

Permanent Address : _____
Street Number, Name and Apartment/Lot Number

City _____ State _____ Zip _____

Phone # (____) _____ - _____ Cell Phone (____) _____ - _____

Education:

- 4+ Years of College
- 1-3 Years College
- 1+Yrs of Trade School
- H.S Diploma
- GED
- Dropped out of H.S
- Still Attending H.S
- Current Grade _____

Housing Situation:

- Live with Spouse
- Live with Parents
- Live with Relatives
- Live with Friends
- Incarcerated
- Homeless
- Live Alone
- Other

Marital Status:

- Single
- Married
- Divorced
- Engaged
- Separated
- Widowed
- Other _____

Citizenship:

- United States
- Other _____

Race:

- White
- Black
- Hispanic
- American Indian
- Asian
- Middle Eastern
- Other _____

English Skills:

- I Read English
- I Write English
- I Speak English

Religion:

Denominational Preference:

- Protestant
- Assemblies of God
- Evangelical Free
- Missionary Alliance
- Catholic
- Baptist
- Lutheran
- Non-Denominational
- Other
- Church of God
- Inter-Denominational
- Presbyterian
- Evangelical Covenant
- Methodist
- Other _____

I Need Help With the Following: (Check all that apply):

- Alcohol Addiction
- Anxiety
- Aggression
- Self Mutilation
- Drug Addiction
- Anger
- Abandonment
- Terminal Illness
- Tobacco Addiction
- Depression
- Eating Disorders
- Suicidal Thoughts
- Gambling
- Grief
- Forgiveness
- Death of a Loved One
- Pornography
- Fear
- Emotional Stress
- Family Relationships
- Homosexuality
- Guilt
- Self Esteem
- Parenting

Referred by: _____ Phone Number: _____

Medical Information:

Medical History: (Check all that apply to your current or past conditions)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rape |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> HIV Virus | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Homicidal Tendency | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Homicidal Thoughts | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Bi-Polar | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Multiple Personalities | <input type="checkbox"/> Suicide Contemplate |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Suicide Thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Venereal Disease | |

Substance Abuse: (Check all that you have used)

- | | | | |
|---------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Crack | <input type="checkbox"/> Huffing/Sniffing | <input type="checkbox"/> Mushrooms |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> LSD | <input type="checkbox"/> PCP |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> GHB/MDMA | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Over the Counter Drugs |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Heroin | <input type="checkbox"/> Meth | <input type="checkbox"/> Prescription Drugs |
| | | | <input type="checkbox"/> Other _____ |

What was the date you last used **any** of the above substances? _____

Drug of Choice: _____ Method of Use: Inject Snort Smoke Oral Other

Do you use tobacco? Yes No If yes, check all that apply: Cigarettes/Cigars Chew/Snuff

Treatment History:

- | | | |
|---|--|----------------------------|
| Have you ever been in a residential treatment facility? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How many? _____ |
| Have you ever been treated for mental disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you ever been treated sleep disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Has a psychiatrist ever treated you? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Last Visit: ____/____/____ |
| Has a psychologist ever treated you? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Last Visit: ____/____/____ |

Medications:

List all current medications: _____

ALL MEDICATIONS MUST BE IN A LABELED PRESCRIPTION BOTTLE AT THE TIME OF ENTRANCE. IF YOUR DOCTOR GIVES YOU SAMPLES, ASK YOUR PHARMASIST IF THEY WILL ASSIST YOU IN THIS MATTER.

Medical Information Continued:

List any additional medications you have taken in the past 2 year's _____

Special Needs:

Do you have any type of disability? Yes No Type: _____

Do you require a special diet? Yes No Type: _____

Do you have any medical restrictions? Yes No Type: _____

Do you have any allergies? Yes No Type: _____

Do you have any chronic conditions? Yes No Type: _____

Do you have any other type of special needs? Yes No Type: _____

If you have any medical restrictions or disabilities, you must supply us with documentation from your physician at the time of entrance into the program. We reserve the right to require this documentation prior to acceptance.

Primary Emergency Contact:

Secondary Emergency Contact:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Email: _____

Email: _____

Insurance Provider:

ID Number: _____

Name: _____

City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

Primary Doctor Information:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment: _____/_____/_____ to _____/_____/_____

Name of Psychiatrist/Psychologist: _____

City: _____ State: _____

Phone: _____ Fax: _____

Dates of Treatment: ___/___/___ to ___/___/___

Reason for Treatment: _____

Prior Treatment Facilities:

Name of Facility: _____

City: _____ State: _____

Phone: _____ Fax: _____

Dates of Treatment: ___/___/___ to ___/___/___

Reason for Treatment: _____

Have you previously been in a Teen Challenge Program? Yes No

If yes, where? _____ When? _____

Did you complete the program? Yes No If not, why? _____

Employment History: Please list your last 5 places of employment:

Employer	Duties	Dates Employed	Reason for Leaving

Legal Information:

Current Legal Status:

- Are you currently on probation? Yes No Type: _____
- Are you currently on parole? Yes No Type: _____
- Do you currently have any court cases pending? Yes No Type: _____
- Are you currently under investigation for anything? Yes No Type: _____
- Do you currently have any outstanding warrants? Yes No Type: _____
- Are you currently involved in any type of lawsuit? Yes No Type: _____
- Do you currently have any unpaid fines? Yes No Amt: _____
- Are you currently required to pay any restitution? Yes No Amt: _____
- Are you currently ordered to do any community service? Yes No Hours: _____
- Are you currently required to pay child support? Yes No Amt: _____
- Are you currently behind in child support payments? Yes No Amt: _____
- Do you receive any Social Security Income? Yes No Amt: _____
- Do you receive any Disability Income? Yes No Amt: _____
- Do you receive any Unemployment Income? Yes No Amt: _____
- Do you receive any retirement income benefits? Yes No Amt: _____
- Do you have any other source of income? Yes No Type: _____

Past Legal Status:

- Have you ever been arrested? Yes No # of times: _____
- Have you ever been in a juvenile detention center? Yes No Age: _____
- Have you ever been sentenced to jail? Yes No Reason: _____
- Have you ever been in prison? Yes No Reason: _____
- Have you ever been on probation? Yes No Reason: _____

Criminal Activity: (Check all that you have been involved with)

- | | | |
|--|---|---|
| <input type="checkbox"/> Aiding & Abetting | <input type="checkbox"/> Driving without a License | <input type="checkbox"/> Probation Violation |
| <input type="checkbox"/> Armed Robbery | <input type="checkbox"/> Drug Manufacturing | <input type="checkbox"/> Prostitution |
| <input type="checkbox"/> Arson | <input type="checkbox"/> Drug Possession | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Assault | <input type="checkbox"/> DUI | <input type="checkbox"/> Restraining Order |
| <input type="checkbox"/> Attempted Assault | <input type="checkbox"/> DWI | <input type="checkbox"/> Robbery |
| <input type="checkbox"/> Attempted Burglary | <input type="checkbox"/> Embezzlement | <input type="checkbox"/> Sex with a Minor |
| <input type="checkbox"/> Attempted Rape | <input type="checkbox"/> Escape from Custody | <input type="checkbox"/> Shoplifting |
| <input type="checkbox"/> Attempted Robbery | <input type="checkbox"/> Felony Conviction | <input type="checkbox"/> Solicitation of Prostitution |
| <input type="checkbox"/> Attempted Murder | <input type="checkbox"/> Fleeing or Eluding Police | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Attempted Theft | <input type="checkbox"/> Fraud | <input type="checkbox"/> Terroristic Threats |
| <input type="checkbox"/> Battery | <input type="checkbox"/> Harassment | <input type="checkbox"/> Theft |
| <input type="checkbox"/> Burglary | <input type="checkbox"/> Incest | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Car Jacking | <input type="checkbox"/> Kidnapping | <input type="checkbox"/> Underage Drinking |
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Larceny | <input type="checkbox"/> Use of Firearm in a crime |
| <input type="checkbox"/> Child Molestation | <input type="checkbox"/> Leaving Scene of Accident | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Child Endangerment | <input type="checkbox"/> Manslaughter | <input type="checkbox"/> Vehicular Homicide |
| <input type="checkbox"/> Child Pornography | <input type="checkbox"/> Murder | <input type="checkbox"/> Violation of No Contact Order |
| <input type="checkbox"/> Concealed Weapon | <input type="checkbox"/> No Contact Order | <input type="checkbox"/> Violation of Order of Protection |
| <input type="checkbox"/> Criminal Sexual Conduct | <input type="checkbox"/> Order of Protection | <input type="checkbox"/> Violation of Restraining Order |
| <input type="checkbox"/> Disorderly Conduct | <input type="checkbox"/> Parole Violation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Possession of Stolen
Property | <input type="checkbox"/> Other: _____ |

Parole/Probation Officer Information:

Name: _____

Address: _____

City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Do you have any court dates pending? _____ If yes, give dates _____

What are the charges? _____

Name of Defense Attorney: _____

Name of Prosecuting Attorney: _____

Teen Challenge is not to be a part of your sentencing or a condition of your court order without prior approval from the Intake Director. If you enter the program while on probation or parole, we must receive approval from your probation/parole officer.

Spiritual Information:

Occult Activity: (Please check all that you have been involved with)

- Animal Sacrifices Fortune Tellers Psychics Witchcraft
 Astrology Ouija Boards Satan Worship Voodoo
 Black Magic Palm Reading Seances Other_____

Church Activity:

- How often do you attend church? Often Occasionally Seldom Never
How often do you read the Bible? Often Occasionally Seldom Never
How often do you pray? Often Occasionally Seldom Never

- Have you ever accepted Jesus Christ as your personal Lord and Savior? Yes No Date: _____
Have you been baptized in water? Yes No Date: _____
Have you ever experience being filled with the Holy Spirit? Yes No Date: _____

If you attend church, please provide as much of the following information as possible:

Name of Pastor: _____

Name of the Church: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

List any church activities you have participated in: _____

What do you believe about God? _____

What do you believe about life after death? _____

What is sin? _____

What purpose does the Bible and prayer have in your life? _____

What are some characteristics in your life that you would like to change?

In your own words, what do you think we can do to help you with your problems?

What words best describe how you feel about yourself? _____

What are your goals in life? _____

Describe your relationship with your family members: _____

What else would you like us to know about you? _____

Family Information: Please provide complete information

Spouse:

Name: _____ Age: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Date Married: _____

Is she supportive of your being here? _____

Children:

Name: _____ Gender _____ Age _____ Living with _____

Name: _____ Gender _____ Age _____ Living with _____

Name: _____ Gender _____ Age _____ Living with _____

Name: _____ Gender _____ Age _____ Living with _____

Mother's Information:

Name: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Father's Information

Name: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Correspondence:

Please list the names and addresses of people you expect to correspond with while in the program. All mail is read/censored by staff.

Name: _____ Relationship: _____

Address: _____
Street Number/Name City State Zip

Phone: _____

Name: _____ Relationship: _____

Address: _____
Street Number/Name City State Zip

Phone: _____

Name: _____ Relationship: _____

Address: _____
Street Number/Name City State Zip

Phone: _____

Name: _____ Relationship: _____

Address: _____
Street Number/Name City State Zip

Phone: _____

Name: _____ Relationship: _____

Address: _____
Street Number/Name City State Zip

Phone: _____

Please list additional family/friends on a separate page.

Admission Agreement:

1. Teen Challenge of Arkansas is a residential Christian discipleship program. It consists of at least 14 months of instruction. At least 4 of those months will be in Hot Springs, AR and at least 10 months in Cape Girardeau, MO. Applicants must commit to complete the entire program in order to be approved for admission.
2. Possession and/or use of drugs, alcohol and tobacco are prohibited while enrolled in our program. Students may be given drug and/or alcohol tests at any time without prior notice. Students who test positive for drug and/or alcohol use while in our program will face disciplinary action and possible expulsion from the program.
3. Students may not lend, buy or sell personal property to or from other students. Teen Challenge will not be responsible for any personal property that becomes lost, stolen or damaged while on our premises.
4. Students, their rooms, and their personal property may be searched at any time without prior notice.
5. Students do hereby declare that any authorized staff member of Teen Challenge of Arkansas may open any incoming or outgoing mail.
6. Students taking prescription medication must come in with at least a 30 day supply. Documentation of the diagnosis for the medication must be brought at the time of admission.
7. I will not hold Teen Challenge responsible for any action taken, concerning myself, while I am participating in the program. I will not file any legal charges or take any legal action, at any time, against Teen Challenge of Arkansas, or any authorized staff member. I release Teen Challenge of Arkansas from all financial and legal responsibilities in case of accident, injury, illness or other misfortune.
8. If I leave voluntarily or if I am dismissed prior to completion of the program, I will forfeit any and all money in my student account.
9. Upon leaving Teen Challenge of Arkansas, I will take my personal belongings with me. I will not expect Teen Challenge to be responsible for my possessions or to forward them to me.
10. If I fail to complete the Teen Challenge program, I will not contact students in the program, their families, or any person I have met as a result of my participation in the program. If I fail to complete the Teen Challenge program, I agree to leave Garland County, Arkansas and not return for at least a 12 month period.
11. Because of the high risk group, I understand that I may be housed with someone who is HIV positive. For this reason, I will practice good daily hygiene.
12. I understand that Teen Challenge of Arkansas will correspond with my family members and friends listed on previous page in regards to fundraising opportunities.

Applicant's Signature: _____

Date: _____

Admission Requirements:

- A. No applicant will be admitted without picture identification, social security card and a completed application.
- B. Applicants requiring detoxification must do so prior to entry.
- C. Applicants must be in good health, free of any infections at the time of entry.
- D. Medical documentation of any disabilities or medical conditions requiring medication is required to accompany application.
- E. Upon entry applicants will be tested for the HIV Virus, Tuberculosis, Venereal Disease and Hepatitis.
- F. Applicants who are entering the program as part of their probation, parole or in lieu of sentencing must supply us with a court order stating that you must complete the entire program.
- G. Upon entry applicants will be required to pay an induction fee of \$650.00.
- H. If applicant is receiving a monthly income from disability, Social Security, retirement or unemployment, they will be required to contribute 35% of that income monthly to the program.
- I. Applicants are required to have read and become familiar with the following (initial each one):
 - 1. Student Guidelines _____
 - 2. Medical Polices _____
 - 3. Student Discipline Policies _____
 - 4. Student Grievance Procedure _____

By my initial, I acknowledge that I have reviewed each segment of the Induction Packet.

Applicant's Signature _____ Date: _____