

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Gender at Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Permanent Address: \_\_\_\_\_  
Street Number, Name and Apartment/Lot Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Education:**

- Bachelor's Degree
- Associate's Degree
- 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:**

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Protestant | <input type="checkbox"/> Assemblies of God    | <input type="checkbox"/> Evangelical Free     | <input type="checkbox"/> Missionary Alliance |
| <input type="checkbox"/> Catholic   | <input type="checkbox"/> Baptist              | <input type="checkbox"/> Lutheran             | <input type="checkbox"/> Non-Denominational  |
| <input type="checkbox"/> Other      | <input type="checkbox"/> Church of God        | <input type="checkbox"/> Inter-Denominational | <input type="checkbox"/> Presbyterian        |
|                                     | <input type="checkbox"/> Evangelical Covenant | <input type="checkbox"/> Methodist            | <input type="checkbox"/> Other _____         |

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

- |  |                                     |   |   |
|--|-------------------------------------|---|---|
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Aggression       | <input type="checkbox"/> Self Mutilation      |
| <input type="checkbox"/> Drug Addiction    | <input type="checkbox"/> Anger      | <input type="checkbox"/> Abandonment      | <input type="checkbox"/> Terminal Illness     |
| <input type="checkbox"/> Tobacco Addiction | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Suicidal Thoughts    |
| <input type="checkbox"/> Gambling          | <input type="checkbox"/> Grief      | <input type="checkbox"/> Forgiveness      | <input type="checkbox"/> Death of a Loved One |
| <input type="checkbox"/> Pornography       | <input type="checkbox"/> Fear       | <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Family Relationships |
| <input type="checkbox"/> Homosexuality     | <input type="checkbox"/> Guilt      | <input type="checkbox"/> Self Esteem      | <input type="checkbox"/> 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: \_\_\_\_\_

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**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<br>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?

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

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What words best describe how you feel about yourself? \_\_\_\_\_

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What are your goals in life? \_\_\_\_\_

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Describe your relationship with your family members: \_\_\_\_\_

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What else would you like us to know about you? \_\_\_\_\_

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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. A letter from your doctor stating he/she will continue to supply you with prescriptions while in the program is required prior to entrance. 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 pages 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 approved to enter the program as part of their probation, parole or in lieu of sentencing must supply us with documentation from said entities stating their approval and notification requirements. If the program is a condition of probation or in lieu of sentencing, documentation must state you are required to 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 Policies \_\_\_\_\_
  - 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: \_\_\_\_\_