Formal Application

Applicant Information **Date of Application:** _____________

Child's First Name: _______________ Middle Name:__________ Last Name: __________________

DOB: _______________________ Age: ____________

Address: ____ City: ___________________________

State: _______________ Zip: _____________

Height: ______ Weight: _______ Race/Ethnicity: ________________ Religion: _______________

Biological or Adopted (Circle One) If adopted, date adoption was final: ___________________

If adopted, are biological parents involved? ____

Any issues related to the adoption? ____

____

Whom does the child live with? ____

If divorced, please provide a copy of the custody agreement.

Parent Information

Father's Name: ______________________________ DOB: ___________ Age: _____________

Address: _________________________ City: _________________ State: _____ Zip: __________

Phone: _______________________________ Alternate Phone: ______________________________

Email: _______________________________ Occupation: _________________________________

Religion: ______________________________

Was the father present during childhood? ___________ Please explain: ___________________

____

Mother's Name: ______________________________ DOB: ______________ Age: ________

Address: ________________________ City: __________________ State: _____ Zip: __________

Phone: _______________________________ Alternate Phone: ______________________________

Email: _______________________________ Occupation: _________________________________

Religion: ______________________________

Was the mother present during childhood? ___________ Please explain: __________________

____

Parent's Current Marital Status (married, divorced, separated, remarried, cohabitating, etc.)

Non-Custodial Parent Information (If Applicable)

Name: ________________________________ Relationship: ___________ Age: ________

Address: _______________________ City: _______________ State: _____ Zip: __________

Phone: _________________________ Alternate Phone: ___________________________

Occupation: ___________________________ Religion: ___________________________

Please explain the youth's relationship with this person: _______________________________

____

____

____

____

Please list all **people living in the household** where the youth resides:

Name	Age	Gender	Relationship to Youth

Please list **biological/adopted children** not living in the same household as the youth:

Name	Age	Gender	Relationship to Youth

Family Relationships

Please indicate childhood family experience (circle each that apply)

Outstanding Normal Chaotic Witnessed Abuse Experienced Abuse

Please explain: ____

____

____

____

How is discipline handled in the home?

____

____

What methods do you or other parents use?

____

____

Describe the relationship with the father/step-father:

____

____

Describe the relationship with the mother/step-mother:

____

____

Describe the relationship with the siblings:

____

____

Contact and Visit Information

Who is permitted to send/receive mail from your son? **Please provide addresses**.

Who is permitted to have phone contact with youth son?

Who is permitted to have on-campus visits with your son?

Who is permitted to have off-campus visits with your son?

Developmental History

Issues during pregnancy- Please check all that apply:

____None	____High Blood Pressure	____ Kidney Infection
____Emotional Stress	____Bleeding	____Alcohol Use
____Drug Use	____Cigarette Use	____Other________________

Were there any complications with birth? _______ Please explain: ________________________

Please circle if there were problems in infancy with: Feeding Sleep Toilet Training

Please indicate the age at which your son had the following, if any:

____Chickenpox	____Lead Poisoning	____Mumps
____Measles	____Diphtheria	____Rheumatic Fever
____Poliomyelitis	____Whooping Cough	____Pneumonia
____Tuberculosis	____Autism	____Asthma

Please indicate any delayed developmental milestones:

____Sitting	____Rolling Over	____Standing
____Walking	____Feeding Self	____Speaking
____Controlling Bladder	____Controlling Bowels	____Sleeping Alone
____Dressing Self	____Engaging Peers	____Tolerating Separation
____Playing Cooperatively	____Bicycle Riding	____Other________________

Please explain any current legal involvement:

Please Explain Any and All Presenting Problems

- The nature of the presenting problem (s)
- The duration and severity of the problem (s)
- Attempts you have made to address the behaviors (include your actions and other professional services)
- The impact these behaviors are having on your family

Medical Information

Please circle the youth's current physical health level: Good Fair Poor

Please explain: ____

Physician Name: __________________________________ Phone: ___________________

Address: ____

Psychiatrist Name: ________________________________ Phone: _________________

Address: ____

Date of Last Physical Exam: ___________ Date of last Psychiatric Appointment: _________

List any past/present medical problems: ____

____

What treatment is being rendered at this time? __________________________________

____

Please list all current medications the youth is taking, including OTC medications, vitamins, etc.

Name	Date Started	Dosage	Frequency	Reason Taking

Any medication brought to Salem must be in correctly labeled pharmacy containers. Our nurse will be in charge of storage/dispensing medications. All refills need to be called into Flanagan Pharmacy for the duration of treatment.

Does your son have a history of refusing or hiding medication? _________________________

Has your son ever had an allergic or negative reaction to any medication? _______________

If yes, please list the medication and reaction: ____________________________________

____

Does your son wear glasses? _______ Contacts? ___________ Braces/Retainer? ___________

Does he have any problems with speech/hearing? ________________ If yes, please explain.____

____

List any other medical conditions and details concerning your son's medical history:

____

____

Has he ever had an infection that did not respond to antibiotics? ________ If yes, please explain:

____

Does your son have issues with bones, joints, or muscles? _______ Please explain: ___________

____

Does your child have any allergies? If so, please indicate what he is allergic to and his reaction.
(Examples- foods, bee stings, bug bites, penicillin, dust/mold, animals, medications, hives, hay fever, eczema, etc.)

____

____

____

Name of Dentist
Office:_____________________________________Phone:_____________________________

When was your child's last dental exam? _____________ By Dr._________________________

How would you rate your child's nutritional intake? Good Average Poor

How would you rate your son's junk food intake? Good Average Poor

Comments: ____

Does your child have any special dietary restrictions or food allergies? ____________________
If so, please describe:

____

____

Please describe any medical, allergy, nutritional, or dental information that has not been covered.

____

____

Is there a history of any of the following in the family?

____Tuberculosis	____Heart Disease	____Birth Defects
____High Blood Pressure	____Emotional Problems	____Alcoholism
____Behavior Problems	____Drug Use	____Thyroid Problems
____Diabetes	____Cancer	____Alzheimer/Dementia
____Mental Retardation	____Stroke	____Other

Mental Health

Does the child have a history of mental health issues? ____ If yes, please list past diagnoses:

____

____

Is the child currently taking medication for mental health conditions (anti-depressant, ADHD, etc.)? ________ If so, please list medications and dosages: _____________________________

____

Has the youth had prior outpatient psychotherapy? __________If yes, on ______ occasions.

Longest treatment by___________________________________ for ________sessions,
(Provider)

From ________________ to ________________. Please list additional therapy providers below.
(Month/Year) (Month/Year)

Provider	City/State	Diagnosis	Reason	Beneficial?

Has any family member received outpatient psychotherapy? ______________________________

If so, please list who and why: ____

____

Has the youth had prior inpatient psychotherapy? _____________ If yes, on ______ occasions.

Longest treatment by____________________________________ for ________days,
(Provider)

From _______________ to _______________. Please list additional inpatient admissions below.
(Month/Year) (Month/Year)

Provider	City/State	Diagnosis	Reason	Length of Stay

Has your child ever run away from home or a treatment center? ______ If so, when? _________

Please explain where he ran, how many times, and how long he was gone: __________________

____

Has your son ever attempted suicide? _______ If so, when? __________ If so, please explain:

____

Has your son ever engaged in self-injurious behavior such as cutting or burning?_____________

If so, please explain:

____

____

Educational History

Name of current school: ____ Grade: __________

Address: ____

Phone:____________________________________Fax:______________________________

Does your son have an IEP? __________ Year written:__________ Special Ed:_____________

If yes, attach any assessment information with this application. Submission of an IEP documentation is necessary for acceptance to Salem4Youth and must be submitted with this application.

Academic Performance (circle one) Above Average Average Below Average Poor

How was your son's attendance? (circle one) Good Fair Poor If poor, please explain:

____

Please list any suspensions or expulsions, including how long and for what behavior:

____

Please list any alternative school your son has attended: _______________________________

Describe any difficulties your son has in school (behavior, relationships, tardy, skipping, etc.):

____

What are his favorite subjects? ____

What are his least favorite subjects? ____

Has he repeated any grade? ________ If so, which grades?_____________________________

Describe your educational goals for your child: ______________________________________

____

____

____

____

Spirituality

Do you and your family identify with a particular faith, church, or religion? _________________

If so, what faith/religion? ____

Please briefly describe the impact of faith on your home life:

____

____

____

Does your son share your beliefs? ________________ If no, please explain: ________________

____

Does your family regularly attend services? ____

If so, what is the name of the church? ______________________________________

Address: ____

Pastor/Religious Leader: _________________________________Phone:__________________

Is there any other information regarding spirituality that you feel we should know? ___________

Are the child's parents/guardians willing for the child to participate in a therapy program that is based upon a Biblical worldview? _____________________________________

Are the child's parents/guardians willing to participate in Salem's parent counseling program?

____

Behavior Concerns

Please circle all that apply:

Difficulty Concentrating	Destroy Property	Suicidal Thoughts
Easily Agitated	Poor Memory	Inability to Handle Stress
Anxiety/Easily Stressed	Anorexic/Bulimic	Irritability
Insomnia	Depression	Short Attention Span
Violent	Easily Angered	Withdrawn
Nightmares	Paranoia	Cruelty to Animals
Suspicious	Fearful	Easily Exhausted
Impulsive	Food Binges	Steals Food
Doesn't Complete Tasks	Mood Swings	Mental Confusion
Apathetic	Walks in Sleep	Does Things for Attention
Plays with Fire	Bedwetting	Poor Appetite
Fakes Illnesses	Panic Attacks	Obsessive Compulsive
Skips Meals	Sluggishness	Gang Involvement
Controlling	Shy/Timid	Dislikes Being Touched
Destructive	Nail Bites	Stutters
Traumatic Events	Social issues	Boundary Issues
Physical to Others	Verbal Assault	Manipulates Others
Cutting or Self-mutilation	Inappropriate Sexual Behavior	Steals
Hyperactive		

Has your son been a victim of past/present abuse (sexual, physical, or emotional)? ___________

If so, please explain: ____

____

Has your son ever been abusive to another person? ___________ If so, please explain:________

____

Does your son have any trauma history (abuse, divorce, legal, bullying, etc.)?________________

If so, please explain: ____

____

Has your son been sexually active? _______ Has he been tested for STDs? _________________

Substance Abuse History

Please list any family members who have had substance abuse issues, as well as what substances:

Name | Current Use? | Substance(s)

____

____

Does your child have a history of alcohol, tobacco, and/or drug use? ________________

If so, please indicate which substances, age of use, frequency, and if he is currently using:

Alcohol	Age:_____________	Frequency__________	Current? ________
Amphetamines	Age:_____________	Frequency__________	Current? ________
Barbiturates	Age:_____________	Frequency__________	Current? ________
Cocaine	Age:_____________	Frequency__________	Current? ________
Hallucinogens	Age:_____________	Frequency__________	Current? ________
Inhalants	Age:_____________	Frequency__________	Current?_________
Marijuana	Age:_____________	Frequency__________	Current? ________
Opioids	Age:_____________	Frequency__________	Current?_________
Prescription	Age:_____________	Frequency__________	Current? ________
Other_____________	Age:_____________	Frequency__________	Current? ________

Has your son ever participated in substance abuse treatment? ________ If so, please describe:

Outpatient? ____

Inpatient? ____

Other: ____

____

____

____

Strengths & Weaknesses

Please describe your child's personality, special interests, likes, and dislikes: ________________

____

____

Please list your son's strengths and talents: ____

____

Please list your son's weaknesses: ____

____

Please list family strengths: ____

____

Please list family weaknesses: ____

____

Additional Information

Does your son feel that he has problems that would require this placement? _________________

Please describe your son's goals for the future: ____

____

Does your son have any special room, board, or additional needs we should know about? ______

____

Please list any distinguishing features he has (tattoos, birth marks, scars, etc.):_______________

____

Please share your immediate and long-term goals for your son in regards to placement at Salem:

____

____

Emergency Contact Information

Pleas list two contacts we may call if there is an emergency and we are unable to contact you:

Name: ______________________________ Relationship: ____________________

Home phone: __________________________ Cell Phone: _____________________

Name: ______________________________ Relationship: ____________________

Home phone: __________________________ Cell Phone: _____________________

Referral Information

Please tell us how you heard about Salem4Youth:________________________________

____

Person completing this application: ____

Relationship to the youth: ____

I agree that the information in this application packet is true and accurate.

Signature: _____________________________________ Date: _______________

Signature: _____________________________________ Date: _______________

Please email or fax

Email: sbenge@salem4youth.com

Fax: (815) 796-4565