

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:

Developmental History

Issues during pregnancy- Please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Cigarette Use | <input type="checkbox"/> 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Autism | <input type="checkbox"/> Asthma |

Please indicate any delayed developmental milestones:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Rolling Over | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Feeding Self | <input type="checkbox"/> Speaking |
| <input type="checkbox"/> Controlling Bladder | <input type="checkbox"/> Controlling Bowels | <input type="checkbox"/> Sleeping Alone |
| <input type="checkbox"/> Dressing Self | <input type="checkbox"/> Engaging Peers | <input type="checkbox"/> Tolerating Separation |
| <input type="checkbox"/> Playing Cooperatively | <input type="checkbox"/> Bicycle Riding | <input type="checkbox"/> Other _____ |

Please explain any current legal involvement:

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: _____ Email: _____

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	Steals
Hyperactive	Behavior	

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: _____

When finished please email to:

sbenge@salem4youth.com