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 ☐ (Check 1) 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☐

Other☐ explain:_____

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 (Check 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 check if there were problems in infancy with: Feeding ☐ Sleep ☐ Toilet Training ☐

Please indicate the age at which your son was diagnosed with 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 check 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☐

Food habit 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? (Check all that apply)

☐ 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 _____.
(Month/Year) (Month/Year)

Please list additional therapy providers on the following page

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,

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 (Check one) Above Average☐ Average☐ Below Average☐ Poor☐

How was your son's attendance? (Check one) Good☐ Fair☐ Poo☐ 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 check all that apply:

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- ☐ Withdrawn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

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:

advisementcouncil@salem4youth.com