

**EAGLE RANCH  
ACADEMY, INC.**

*Application / Student  
Intake Assessment*

2005



<b>APPLICANT HISTORY</b>					
Student's Name			Age	Today's Date	
Gender	Date of Birth		Grade in School		
Address					
City			State / Zip		
Phone (Home)			(Work)		
Place of Birth			Social Security No.		
Height	Weight	Hair Color	Shirt Size	Pant Size	Shoe Size
Who has Legal Custody of the Student?					
Who has Physical Custody of the Student?					

<b>PARENT INFORMATION</b>			
Who does the Student live with at this time?			
Are Parent's Divorced or Separated?	If Yes at What Age was Student?		Parent's ever Married?
Is there any significant information about the Parent's relationship toward the Student which will be beneficial in counseling? If Yes, please describe.			
Biological Mother's Name	Age	Occupation	Home Phone
Where Employed		Social Security No.	
Home Address		City, State, Zip	
Work Phone	Cell	Email	
Date of Birth	Education	Is Student living with Biological Mother?	
Is there anything notable, unusual or stressful about Student's relationship to Biological Mother? Explain			

**PARENT INFORMATION Continued**

Biological Father's Name	Age	Occupation	Home Phone
Where Employed		Social Security No.	
Home Address		City, State, Zip	
Work Phone	Cell	Email	
Date of Birth	Education	Is Student living with Biological Father?	
Is there anything notable, unusual or stressful about Student's relationship to Biological Father? Explain			

Step Mother's Name	Age	Occupation	Home Phone
Where Employed		Social Security No.	
Home Address		City, State, Zip	
Work Phone	Cell	Email	
Date of Birth	Education	Is Student living with Step Mother?	
Is there anything notable, unusual or stressful about Student's relationship to Step Mother? Explain			

Step Father's Name	Age	Occupation	Home Phone
Where Employed		Social Security No.	
Home Address		City, State, Zip	
Work Phone	Cell	Email	
Date of Birth	Education	Is Student living with Step Father?	
Is there anything notable, unusual or stressful about Student's relationship to Step Father? Explain			

## LEGAL GUARDIAN INFORMATION

If Guardian has Custody What is the Relationship to Student?			Permanent or Temporary?	
If Temporary How Long is it Ordered?		How Long Has Guardianship been Enforced?		
Guardian's Name		Age	Occupation	
			Home Phone	
Where Employed		Social Security No.		
Home Address			City, State, Zip	
Work Phone		Cell		Email
Date of Birth	Education		Is Student living with Guardian?	
Is there anything notable, unusual or stressful about Student's relationship to Guardian? Explain				

<p>Chief Behavior Complaint of Student:</p>          
<p>Presenting Problems:</p>          

**SIBLINGS/OTHERS WHO LIVE IN THE HOUSEHOLD**

Name of Siblings/Others	Age	Gender		Live @		Relationship with Student			
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great
		M	F	Home	Away	Poor	Average	Good	Great

Comments:

**INSURANCE INFORMATION**

Insurance Company Name			
Insurance Company Address			
City	State	Zip	Phone
Policy Holder Name		Policy Holder Social Security No.	
Policy No.	Group No.		ID No.
Employer Name		Employer Phone #	
Employee Address		City, State, Zip	
Additional Insurance - Name and Address			

## MEDICAL AND PHYSICAL HEALTH INFORMATION

A basic appraisal of your Student's over all health is imperative. Please complete every question on this form so that we may know of any health conditions or medication requirements during your Student's stay in our program. All medications must be documented on this list, and in a prescription bottle, or they will be considered contraband and confiscated.

Has your Student Experienced	Yes	No	Present Condition or Medication Dose
Ear Pain or any Problems with Hearing			
Eye Discomfort or Other Difficulties			
Frequency or Migraine Headaches			
Dizziness or Fainting Spells			
Hay Fever or Nasal Problems			
Hives or Skin Allergies			
Skin Sores or Rashes			
Warts or Sores on Their Feet			
Lump, Mole, or Swelling			
Chest Pain or Shortness of Breath			
Sweating at Night			
Spitting or Coughing up Blood			
Urinary Burning, Frequent or Dark Urination			
Stomach Aches, Burring, or Indigestion			
Difficult Starting Urination or Dribbling			
Difficulty Walking, Running, Lifting Things			
Pain in Back, Neck, Joints			
Excessive with Weight Gain			
Unexplained Weight Loss			
A Rupture or Hernia			
Diarrhea or Unusual Bowel Movements			
Any Injury or Illness not Already Noted			
High Blood Pressure			
Excess Bleeding			
Venereal Disease			
Tumor, Growth, Cyst, or Cancer			
A Knee or Ankle Injury			
Arthritis or Swollen or Painful Joints			
Does Your Student Currently Wear Glasses			

<b>Has your Student Experienced</b>	<b>Yes</b>	<b>No</b>	<b>Present Condition or Medication Dose</b>
Nervous Breakdowns			
Appendicitis			
Frequent Colds			
Rheumatism			
Kidney Disorders			
Chronic Ear Infections			
Pneumonia			
Scarlet Fever			
Long Measures or 3 Day Measles			
Typhoid			
Chicken Pox			
Polio			
Chronic Tranquilizer User			
Hypoglycemia			
Obesity			
Renal Disease			
Anemia			
Mumps			
Rheumatic Fever			
Birthmarks			
Seizures, Convulsions, or Epilepsy			
Ulcers			
Asthma or Wheezing			
Back Injury or Deformity			
Heart Trouble Disease			
Diabetes or Sugar in the Urine			
Golfer or Thyroid Problems			
<b>FEMALES ONLY</b>			
Vaginal Discharge			
Pregnancy			
Painful Menstruation			
Spotting Between Periods			
Flowing Longer than 8 Days			

<b>MEDICAL EXAMINATION HISTORY</b>			
<b>Exam</b>	<b>Date</b>	<b>Exam</b>	<b>Date</b>
Physical Exam		Hearing Exam	
Eye Exam		Blood Type	
Dental Exam		Other	

<b>IMMUNIZATIONS</b>			
<b>Immunizations</b>	<b>Dates</b>		
Diphtheria, Tetanus and Pertussis (DTP)			
Diphtheria, Tetanus (DT)			
Tetanus Toxoid			
Measles, Mumps, and Rubella (MMR)			

<b>HAS YOUR STUDENT EVER HAD ANY OF THE FOLLOWING</b>					
<input type="checkbox"/>	Abortion	<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Pleurisy
<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Congenital Problems	<input type="checkbox"/>	Lead Poisoning	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Croup	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Severe Colds
<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Std
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Thyroid Disorders
<input type="checkbox"/>	Ear Aches	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	Wearing Glasses
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	

**CHECK THE FOLLOWING BEHAVIORS OR SKILLS THAT DESCRIBE POSITIVE CHARACTERISTICS OF YOUR STUDENT**

Accepts Praise	Writing	Hobbies/crafts	Organized
Assertive	Safety Skills	Insightful	Grooming/hygiene
Cooperative	Survival Skills	Motivated	Honesty
Dependable	Affectionate	Respects Others	Listening Skills
Friendly	Cleanliness (Household)	Sense of Humor	Polite
Helpful	Courteous	Verbal Expression	Responsible
Independent	Emotional	Apologizes	Shares
Money Management	Gregarious	Community Skills	Works Hard
Reading	Leader	Musical	Athletic

Comments on any of the above:

**CHECK THE FOLLOWING THAT ARE TYPICAL FOR YOUR STUDENT**

Affectionate	Head Banging	Shares	Excessive Masturbation
Aggressive	Hopelessness	Sick Often	Expects Failure
Alcohol	Hurts Animals	Short Attention Span	Fatigue
Angry	Imaginary Friends	Shy, Timid	Psychiatric Problems
Anxiety	Impulsive	Sleeping Problems	Moody
Attachment to Dolls	Irritable	Slow Moving	Nightmares
Avoids Adults	Lazy	Soiling	Obedient
Bed-wetting	Learning Problems	Speech Problems	Often Sick
Bizarre Behavior	Lies Frequently	Steals	Over Weight
Bullies, Threatens	Listen to Reason	Stomach Aches	Panic Attacks
Clumsy	Loner	Suicidal Threats	Phobias
Confident	Low Self-Esteem	Suicidal Attempts	Poor Appetite
Cooperative	Messy	Depression	Frequent Injuries
Cyber Addiction	Sad	Destructive	Disrespectful
Defiant	Selfish	Difficulty Speaking	Thumb Sucking
Frustrated Easily	Separation Anxiety	Dizziness	Unsafe Thinking
Gambling	Sets Fires	Drugs Dependence	Weight Loss
Generous	Sexual Addiction	Eating Disorder	Withdrawn
Hallucinations	Sexual Acting Out	Enthusiastic	Worries Excessively

**WHICH OF THE FOLLOWING NORMAL EMOTIONS OR RESPONSES DO YOU RECOGNIZE AS SOMETIMES TAKING PLACE WITH THE STUDENT**

Anger	Anxiety	Loneliness	Grief
Depression	Embarrassment	Boredom	Stress
Fear	Frustration	Envy	Happiness

List any concern you have regarding any of the above emotions or responses:

Briefly describe aggressive acts to people or property:

Describe any inappropriate sexual behavior (if known):

Describe any inappropriate social behavior (if known):

Describe any past events that may be difficult for Student to handle at this time (e.g. abuse, injuries):

Describe any past events that were particularly encouraging or led to positive life changes for the Student:

**I. Social History:**

A. Work/School Productivity:

Job: Yes No Where \_\_\_\_\_

Type of School Attended: Private Public Special/Alternative

Current School: Grade \_\_\_\_\_ GPA \_\_\_\_\_

Activity at School:

Sports: Yes No What \_\_\_\_\_

Clubs: Yes No What \_\_\_\_\_

Teams: Yes No What \_\_\_\_\_

Youth Groups: Yes No Where \_\_\_\_\_

Extended Social Network:

Names of Three to Five Best Friends/How long have they been friends:

1. \_\_\_\_\_ / \_\_\_\_\_ 4. \_\_\_\_\_ / \_\_\_\_\_

2. \_\_\_\_\_ / \_\_\_\_\_ 5. \_\_\_\_\_ / \_\_\_\_\_

3. \_\_\_\_\_ / \_\_\_\_\_

**II. Legal/Criminal History:**

Has Student ever been arrested: Yes No

If Yes, what was the charge(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**III. Previous Treatment History:**

OUTPATIENT: Yes No

Beginning at what age? \_\_\_\_\_ How frequent would student go? \_\_\_\_\_

Was your Counselor a: Psychiatrist Psychologist Other How long since last visit? \_\_\_\_\_

INPATIENT: Yes No

If Yes, what is the name of the facility(s) \_\_\_\_\_

\_\_\_\_\_

How long there? \_\_\_\_\_ Why was the Student there? \_\_\_\_\_

#### IV. Current Skill Level:

Please evaluate Student for the following skills:

1. Food
  - A. Can Student plan all the meals he/she would eat for a week? Yes No
  - B. Does Student know how to shop for food? Yes No
  - C. Does Student know how to prepare/cook food? Yes No
  
2. Finances
  - A. Does Student know how to make a budget? Yes No
  - B. Has Student ever saved money? Yes No
  - C. Does Student have good money management skills? Yes No
  
3. Independent Living Skills
  - A. Does Student keep his/her room clean? Yes No
  - B. Does Student know how to interview or has he/she ever interviewed for a job? Yes No
  - C. Is Student on time for things? Yes No
  - D. Does Student set times to get things done? Yes No
  - E. Is Student a good student in school? Yes No
  - F. Does Student have more than three activities he/she does in his/her spare time? Yes No
  
4. Social Skills
  - A. Does Student make good decisions? Yes No
  - B. Does he/she know how to solve a problem between themselves and others? Yes No
  - C. Does Student know how to negotiate to get what he/she needs? Yes No
  - D. Does Student know how to resolve a conflict with others? Yes No
  - E. Does Student have a problem with people in authority telling them what to do? Yes No
  - F. Does Student stand up for what he/she believes is right? Yes No
  - G. Is Students' communication with others good? Yes No
  
5. Appropriate Behaviors
  - A. Is Student a good listener? Yes No
  - B. Can Student give and receive feedback from/to others? Yes No
  - C. Does Student handle frustration very well? Yes No
  - D. Does Student manage anger very well? Yes No
  - E. Is Student impulsive? Yes No
  - F. If Student gets depressed is he/she able to get out of it easily? Yes No
  - G. Does Student criticize or put his/herself down? Yes No
  - H. Does Student know how to stay out of trouble? Yes No
  - I. Is Student appropriate in his/her sexual behavior, i.e.
    1. Are they sexually active? Yes No
    2. Do they use protection when they have sex? Yes No
    3. Have they had more than 3 sexual partners? Yes No



C. Has anyone in Student's family committed suicide? Yes No

D. Has Student ever attempted suicide? Yes No

If Yes, describe (times, how, last attempt) \_\_\_\_\_

\_\_\_\_\_

E. Has Student ever done any self-mutilating (i.e. cutting or burning his/her self)? Yes No

If Yes, describe \_\_\_\_\_

\_\_\_\_\_

F. Does Student have any tattoos? Yes No

If Yes, describe (number, place, type) \_\_\_\_\_

\_\_\_\_\_

G. Does Student have any body piercing? Yes No

If Yes, describe where they are located \_\_\_\_\_

\_\_\_\_\_

**VII. Drug and Alcohol Use, Including Past and Present (If Known):**

A. Has Student ever used illegal drugs? Yes No Don't Know

B. If Yes, describe use (including type of drugs, frequency, amount used, and the date of last use) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

C. What is Student's drug of preference? \_\_\_\_\_

D. Has Student ever done any Huffing? (i.e. inhaling glue, gas, NO<sub>2</sub>, etc.) Yes No Don't Know

If Yes, describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E. Has Student ever misused over the counter drugs like cough syrup, ephedrine, etc.?

Yes No Don't Know

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Has Student ever misused prescription drugs? Yes No Don't Know

If Yes, describe the type and amount of use. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

G. Has Student ever used alcohol? Yes No Don't Know

If Yes, describe frequency of use, when they started to drink and what they prefer to drink. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This Application / Student Intake Assessment has been completed to the best of my knowledge, and has been completed and signed by:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Student