Thank you for considering Providence Pass for your daughter.

The following admissions application is designed to help us understand you and your child. Please fill out all applicable information as completely and honestly as possible.

Please print a hard copy of the document to complete it and return to me by fax or email. Once we have reviewed the application we will get in touch with you to let you know the acceptance status of your child.

If you have any questions, please feel free to contact Jennifer at 828-777-9428 or teenkeyoflight@gmail.com

We look forward to the opportunity to work with your family.

Sincerely,

Jennifer Del-Giudice
Executive Director

GENERAL INFORMATION

Your Name

_____

Home Phone _____ Cell Phone _____

Work Phone _____

Address

_____

Email

_____

Relationship to Student

_____

Your Preferred Method of Contact _____

When are you hoping to enroll your daughter? _____

Name of Health Insurance

_____

Student's Name

_____

Date of Birth

_____

Comments or Questions You Have for Us:

PARENT QUESTIONNAIRE FOR CONSIDERATION OF ENROLLMENT

The following sections will help you describe your child's issues in greater detail and also identify problems that might otherwise go unnoticed:

Behaviors *Please check/mark each of the following that often apply to your child*

- ☐ Overeating ☐ Performs repeated ☐ Chronic worrying
- ☐ Suicidal attempts senseless acts ☐ Taking drugs
- ☐ Withdrawal ☐ Temper outbursts ☐ Odd behavior symptoms ☐ Vomiting ☐ Smokes
- ☐ Drinking ☐ Crying ☐ Nervous tic
- ☐ Procrastination ☐ Working too much ☐ Impulsive acts
- ☐ Sleeps too much ☐ Poor concentration ☐ Senseless fears
- ☐ Problems with jobs ☐ Loss of control ☐ Insomnia
- ☐ Panic attacks ☐ Nightmares ☐ Destructive acts
- ☐ Eating problems ☐ Laziness ☐ Aggressive behavior

Feelings *Please check/mark each of the following that often apply to your child*

- ☐ Anger ☐ Guilty ☐ Restless
- ☐ Annoyed ☐ Happy ☐ Lonely
- ☐ Sad ☐ Conflicted ☐ Contended
- ☐ Depressed ☐ Regretful ☐ Excited
- ☐ Anxious ☐ Hopeless ☐ Optimistic
- ☐ Fearful ☐ Hopeful ☐ Tense
- ☐ Panic ☐ Relaxed ☐ Unhappy
- ☐ Energetic ☐ Jealous
- ☐ Envious ☐ Bored

Physical *Please check/mark each of the following that describes your child*

- ☐ Headaches ☐ ☐ Doesn't like to be
- ☐ Dizziness ☐ Bowel disturbance touched ☐ Fainting spells ☐ Skin problems ☐ Tension
- ☐ Hearing problems ☐ Burning/itching ☐ Muscle spasms
- ☐ Visual problems skin ☐ Twitches
- ☐ Watery eyes ☐ Swelling ☐ Tremors

☐ Dry mouth ☐ Sexual disturbances ☐ Tingling
☐ Chest pain ☐ Blackouts ☐ Numbness
☐ Rapid heart beat ☐ Hears things ☐ Fatigue
☐ Back pain ☐ Tics ☐ Unable to relax
☐ Stomach trouble

Perception of Self *Please check/mark each of the following your child may feel*

☐ Worthless ☐ Evil ☐ Trustworthy
☐ Useless ☐ Crazy ☐ Honest
☐ Unlovable ☐ Degenerate ☐ Considerate
☐ Unattractive ☐ Deviant ☐ Attractive
☐ Incompetent ☐ Intelligent ☐ Sensitive
☐ Stupid ☐ Confident ☐ Full of regrets
☐ Naïve ☐ Worthwhile ☐ Inadequate
☐ Ambitious ☐ Ugly ☐ Confused
☐ Undesirable ☐ Loyal

Attitudes *Please fill in/highlight the number that best fits your child's perspective*

KEY: Strongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)

I should not make mistakes ① ② ③ ④ ⑤
I should be good at everything I do ① ② ③ ④ ⑤
When I don't know, I should pretend to know ① ② ③ ④ ⑤
I should not disclose personal information ① ② ③ ④ ⑤
I am a victim of circumstances ① ② ③ ④ ⑤
My life is controlled by outside forces ① ② ③ ④ ⑤
Other people are happier than I am ① ② ③ ④ ⑤
Play it safe; don't take any risks ① ② ③ ④ ⑤
I don't deserve to be happy ① ② ③ ④ ⑤
If I ignore my problems, they will disappear ① ② ③ ④ ⑤
It is my responsibility to make others happy ① ② ③ ④ ⑤
I should strive for perfection ① ② ③ ④ ⑤

Student's Name: _____

Reason for Referral

In your own words, what is the reason you're referring your child for treatment?

What other problems do you see that might be contributing to your child's need for treatment?

Has your child made suicide attempts in the past, to your knowledge? If so, please explain:

Has your child ever threatened or planned to kill someone else? If so, please explain:

Has your child ever voiced thoughts or beliefs that others consider strange? If so, please explain:

_____

Has your child ever expressed hearing noises or voices that others do not hear? If so, please explain:

_____
_____
_____
_____

Has your child ever expressed seeing things or people that others do not see? If so, please explain:

_____
_____
_____
_____

How does your child deal with their emotions in general?

_____
_____
_____
_____

How does she express anger?

_____
_____
_____
_____

Previous Treatment

Has your child been in treatment (hospital or outpatient) previous to this treatment center?

Hospital Name _____ *Physician Name* _____
Date of Stay _____ *Length of Stay* _____

Problem _____

Name of Practice _____ *Therapist Name* _____

Beginning Date _____ *Ending Date* _____

Problem _____

Family

List all people living at home. Include yourself:

Name *Sex* *Age* *Relationship to Client* *Career*

_____

_____

_____

_____

_____

_____

_____

List immediate family members who are not currently living in your home:

Name *Sex* *Age* *Relationship to Client* *Marital Status* *Career*

_____

_____

_____

_____

Are there any members of immediate family who are deceased?

Name *When deceased* *Age at Death* *Relationship to Client*

_____

_____

What tragedies or major life events in your family may have contributed to your child's current problems?

_____

_____

_____

_____

How do you get along with your child?

_____

_____

_____

How are children in your home disciplined?

_____

_____

_____

_____

What religion is predominant in your family?

_____

Is your family active in that religion?

_____

Developmental

Was there an unusual pregnancy, labor or delivery with this child? Yes ☐ No ☐

If so, explain:

_____

_____

Did your child ever have extremely high fevers, convulsions or injuries? Yes ☐ No ☐

If so, please explain:

_____

_____

Did your child have any difficulty learning to walk, climb, hop or skip? Yes ☐ No ☐

If yes, please explain:

_____

_____

Has she ever been clumsy or awkward for her age? Yes ☐ No ☐

If yes, please explain:

_____

_____

Is there a language other than English spoken in the home? Yes ☐ No ☐

Which is the principle language used?

_____

Does your child currently have any unusual sleeping habits? (Nightmares, late retiring, bed wetting, morning fatigue, etc.) If so, please explain:

_____

_____

Has your child been separated from either parent longer than a month in the past 3 years? If so, please explain:

_____

_____

Has there been any serious marital conflict or divorce in the family? If so, please explain the child's reaction:

_____

_____

_____

_____

Has your child ever run away from home? If so, please explain:

_____

_____

_____

Drugs and Alcohol

What drugs has your child used in her lifetime of which you are aware? Please fill in the following:

Substance Used	*When Started*	*When Stopped*	*Amount Used Each Time*	*How Often Used*

In your estimation, what percentage of her friends have used drugs/alcohol? _____%

Has substance abuse led to family, school and/or peer problems for her? Please explain:

_____

_____

_____

_____

What does your child like to do in her free time?

_____

_____

_____

Has anyone in your family had a history of drug or alcohol addiction? If yes, please explain:

_____

_____

_____

_____

Medical

Does she now have a chronic illness? Yes ☐ No ☐

Hearing problems? Yes ☐ No ☐

Vision problems? Yes ☐ No ☐ Speech problems? Yes ☐ No ☐

Lung disorder? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐

Nervous disorder? Yes ☐ No ☐

Heart trouble? Yes ☐ No ☐

Any form of cancer? Yes ☐ No ☐

Vision problems? Yes ☐ No ☐

Digestive disorder? Yes ☐ No ☐

Muscular disorder? Yes ☐ No ☐

Blood disorder? Yes ☐ No ☐

Disease of the kidney? Yes ☐ No ☐

Diabetes? Yes ☐ No ☐

Arthritis? Yes ☐ No ☐

Hepatitis? Yes ☐ No ☐

Malaria? Yes ☐ No ☐

Physical deformity? Yes ☐ No ☐

Any contagious disorder? Yes ☐ No ☐

Any life-threatening condition? Yes ☐ No ☐

Please explain if you answered "yes" to any of the above:

_____

_____

_____

_____

Describe any food allergies she may have:

_____

_____

_____

Describe any drug sensitivity or allergies she may have:

_____

_____

_____

_____

Has she been treated by a physician or been disabled or hospitalized in the last year?

_____

_____

_____

Has she been advised to have a surgical operation in the last 5 years? If so, please describe:

_____

_____

_____

_____

Describe important medical problems of her mother:

_____

_____

_____

_____

Describe important medical problems of her father:

_____

_____

_____

_____

Date of last physical:

_____

Any other medical information that we should be aware of:

_____

_____

_____

Legal

Does your child have any charges/convictions in the juvenile court system?

The Offense *Date of Offense* *Been to Court?* *Parole?* *Next Court Date*

_____

_____

_____

_____

_____

_____

Sexual

Are you aware if your child is sexually active? _____

Has she discussed this with you? _____

If so, how old was she when she had her first sexual experience? _____ How many sexual partners are you aware of? _____

Do you have any other information about your child's sexual activity?

_____

_____

_____

Has your child had any problems with pornography? Explain:

_____

_____

_____

Has your child been physically or sexually abused by a family member or anyone else? Explain:

_____

_____

_____

_____

Has anyone in your family or extended family been accused or convicted of physical or sexual abuse? If so, please explain:

_____

_____

_____

School/Work

What is your child's present school GPA? _____

What is her present school situation? Has she been attending? Are there any present school problems? Has your child ever been or is your child presently expelled? If so, please explain:

_____

_____

_____

_____

_____

_____

What employment experiences has your child had?

_____

_____

_____

Medication

Is she now or ever been on any kind of regular medication for:

Depression	Yes ☐ No ☐
Seizures	Yes ☐ No ☐
Hyperactivity	Yes ☐ No ☐
Other?	Yes ☐ No ☐

If you answered yes to any of the above, please explain:

_____

_____

_____

Is your child on any current medication? If so, please list below:

Medication	*Purpose Amount per dose*	*X's per Day*	*Refill when?*

_____

_____

_____

Strengths and Weaknesses

As a mother, what do you see as your child's strengths?

_____

_____

_____

As a mother, what do you see as your child's weaknesses?

_____

_____

_____

As a father, what do you see as your child's strengths?

_____

_____

_____

As a father, what do you see as your child's weaknesses?

_____

_____

_____

Goals

As a mother, what goals would you like your child to accomplish?

_____

_____

_____

_____

As a mother, what are your aspirations and hopes for your child in her life?

_____

_____

_____

_____

As a mother, what opportunities of growth or change do you see for yourself and for other family members (or for family in general) while your child is in treatment?

_____

_____

_____

_____

_____

_____

As a father, what goals would you like your child to accomplish?

_____

_____

_____

_____

As a father, what are your aspirations and hopes for your child in her life?

_____

_____

_____

_____

As a father, what opportunities of growth or change do you see for yourself and for other family members (or for family in general) while your child is in treatment?

_____

_____

_____

_____

_____

_____