Eagle Quest

Admissions Phone & Fax: 866-998-7095
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Enrollment Assessment / Application - Adult

Please type or print. Please complete all questions in this application. All forms must be filled out in their entirety.

Participant Information

Full name: _____ Date of Birth: _____

Age: _____Gender: _____Height: _____ Weight: _____ Hair Color:_____

Social Security Number:_____

Place of Birth: _____

Natural Child _____ Adopted _____ If adopted, at what age? _____

Are you currently living at home?_____

If No, please explain:_____

Have you had previous placements outside the home? _____

If yes, please list other homes, schools, institutions, programs with length of stay and addresses below:

_____

_____

Parent Information

Mother's Name: _____

Home address:_____

Home phone: _____ Work phone: _____ Fax: _____

E-mail: _____ Occupation: _____

Father's Name: _____

Home address:_____

Home Phone: _____ Work phone: _____ Fax: _____

Email: _____ Occupation: _____

Stepfather's Name:_____

Stepmother's Name: _____

Who does the participant live with?
Both parents_____ Mother_____ Father_____ Other_____

Please list immediate family members:

Name	**Age**	**Gender**	**Relation**	**Currently living with**

Person to notify in case of emergency (other than parents)

Name: _____ Relationship:_____

Day phone number: _____ Night phone number_____

Name: _____ Relationship:_____

Day phone number: _____ Night phone number_____

Participant Information

Present Difficulties

1. What do you see as your largest life difficulties?

_____
_____
_____
_____

2. How would you describe your emotional state?

_____
_____
_____
_____

3. What are you currently doing to cope with your struggles?

_____
_____
_____
_____

4. What are your plans after completing Eagle Quest? (ex. Home, school, work, etc.)

_____
_____

5. How do you think Eagle Quest can help you?

_____
_____

6. What long term goals have you set for your self at present?

_____
_____

Drug Use

7. Are you currently using drugs? _____

8. If yes, please use the following chart to further explain your drug history.

	Has used (age began)	**Frequency – Current use**
Tobacco		
Wine		
Beer		
Hard liquor (tequila, vodka, etc.)		
Marijuana		
Hallucinogens (LSD, PCP, etc.)		
Stimulants (uppers, cocaine, crack, etc.)		

Depressants (sedatives, barbiturates, etc.)		
Opiates (meth, heroine, etc.)		
Inhalants (glue, gasoline, spray paint, etc.)		
Other		
Other		

9. When did you start using drugs? _____

Behavioral History

10. Have you ever demonstrated violent behavior? _____ If yes, please explain:
_____
_____
_____

11. Have you had any involvement with the legal system? _____ If yes, please explain:
_____
_____
_____

12. Have you ever tried to commit suicide, or talked about suicide? _____ If yes, please explain:
_____
_____
_____

13. Have you had any changes in behavior and/or mood? (anxious, sad, withdrawn, angry, overly happy, etc.) Please explain:
_____

About when did these changes occur?
_____

14. Have you had any abnormal thoughts? _____ If yes, please explain:

_____

15. Please check any of the following characteristics that applied to you growing up or currently. If current behavior, please denote with a C.

	Shy or timid		Strange thoughts
	Withdrawn		Difficult to control
	Temper tantrums		Often aggressive towards others
	Daredevil behavior		Loner
	Bedwetting		Destructive
	Cruel to animals		Disliked being touched
	Played with fire		Restless
	Basically an unhappy child		Let self be pushed around
	Other		Other

Medical History

Participants Name: _____ Age: _____ Blood type:_____

A candid appraisal of your health is necessary. Please complete every question on this form so that we may know of any health conditions or medication requirements during your participation in Eagle Quest. All medications must be listed on the medical report form and sealed in the original pharmacy container. Participation in Eagle Quest should **NOT** be considered if any of the following conditions exist:
EXTREME OBESITY, RENAL DISEASE, ANOREXIA/BULIMIA, DIABETES, ARTHRITIS, EXTREME DRUG ADDICTION THAT REQUIRES DETOX FACILITY, OR PREGNANCY.

Physician's Name: _____ Phone Number:_____

Orthodontist Name: _____ Phone Number:_____

Physical

Do you wear glasses or contacts? _____ If yes, when are they required? _____
All the time _____ Reading only? _____ If contacts are worn, the participant needs to come to the program with glasses. **Contacts CAN NOT be worn in the field.**

Do you have any problems hearing? _____ If yes, explain: _____
_____

Have you ever been hospitalized? _____ If yes, explain: _____
_____
_____

Have you ever broken a bone? _____ If yes, explain: _____
_____
_____

Are you allergic to any of the following? If yes, please describe.

Penicillin _____
Sulfa Drugs _____
Aspirin _____
Shell Fish _____
Nuts _____
Bees _____
Other _____

Do you have any allergies including: hay fever, asthma, eczema, foods, etc.?
If yes, please explain:
_____
_____
_____

Do you have any physical limitations that would prevent you from hiking, carrying a pack, etc.? If yes, please explain:
_____

Do you have, or have experienced the following in the past year? (check all that apply)

	Dizziness or fainting spells		Constipation or diarrhea
	Frequent or migraine headaches		Pain or bleeding during bowel movements
	Skin allergies or rashes		Unexplained weight change
	Wart or sores on feet		Rheumatism
	Chest pain or shortness of breath		A rupture or hernia
	Spitting or coughing up blood		Pain in back, neck or joints
	Sweating at night		Difficulty walking, running or lifting
	Stomach aches or indigestion		Heart trouble or disease
	Urinary bleeding, frequent urination		Diabetes or sugar in the urine
	Arthritis		Goiter or thyroid disease
	High blood pressure		Venereal disease
	Excessive bleeding		Tumor, growth, cyst or cancer
	Hemophilia		Knee or ankle injury
	Ulcer		Rheumatic fever
	Anemia		Mumps
	Scarlet fever		Chicken pox
	Seizures, convulsions, or epilepsy		Pneumonia
	Kidney disorder		Typhoid
	Measles		Appendicitis
	Ear infection		Polio
	Back injury or deformity		Frequent Colds
	For Females only		**Painful periods**
	Heavy periods		**Periods longer than eight days**

Explanation for any of the conditions checked above (if necessary): _____
_____
_____
_____
_____
_____
_____
_____

List any other significant illnesses, problems, diseases or disorders not listed above: _____
_____
_____
_____
_____
_____
_____
_____

Applicant's Signature: _____ **Date:** _____

Eagle Quest

Authorization for Release of Confidential Information

Participant Name: _____ Date of Birth: _____

I, _____, authorize Eagle Quest to speak candidly with the following people, (please include psychologists, therapists, referral sources, specific schools, or programs, and educational consultants that we may need to speak with) concerning my past records, history, and progress in the Eagle Quest program, while I am their client during the year 200_____.

Name	**Phone Number**	**Fax number**	**Type of Professional (i.e. Therapist etc.)**

The information to be disclosed includes:

1.	Social, medical, or psychological reports.	Yes	No
2.	Medications used in treatment.	Yes	No
3.	Treatment goals and results.	Yes	No
4.	Information about drug and/or alcohol abuse or treatment	Yes	No
5.	Court or probation records.	Yes	No
6.	Academic transcripts.	Yes	No

_____ _____

Signature Date

_____ _____

Signature Date

Consent to Treat

Participant:_____

Upon request of the staff of Eagle Quest, I authorize the physicians on the approved referral list and staff of:

1. Central Valley Medical Center — Nephi, Utah
2. Delta Family Practice Clinic — Delta, Utah
3. Delta Community Medical Center — Delta, Utah
4. Other appropriate emergency medical facilities.

To perform such medical/surgical evaluations and procedures as may be deemed necessary, with the exception of:

_____(if none, so state), in rendering of treatment in the interest and

care of _____(participant's name) while a participant at Eagle Quest.

If medical treatment in an above-named hospital is undertaken, I wish the following physician to be contacted:

Physician Name: _____Phone #: _____

Complete Address:_____

I also authorize Eagle Quest to release/receive pertinent information requested by consulting healthcare providers.

_____

Signature of Insured/Guarantor, Relationship Date

_____

Signature of Participant Date

_____

Witness Date