Eagle Quest

Admissions Phone and Fax: 866-998-7095
Website: www.eagle-quest.com / Email: eqinfo@eagle-quest.com

Enrollment Assessment / Application - Teen

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: _____
Current Grade in School: _____ School Currently Attending: _____
Social Security Number: _____ Ethnicity: _____
Place of Birth: _____ Natural Child? _____
Adopted? _____ If adopted, at what age? _____ Is your child currently living at home? _____
If no, please explain: _____
Has your child had previous placements outside the home? _____
If yes, please list other homes, schools, institutions, programs with length of stay and addresses below:
_____
_____
_____

Parent Information ****If not living w/Bio Parent, please put appropriate Person's Information below.**

Mother's Name: _____ Age: _____ Best Phone #: _____
Full Home Address: _____
Home Phone: _____ Work phone: _____
Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____
**Status of Bio Mother (if other than above)

Father's Name: _____ Age: _____ Best Phone #: _____
Full Home Address: _____
Home Phone: _____ Work Phone:_____
Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____
**Status of Bio Father (if other than above):

Parent Information Continued

Stepfather's Name:_____ Age: _____ Best Phone #: _____
Full Home Address: _____
Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____

Stepmother's Name: _____ Age: _____ Best Phone #: _____
Full Home Address: _____
Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____

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

Referral / Family / Emergency Contact Information

How did you hear about Eagle Quest? _____ Name of Referral: _____

May we contact this person? _____ Phone number of Referral: _____

Referral Type:

_____ Educational Consultant
_____ Previous Parents
_____ Previous Student
_____ Therapist/Psychologist
_____ Other _____
_____ School
_____ Other Program
_____ Internet
_____ Word of Mouth

Please list immediate family members:

Name	Age	Gender - M or F	Live @ home or away	Relationship w/ Student

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: _____

Student Information

Present Problems

1. What are your child's current behavioral problems? _____
_____
_____
_____
_____

2. What are your child's emotional problems? _____
_____
_____
_____
_____

3. What is currently being done about these problems? _____
_____
_____
_____
_____

4. What are your plans for your child after completing Eagle Quest? (ex. Home, boarding school, etc.)
_____
_____

5. What do you hope Eagle Quest can accomplish for your child? _____
_____
_____

Social Relationships Please provide explanation when appropriate.

6. Does your child make friends easily, or have difficulty making friends? _____

7. Does your child prefer to be alone? _____

8. Does your child get along well with others? _____

9. Does your child have more friends his/her own age, or friends that are older/younger? _____
_____

10. Does your child have more friends of the same sex, or the opposite sex? _____
_____

11. Has your child recently changed friend groups, or stopped hanging out with long time friends? _____
_____

Drug Use

12. To your knowledge, is your child currently using drugs? _____

13. If yes, please use the following chart to further explain your child's 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		

14. When did you discover your child was using drugs? _____

Sexual History

15. To your knowledge, has your child been sexually active? (please describe history/frequency, patterns, abortions etc.):_____
_____
_____

16. To your knowledge, has your child had any sexual problems? _____
_____
_____

17. Has your child exhibited any inappropriate sexual behaviors (i.e. sexual acting out):_____
_____
_____

18. To your knowledge, has your child ever been sexually abused? _____
_____

Behavioral History

19. Has your child ever demonstrated violent behavior? _____ If yes, please explain: _____
_____
_____
_____

Behavioral History Continued

20. Has your child had any involvement with the legal system? _____ If yes, please explain: _____
_____
_____

21. Has your child ever tried to commit suicide, or talked about suicide? _____ If yes, please explain: ____
_____
_____

22. Has he/she had any changes in behavior and/or mood? (anxious, sad, withdrawn, angry, overly happy, etc.)
Please explain: _____
About when did these changes occur? _____
_____

23. To your knowledge, has he/she had any abnormal thoughts? _____ If yes, please explain: _____
_____

24. Please check any of the following characteristics that applied to your child 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 (describe)		Other (describe)

School History

25. Please describe your child's school performance (examples: did your child do well in school until recently?, Has your child always struggled in school?): _____
_____
_____

26. Has your child had difficulties in school? _____ If yes, what type of difficulties? _____
_____
_____

27. Has your child ever been in any special education or resource classes? _____ If yes, which grades? ___
_____
_____

28. Has your child repeated a grade (s)? _____ If yes, which ones(s): _____

29. Has your child skipped a grade (s)? _____ If yes, which ones(s): _____

School History Continued

30. Has your child ever been suspended or expelled? _____ If yes, when and why: _____
_____
_____

31. Current grade: _____ Still attending? _____ Last completed grade? _____

32. Name of School: _____ Phone Number: _____

33. School Counselor:_____ Phone Number: _____

Divorce

34. Are parents divorced? _____ If yes, please give date: _____
**** If parents are divorced, please have a copy of the court custody agreement available upon request.****

35. How old was your child at the time of your divorce? _____

36. Has the divorce been an issue for your child? _____

37. Who has custody of your child? _____

38. Any past or current divorce/custody battles? _____

39. Have parent's remarried? _____ If yes, please give dates: _____
_____

40. Has the remarriage been an issue for your child? _____
_____

Personal Information

41. To your knowledge has your child possibly been traumatized? (sexual abuse, death of a friend or family member, abandonment, remarriage, physical abuse, violence) or witnessed any trauma? Please explain and tell when: _____
_____
_____

42. What are your child's strengths? _____
_____
_____

43. What are your child's weaknesses? _____
_____
_____

44. Is there any additional information we should know about your child that would help us better understand him/her? _____
_____

Adoption

45. Was your son/daughter adopted? _____ If yes, when? _____ Age: _____

46. Where was your child adopted from? _____

47. Did your child have any previous foster homes? _____ If yes, how many? _____

48. Were there any special circumstances leading up to the adoption? _____ If yes, explain: _____
_____

49. Has the adoption been an issue for your child? _____
_____

Psychological Information

50. Has your child been in counseling? _____

51. Please list the names and licensure (ie. psychiatrist, psychologist, LPC), phone number and dates your child attended sessions.

Therapist Name	Licensure	Phone number	Dates of Service
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

52. Please describe your child's past and present relationship with:

Mother: _____
_____
_____
_____

Father: _____
_____
_____
_____

Stepmother: _____
_____
_____

Stepfather: _____
_____
_____

53. Please describe your child's relationship with his/her siblings: _____
_____
_____
_____
_____

Family History Continued

54. Please describe any significant relationships with family members your child may have (ie. Grandparents, aunt, uncle etc.): _____
_____
_____
_____
_____

55. Is there any history of emotional, medical or physical problems in the family? _____
_____
_____
_____
_____

56. Please describe your family structure and any support systems for your child: _____
_____
_____
_____
_____

Emotional

57. Has your child ever been hospitalized for psychological reasons (ODD, depression, anxiety, etc)? _____
If yes when, where? _____
_____
_____

Diagnosis:_____When Diagnosed:_____

Therapist Name:_____ Telephone Number_____

58. Has your child ever been diagnosed with AD(H)D: _____

Medical History

Participants Name: _____ Age: _____ Blood type: _____

A candid appraisal of your child's health is necessary. Please complete every question on this form so that we may know of any health conditions or medication requirements during your child's 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 Condition

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

60. Does your child have any problems hearing? _____ If yes, explain: _____
_____

61. Has your child ever been hospitalized? _____ If yes, explain: _____
_____
_____

62. Has your child ever broken a bone? _____ If yes, explain: _____
_____
_____

63. Is your child allergic to any of the following? If yes, please describe.

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

64. Does your child have any allergies including: hay fever, asthma, eczema, foods, etc.? _____
If yes, please explain: _____
_____
_____

Physical Condition Continued

65. Does your child have any physical limitations that would prevent him/her from hiking, carrying a pack, etc.? _____ If yes, please explain: _____
_____
_____

66. Does your child have, or has he/she 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**

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

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

Immunization

69. Please complete the following chart regarding your child's current immunizations:

Immunization	**Date**
Diptheria-Pertussia (whooping cough) – Tetanus **DPT**	
OR Diptheria-Tetanus **DT**	
OR Tetanus Toxoid	
Mumps, Measles, Rubella **MMR**	

Medications

70. Is your child currently taking an over the counter medication? _____ If yes, explain: _____
_____

**** If this medication needs to continue while your child is in Eagle Quest, please send a supply of the medication with your child, include instructions (dosage, times etc.)****

71. Has your child previously taken prescription medications? _____ If yes, explain: _____
_____

72. Has your child recently been taken off any prescription medications? _____ If yes, explain: _____
_____

73. Is your child currently taking any prescription medications? _____ If no, you do not need to complete the prescription medications. If yes, continue with the prescription medication form.

Prescription Medications

If your child is currently taking medications, please do the following upon enrollment at Eagle Quest:

- ✓ Send at least a 60 day supply of the medication. Please keep all medications in their original prescription bottles.
- ✓ If your insurance will not allow you to obtain a 60 day supply of medication you will need to refill the medication while your child is at Eagle Quest and send the medication to our medical department. Prescriptions CAN NOT be refilled at Eagle Quest.
- ✓ If your child uses an inhaler, please send two (2) inhalers.
- ✓ Please include copies of any literature/instruction you have on the medication for our files.
- ✓ **Please attach a copy of your child's insurance/medical card.**

For each medication, complete the following: Note – This MUST be completed as part of the Assessment.

Medication 1
Medication Name: _____ mg. _____ Dosage Schedule: _____
Starting date: _____ Ending date (if applicable): _____
Name of prescribing physician: _____ Phone number: _____
Why medication is being taken: _____
Any side effects: _____

Prescription Medications Continued

Medication 2
Medication Name: _____ mg. _____ Dosage Schedule: _____
Starting date: _____ Ending date (if applicable): _____
Name of prescribing physician: _____ Phone number: _____
Why medication is being taken: _____
Any side effects: _____

Medication 3
Medication Name: _____ mg. _____ Dosage Schedule: _____
Starting date: _____ Ending date (if applicable): _____
Name of prescribing physician: _____ Phone number: _____
Why medication is being taken: _____
Any side effects: _____

Medication 4
Medication Name: _____ mg. _____ Dosage Schedule: _____
Starting date: _____ Ending date (if applicable): _____
Name of prescribing physician: _____ Phone number: _____
Why medication is being taken: _____
Any side effects: _____

Reminder – The Medications must be listed as part of the Assessment / Application process.

Clothing and Gear

IMPORTANT – Since we provide all necessary clothing (except underwear) we ask that your child arrive with only the clothes they are wearing and four (4) sets of underwear.

To insure comfort and proper fit of clothing, please fill out the following information accurately.

Pant Size: _____ Shirt Size: _____ Shoe Size: _____

**There are numerous activities that make jewelry an unsafe item. In order to prevent injury or infection, we do not allow any jewelry in the field.

Authorization for Release of Confidential Information

Student 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 child's 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

This Application / Assessment and Release of Confidential Information has been completed to the best of my knowledge, and has been completed and signed by:

_____ _____
Signature (Parent or Guardian) Date

_____ _____
Print Name Relationship to Student

_____ _____
Signature (Parent or Guardian) Date

_____ _____
Print Name Relationship to Student