

TEEN CHALLENGE COLUMBUS  
PO BOX 24099  
COLUMBUS, OH 43224  
(614)-476-4600 FAX # (614)-476-3259

APPLICATION / INTERVIEW

DATE: \_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell #: \_\_\_\_\_ E-mail: \_\_\_\_\_ Fax # \_\_\_\_\_

**I. PERSONAL HISTORY**

Marital status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated

Current spouse (full name): \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Is your spouse (Supportive) \_\_\_\_\_ (Non-Supportive) \_\_\_\_\_

Do you have any Children? \_\_\_ Yes \_\_\_ No

<b>Name of Child</b>	<b>Age</b>	<b>Where Living</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Relationship with children (Positives) \_\_\_\_\_

(Negatives) \_\_\_\_\_

Rate your own health in the last year to the present: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Are you on any type of special diet prescribed by a Doctor? \_\_\_ Yes \_\_\_ No If yes, please explain:  
\_\_\_\_\_

Are you experiencing any current Medical or Dental Problems / Concerns? \_\_\_\_\_

\*\*If yes, you must take care of all medical or dental needs before entering the program.

Do you have any allergies we should be aware of? \_\_\_\_\_

Have you had any serious medical conditions in the past five years? \_\_\_\_\_

Please list the Medications you are currently taking & why? (1) \_\_\_\_\_

(2) \_\_\_\_\_ (3) \_\_\_\_\_

(4) \_\_\_\_\_ (5) \_\_\_\_\_

\*\*Narcotics, Mood Altering, or Mind Controlling drugs are not permitted while in our program.

Prospective Students must be off all prescribed Narcotics, Mood Altering or Mind Controlling medications for 3 weeks, with a Doctor's note, prior to entering Teen Challenge.

Are you on any kind of herb? \_\_\_\_\_ Herbs may not be brought in without a doctor's prescription. No over-the-counter-medication that has been opened, may be brought in. If you have medication prescribed by a doctor, only the doctor's prescription should be brought in. Staff will get it filled.

## **II. LIFE CONTROLLING PROBLEM**

1. Do you have a problem with Drug / Alcohol Abuse? \_\_\_\_ Yes \_\_\_\_ No If yes, please explain:

2. What is your drug of choice? \_\_\_\_\_

3. Are there any other problems you are dealing with, such as cutting, eating disorder, etc.?

How do / did you support your Drug / Alcohol dependency? \_\_\_\_\_

Are you currently using? \_\_\_\_ Yes \_\_\_\_ No If "No" what was date of last use? \_\_\_\_\_

At what age did you start using? (Drugs) \_\_\_\_\_ (Alcohol) \_\_\_\_\_

4. If Drugs and / or Alcohol are not the problem – what life-controlling problem do you struggle with?

## **III. LEGAL**

Are you on Parole? \_\_\_\_ Yes \_\_\_\_ No Are you on Probation? \_\_\_\_ Yes \_\_\_\_ No

Cause of Parole or Probation? \_\_\_\_\_

P. O.'s Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## **COURT HEARINGS**

Cause of Hearing(s)?

Dates(s)

1. \_\_\_\_\_

2. \_\_\_\_\_

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

Attorney's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Judge's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have any other charges pending?  Yes  No If so, what are the charges?  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Has anything been set in place with the Judge, your P.O. or Attorney in order to apply for entrance to Teen Challenge?  Yes  No If yes, what? \_\_\_\_\_

**If working with the courts, we will discuss details later.**

Have you ever been convicted of a Sexual or Violent crime?  Yes  No If yes, explain?  
Charge: \_\_\_\_\_  
Sentence: \_\_\_\_\_  
Year Sentenced: \_\_\_\_\_  
Amount of time served: \_\_\_\_\_  
County & State served in: \_\_\_\_\_

#### **IV. THE PROBLEM / SOLUTION**

Why are you seeking help at this time?  
\_\_\_\_\_

How do you feel Teen Challenge will benefit you? \_\_\_\_\_

Have you read the Preliminary Student Agreement from Teen Challenge?  Yes  No If yes, how do you feel about it?  
\_\_\_\_\_

Do you feel you might have a problem following the rules?  Yes  No Explain: \_\_\_\_\_

Do you believe in God?  Yes  No  
Are you ready to let God help you change your life?  Yes  No Explain: \_\_\_\_\_

How would you describe your current spiritual condition?  Good  Average  Poor  
Please explain your answer? \_\_\_\_\_

Do you have a personal relationship with Jesus Christ?  Yes  No Please share with me a little about it: \_\_\_\_\_

Do you attend church now?  Yes  No If so, which denomination is it? \_\_\_\_\_

Have you ever been involved in other religions besides Christianity?  Yes  No  
(example – Jehovah’s Witness, Mormonism, New Age, Satanism, Scientology.....)

If yes, please name them: \_\_\_\_\_

**V. ACADEMIC HISTORY**

Highest grade you have completed? \_\_\_\_\_ If, not completed High School do you have a GED? \_\_\_\_\_

Are you currently in an education program? \_\_\_\_\_

Have you received vocational training? \_\_\_\_\_

How well do you read?  Good  Average  Poor

How well do you write?  Good  Average  Poor

Do you have any interest in furthering your education?  Yes  No If yes, please explain:

\_\_\_\_\_

Please Sign:

\_\_\_\_\_

Student

\_\_\_\_\_

Date

\_\_\_\_\_

Staff

\_\_\_\_\_

Date

**After completing this application, please mail to**

**Teen Challenge Columbus  
Intake Coordinator  
P.O. Box 24099  
Columbus OH 43224-0099**

**If there are any questions, you may call 614-476-4600. Thank You!**