NEW LIFE FOR ADULTS AND YOUTH ENROLLMENT APPLICATION

GENERAL INFORMATION

FIRST NAME	LAST NAME	MIDDLE

CURRENT ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS	PHONE	GENDER (Circle) M F	DATE OF BIRTH

ARE YOU A U.S. CITIZEN? Y N	IF YES, WHAT STATE IS YOUR RESIDENCE?	IF NO, WHAT IS YOUR COUNTRY OF RESIDENCE?

MARITAL STATUS

☐ SINGLE ☐ MARIED

☐ ENGAGED ☐ SEPERATED

☐ DIVORCED

RACE

☐ AFRICAN-AMERICAN ☐ CAUCASION ☐ HISPANIC

☐ NATIVE AMERICAN ☐ ASIAN ☐ OTHER

☐ MULTI-CULTRUAL

DO YOU READ AT A 5TH GRADE LEVEL?	DO YOU HAVE A HIGH SCHOOL DIPLOMA?	DO YOU HAVE A GED?

DO YOU HAVE FRIENDS OR RELATIVES IN THIS PROGRAM?	HAVE YOU BEEN ENROLLED AT NEW LIFE FOR YOUTH BEFORE?

WHAT DO YOU PRIMARILY NEED HELP WITH? ALCOHOL DRUGS OTHER (*Explain)*:	DO YOU USE TOBACCO? Y N

HAVE YOU EVER BEEN TREATED AT AN ADDICTION RECOVERY FACILITY? Y N (*If yes, provide facility information below*)

FACILITY 1			
	FACILITY NAME	**ADDRESS**	
	CITY	**STATE**	**ZIP**
	TREATMENT DATE RANGE	**REASON FOR TREATMENT**	**DID YOU COMPLETE TREATMENT?** Y N

FACILITY 2			
	FACILITY NAME	**ADDRESS**	
	CITY	**STATE**	**ZIP**
	TREATMENT DATE RANGE	**REASON FOR TREATMENT**	**DID YOU COMPLETE TREATMENT?** Y N

HOW DID YOU HEAR ABOUT NEW LIFE FOR YOUTH?

Version Date: 09/01/2022

GENERAL INFORMATION (CONTINUED)

PLEASE LIST YOUR MAIN REASON FOR WANTING TO ATTEND THE NEW LIFE FOR ADULTS AND YOUTH PROGRAM AND ANY OTHER ISSUES YOU WOULD LIKE TO ADDRESS WHILE IN THE PROGRAM.

PHYSICAL HEALTH

MEDICAL HISTORY *(Check all that apply to your current and past conditions).*

☐ ALCOHOL ABUSE	☐ ASTHMA	☐ BACK PROBLEMS
☐ BROKEN BONES/SPRAINS	☐ DIABETES	☐ DRUG ABUSE
☐ HEAD TRAUMA/TBI	☐ HEART CONDITION	☐ HEPATITIS
☐ HIGH BLOOD PRESSURE	☐ HIV/AIDS	☐ MIGRAINES
☐ RESPIRATORY PROBLEMS	☐ SEIZURES	☐ STI/STD
☐ TUBERCULOSIS		

PLEASE LIST ANY CURRENT MEDICAL CONCERNS YOU MAY HAVE:

ARE YOU CURRENTLY BEING TREATED BY A DOCTOR? Y N (*If yes, provide contact information below*)

PRIMARY DOCTOR INFORMATION

NAME	**ADDRESS**	
CITY	**STATE**	**ZIP**
OFFICE PHONE	**FAX**	
DATES OF TREATMENT FROM: / /	TO: / /	
REASON FOR TREATMENT		

ARE YOU PREGNANT? Y N

If yes, what is your due date? / /

PHYSICAL HEALTH (CONTINUED)

ARE YOU ALERGIC TO ANY MEDICATIONS? Y N If yes, please list them below:

ARE YOU CURRENTLY BEING TREATED WITH PRESCRIBED NARCOTIS? Y N If yes, please list them below:

ARE YOU CURRENTLY PRESCRIBED ANY NON-PSYCHIATRIC MEDICATIONS? Y N
If yes, please list the medication, reason, and dosage below:

MEDICATIONS	MEDICATION	REASON	DOSAGE
	MEDICATION	**REASON**	**DOSAGE**

SPECIAL NEEDS

DO YOU HAVE ANY TYPE OF DISABILITY? Y N If yes, please explain.

DO YOU HAVE ANY CHRONIC CONDITIONS? Y N If yes, please explain.

DO YOU HAVE ANY MEDICAL RESTRICTIONS? Y N If yes, please explain.

DO YOU HAVE ANY TYPE OF SPECIAL NEEDS? Y N If yes, please explain.

DO YOU HAVE ANY ALLERGIES? Y N If yes, please explain.

DO YOU REQUIRE A SPECIAL DIET? Y N If yes, please explain.

DENTAL & VISION HEALTH

DO YOU HAVE ANY DENTAL ISSUES THAT NEED TREATMENT? Y N If yes, please explain.

DO YOU WEAR GLASSES OR CONTACTS? Y N	**DO YOU HAVE YOUR GLASSES OR REPLACEMENT CONTACTCS?** Y N

MENTAL HEALTH

HAVE YOU EVER BEEN TREATED FOR MENTAL DISORDERS? Y N

If yes, when? / /

HAVE YOU EVER BEEN TREATED BY A PSYCHIATRIST/PSYCHOLOGIST? Y N If yes, please provide the following information:

PSYCHIATRIC/PSYCOLOGIST

NAME	**ADDRESS**	
CITY	**STATE**	**ZIP**
OFFICE PHONE	**FAX**	
DATES OF TREATMENT FROM: / /	TO: / /	
REASON FOR TREATMENT		

ARE YOU CURRENTLY PRESCRIBED ANY PSYCHIATRIC MEDICATIONS? Y N

If yes, please list the medication, reason, and dosage below:

MEDICATIONS

MEDICATION	**REASON**	**DOSAGE**
MEDICATION	**REASON**	**DOSAGE**

PLEASE, TELL US OF ANY CURRENT MENTAL/EMOTIONAL HEALTH CONCERNS YOU MAY HAVE:

HAVE YOU THOUGHT ABOUT OR ATTEMPTED SUICIDE IN THE PAST SIX MONTHS? Y N

If yes, when? / /

MENTAL HEALTH HISTORY *(Check all that apply to your current and past conditions).*

☐ ADD/ADHD	☐ ANOREXIA	☐ ANXIETY DISORDER
☐ BIPOLAR DISORDER	☐ BULIMIA	☐ DEPRESSION
☐ HALLUCINATIONS	☐ HEARING VOICES	☐ HOMOCIDAL THOUGHTS/TENDENCIES
☐ INSOMNIA	☐ MULTIPLE PERSONALITIES	☐ PARANOIA
☐ PERSONALITY DISORDER	☐ PHYSICAL ABUSE	☐ POST TRAUMATIC STRESS DISORDER
☐ RAPE VICTIM	☐ SEXUAL ABUSE	☐ SCHIZOAFFECTIVE DISORDER
☐ SCHIZOPHRENIA	☐ SUICIDAL ATTEMPT	☐ SUICIDAL THOUGHTS

LEGAL ISSUES

ARE YOU CURRENTLY ON PROBATION? Y N If yes, please provide the following information:

PROBATION CONTACT INFORMATION

STATE AND COUNTY OF PROBATION		
PROBATION OFFICER'S NAME	**PROBATION OFFICER'S ADDRESS**	
CITY	**STATE**	**ZIP**
PROBATION OFFICER'S OFFICE PHONE	**PROBATION OFFICER'S CELL PHONE**	
FAX	**PROBATION OFFICER'S EMAIL ADDRESS**	

ARE YOU CURRENTLY ON PAROLE? Y N If yes, list the state and county of your parole.

DO YOU CURRENTLY HAVE ANY COURT CASES PENDING? Y N If yes, please provide the following information:

State and county of your hearing(s):

Court dates and nature of charge(s):

ARE YOU CURRENLTY UNDER INVESTIGATION? Y N If yes, list the state and county conducting the investigation.

DO YOU HAVE ANY OUTSTANDING WARRANTS FOR YOUR ARREST? Y N If yes, list the state and county of the warrant(s)

HAVE YOU EVER BEEN CONVICTED OF A VIOLENT CRIME? Y N If yes, list each conviction and date.

ARE YOU CURRENTLY FACING CHARGES FOR A VIOLENT OR SEX-RELATED CRIME? Y N If yes, describe the charges.

ARE YOU REQUIRED TO REGISTER AS A SEXUAL OR PREDATORY OFFENDER? Y N

DO YOU HAVE AN ATTORNEY? Y N If yes, please provide the following information:

ATTORNEY INFORMATION

ATTORNEY'S NAME	**ADDRESS**	
CITY	**STATE**	**ZIP**
OFFICE PHONE	**CELL PHONE**	
FAX	**ATTORNEY'S EMAIL ADDRESS**	

LEGAL ISSUES (CONTINUED)

LEGAL HISTORY *(Check all that you have been involved with)*

☐ AIDING & ABETTING	☐ ATTEMPTED MURDER	☐ ATTEMPTED ROBBERY
☐ BATTER	☐ CREDIT CARD FRAUD	☐ DRUG DISTRIBUTION
☐ DUI	☐ DWI	☐ EMBEZZLEMENT
☐ FRAUD	☐ IDENTITY THEFT	☐ LARCENY/GRAND LARCENY
☐ MANSLAUGHTER	☐ MURDER	☐ PAROLE VIOLATION
☐ PROSTITUTION	☐ SEX WITH A MINOR	☐ SHOPLIFTING
☐ SOLICITING PROSTITUTION	☐ OTHER	

If other, please list:

EMERGENCY CONTACT

EMERGENCY CONTACT NAME			**EMERGENCY CONTACT RELATION**
ADDRESS			**CITY**
STATE	**ZIP**	**EMAIL ADDRESS**	
HOME PHONE	**CELL PHONE**		**WORK PHONE**

FINANCIAL INFORMATION

ARE YOU CURRENTLY EMPLOYED? Y N

DO YOU RECEIVE ANY OTHER INCOME (SSI, Disability, etc.)? Y N If yes, what is the monthly amount?

DO YOU CURRENTLY RECEIVE GOVERNMENT ASSISTANCE? Y N If yes, what type?

CERTIFICATION AND AGREEMENT

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that, should an investigation disclose untruthful or misleading answers, I may be discharged from the New Life For Adults and Youth program. Furthermore, I understand that New Life For Youth is a voluntary Christian, faith-based program.

Please initial the following lines to indicate that you have received, read, and agree to abide by the program guidelines listed below.

_____ Program Policies and General Information

_____ _____

Applicant Signature Date

Email completed applications to info@newlifeforyouth.org
Please, mail completed applications to:

New Life For Adults and Youth Intake Dept.
PO Box 13526
Richmond, VA 23225