

Ohio Valley Teen Challenge Application - CONFIDENTIAL -

Date: _____

1. **Inquirer's Name** _____ Age: _____ DOB: _____

Street Address (See Note **): _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

S.S.# (optional) _____ Referred By: _____

(** If the inquirer (1) is not a permanent resident of the address given above, then indicate the relationship of the person(s) whose house he or she is staying at):

How did you hear about OVTC? _____

Do you know anyone currently in the program? Y / N If so, who? _____

What is your relationship to that person? _____

2. **Previous Substance Abuse Programs, Institutions, Professional Counselors**

	Name	Location	Date
<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____

3. **Religious/Church Background**

Home Church _____ Born Again? Y/N _____

Pastor/Rabbi/Priest: _____

Additional Information: _____

4. **Background**

High School (yrs completed) _____ College (yrs completed) _____

Military Experience _____ Ethnic Background _____

Receiving Government Aid _____ Current Debts _____

Additional Information: _____

Applicant's Name: (First)

Applicant's Name: (Last)

Applicant's Name:

5. Marital Status

Single Married (how long?) _____ Separated Divorced Widowed

Additional Information: _____

Do you have children? (If so, how many and what are their ages?) _____

Do you pay child support? (Y/N) _____ How much? _____ Who has custody? _____

Additional Information: _____

6. Medical, Dental, and Mental Health Issues

Impairments: Mental Health Physical Health Hearing Impaired Visually Impaired

If yes, Please describe impairment: _____

Allergies _____ Asthma _____ Diabetes _____ High Blood Pressure _____ Seizures _____

Migraines _____ Wear Glasses/Contacts _____ Dental Problems _____ Back Problems _____

Additional Information: _____

Prescription Medication: Yes No If yes, will medication be required while in the program? Yes No

Name of Medication prescribed: _____

Reason for taking: _____

Frequency of use: _____

Prescribed by whom? _____

How will medication be paid for? _____

Please Note: OVTC is not a medical facility, does not have medical professionals on staff, and will not cover any of the applicant's medical, dental, prescription medication, or non-prescription supplies & medication costs.

7. Sex Offense Issues

Have you ever been **arrested, charged** or **convicted** of a sex offense? Yes No

If Yes, Please explain the nature of the offense _____

8. Legal Issues (Give a brief description)

a. **Ever Incarcerated?:** Yes No When / Where / For What? _____

b. **Mental Health related :** Yes No Explanation: _____

c. **Parole:** Yes No Starting When? / How long? _____

Parole Officer's Name: _____ Phone: _____

Address: _____

d. Probation: Yes No Starting When / How long? _____

Officer's Name: _____ Phone: _____

Address: _____

e. Criminal Charges: Yes No Explanation: _____

f. Pending Court Case: Yes No Explanation: _____

Attorney / PD Name: _____ Phone: _____

Address: _____

g. Outstanding Warrants of Arrest: Yes No Explanation: _____

h. Pending Divorce: Yes No Explanation: _____

i. Other Legal Issues: Yes No Explanation: _____

9. **Presenting Problem(s)** (Give a brief description: How much, how often, how long, type, etc)

a. Drugs: Yes No Explanation: _____

b. Alcohol: Yes No Explanation: _____

c. Gang Involvement: Yes No Explanation: _____

d. Mental Health Issues(suicidal, rage, etc): Yes No Explanation: _____

e. Homosexual Activity: Yes No Explanation: _____

f. Tobacco Use: Yes No If Yes, What Type: _____ How Long _____ How often _____

Please Note: OVTC is a tobacco free facility. Are you willing to quit. (Y/N)_____
If yes, you may use a nicotine patch during your first 30 days in the program to help you through the process of withdrawal from nicotine.

****If you are in need of a medical detox, please do so prior to coming to OVTC. The only help we can offer is bed rest, fluids and OTC meds.****