ADMISSIONS PACKET

Applicant Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

E-mail Address: _____

Social Security Number or Government ID: _____

Birth Date: _____ Birth Place: _____

Religious Preference (optional):_____ Languages spoken:_____

Height_____ Weight_____ Eye Color_____ Hair Color_____ Hair length_____

Any identifying marks, tattoos, scars, etc

Parents Information

Father _____ Mother: _____

Address: _____ Address: _____

E-Mail Address: _____ E-mail Address: _____

Phone (best): _____ Phone best: _____

Step Parent: _____ Step Parent _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

For office use only:

Date Received:	*Date of Enrollment:*

To Be Completed by Parent or Guardian

Please describe primary reason for enrollment:

Describe the client's primary strengths:

Client's Areas of interest/major accomplishments

What challenges has the client overcome?

To be Completed by Client

Please describe primary reason for enrollment:

Describe your primary strengths:

Areas of interest/major accomplishments

What challenges have you overcome?

Describe your relationship with the following:

Father:

Mother:

Siblings:

Extended Family:

Friends:

Teachers/Employers:

Educational History

Current Academic Status:_____

Highest Grade Level Achieved:_____

Please describe the following:
Academic/Vocational Goals:

Academic/Vocational Accomplishments:

Academic Challenges/Dislikes:

Describe your overall experience with your academic history:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐M ☐F	**DOB:**
Marital status: ◯Single ◯Partnered ◯Married ◯Separated ◯Divorced ◯Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐Polio		
Immunizations and dates:	☐Tetanus	☐Pneumonia
	☐Hepatitis	☐Chickenpox
	☐Influenza	☐MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Please describe any recreational or street drug usage:				

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Please check any of the following that you have experienced in the last 90 days:

- ☐ Headaches
- ☐ Palpations
- ☐ Bowel Disturbances
- ☐ Anger
- ☐ Nightmares
- ☐ Can't Make Friends
- ☐ Memory Problems
- ☐ Lonely
- ☐ Excessive Sweating
- ☐ Lack of Motivation
- ☐ Conflict
- ☐ Can't make a decision
- ☐ Cry Frequently
- ☐ Unable to enjoy self
- ☐ Dizziness
- ☐ Sleep Walking
- ☐ Tension
- ☐ Depressed
- ☐ Unable to relax
- ☐ Over ambitious
- ☐ Inferiority feelings
- ☐ Sexual problems
- ☐ Shy
- ☐ Can't keep a job
- ☐ Financial Problems
- ☐ Stomach Trouble
- ☐ Fatigue
- ☐ Taking Sedatives
- ☐ Panic Attacks
- ☐ Lethargic
- ☐ Suicidal Ideas
- ☐ Alcoholism
- ☐ Tremors
- ☐ Take drugs
- ☐ Allergies
- ☐ Concentration Difficulties
- ☐ Physical Pain
- ☐ Fainting Spells
- ☐ Anxiety
- ☐ No appetite
- ☐ Difficulty Sleeping

Please describe in detail on below items you have checked.

Are there any other factors that are significantly impacting your current situation? (ie: finances, friends, legal etc)

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Have you ever had a psychological evaluation and if so, please include a copy.

Please list all prior out of home placements including special purpose boarding school, wilderness program, substance abuse treatment programs, psychiatric hospitalizations, residential treatment centers and provide discharge summaries from each:

Name of School/Program: Date of Placement:

Reasons for Admissions:

Departure Circumstances:

Name of School/Program: Date of Placement

Reason for Admissions:

Departure Circumstances:

Contract, Medical Authorization, Release, and Consent Agreements

_____ ___/____/_____ _____ _____ _____
Print full name of participant Date of Birth Social Security Number

CONSENT TO PARTICIPATE

I hereby consent participation as a student in all activities conducted as part of Q&A Associates, Inc. I understand that the program is experiential in nature and that the learning and personal growth process may be physically, and emotionally challenging to me I do hereby release Q&A Associates, Inc., its principals, directors, officers, employees, agents, and faculty, from any and all liability arising from injury or damages of any kind to my child's property or person arising out of his or her participation in all facets of the Q&A Associates, Inc.

CONSENT TO EXAM AND TREAT

I hereby authorize medical personnel contacted by the staff of Q&A Associates, Inc. and under the general or special supervision of a physician licensed under the provisions of the Medical Practice Act, to provide or conduct, upon the advice of the supervising physician, such medical procedures, as they deem appropriate to diagnose or treat me. This may include physical examination, X-ray examination, anesthetic, inoculation, immunization, vaccination, medical or surgical diagnoses or treatment, or hospital care, psychiatric evaluation, observation or treatment, psychological evaluation, testing or treatment. I further hereby authorize and consent to X-ray examination, anesthetic, dental or surgical diagnoses or treatment, or hospital care to be rendered to me as needed, by a dentist licensed under the provisions of the Dental Practice Act. I agree to pay all fees and costs to anyone rendering emergency medical or dental care to me.

PROCEDURES AND POLICIES FOR SAFETY AND WELL BEING

Search and Seizure: I hereby authorize the duly trained, designated, and supervised personnel of Q&A Associates, Inc. to search my person or personal effects for the sole purpose of discovering and taking possession of any substances, items or things that Q&A Associates, Inc. considers, in its absolute discretion, to be dangerous or not in compliance with policies, rules and procedures including also prescription, over the counter, or illicit medications, drugs, or substances. Physician prescribed medications shall remain in my possession. I understand that all confiscated materials may be held and turned over to me or they will be disposed of or destroy.

UNAUTHORIZED DEPARTURES FROM PROGRAM

I release Q&A Associates, Inc. and its staff from any liability arising out of my leaving the program. I agree to pay all costs incurred by Q&A Associates, Inc. in returning me to a safe location. I further understand there will be no refund made should I decide to depart the program.

AGREEMENT TO ARBITRATE ALL DISPUTES

Q&A Associates, Inc. and the participant agree that any claim of any nature and description arising out of or connected in any way with my participation in the program, activity, mentoring, or lodging, or with any other matter arising from me and agreements with Q&A Associates, Inc., will be resolved by arbitration in accordance with the rules and procedures of the American Arbitration Association at its McLean, Virginia office. Questions regarding the scope of this Arbitration Agreement will be resolved by arbitration in accordance with the rules and procedures of the American Arbitration Association at its McLean, Virginia office. Any judgment on the findings or award rendered by the arbitrator may be entered in any court having jurisdiction. By entering into this agreement Q&A Associates, Inc. and the Participant each relinquish their right to have any such dispute decided in a court of law and further agree to waive their right to have a jury rule on any dispute. Instead, all parties accept the use of arbitration as an economical and expeditious way of resolving any such dispute.

HIGH-ADVENTURE ACTIVITIES

I understand that I am likely to participate in the following high-adventure type activities that may be consider risky such as rock climbing, repelling, rafting, kayaking, cross-country skiing, downhill skiing, sledding, tubing, swimming, etc. Some of these may have extra fees involved and you will be responsible for the fee in the event you chose to participate in non-included activities.

Signature Participant _____ **Date** ____/____/____

RELEASE OF INFORMATION

The following individuals, Medical Doctors, Dentists, Psychologists, Psychiatrists, Counselors, Therapists, Teachers, Coaches, Educational Consultant, Admissions Officer, or representatives of institutions who have treated, counseled, educated, or evaluated me do hereby authorize to release all information, medical history, treatment history, diagnoses, results of psychological, psychiatric, and educational evaluations, or academic records or transcripts to Q&A Associates, Inc. Staff or consultants who will be involved in my program. I do hereby authorize the staff of e Q&A Associates, Inc. to release information regarding me to any one listed below. These individuals may have worked with me, in the capacity indicated, prior to my enrollment in Q&A Associates, Inc., may be associated with a school or program to which I might apply or re-apply after completion of the Q&A Associates, Inc. A fax or photocopy of this agreement shall be deemed as effective as the original.

Name _____ Role_____

Phone: _____ Address: _____

Name _____ Role _____

Phone: _____ Address: _____

Name _____ Role _____

Phone: _____ Address: _____

These Authorization, Release, and Consent Agreements are entered into effective ____/____/____(date) by and between Q&A Associates, Inc. and_____ the Participant, attending Q&A Associates, Inc. These agreements shall remain in effect for the entire period of my participation. I have carefully read and understood all terms of these agreements and by signing I execute them voluntarily. I further agree to accept full financial responsibility for any medical costs or fees charged by any licensed medical doctor or medical institution providing medical services to me.

Signature of Participant_____ **Date** __/__/____

_____

Printed Name

Cell Phone Number_____ Emergency Phone Number_____

Address _____

Social Security Number _____

Date_____

Medical Insurance Company: _____

Policy #_____ Group # _____

(PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARDS)