



**MAIN PLACE YOUTH  
TEEN CHALLENGE**

1111 N. Main St.  
Kingman, KS 67068  
(620) 532-2681 Phone (620) 532-3221 Fax  
*email: bryan@mainplaceyouth.org*

**APPLICATION FOR ADMISSION**

**Student Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ S.S.# \_\_\_\_\_ Race: \_\_\_\_\_  
Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

**Parent/Guardian Information:**

If applicable, who has primary custody: \_\_\_\_\_

Name of mother: \_\_\_\_\_  
(Stepfather if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home telephone: \_\_\_\_\_  
Work telephone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Fax number: \_\_\_\_\_  
E-mail address: \_\_\_\_\_

Name of father: \_\_\_\_\_  
(Stepmother if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home telephone: \_\_\_\_\_  
Work telephone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Fax number: \_\_\_\_\_  
E-mail address: \_\_\_\_\_

**Emergency Information** (other than parent/guardian listed on page 1):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home telephone: \_\_\_\_\_ Work telephone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ Email address: \_\_\_\_\_

**Family History:**

Mother's Occupation: \_\_\_\_\_  
Mother's Employer: \_\_\_\_\_  
Stepfather's Occupation: \_\_\_\_\_  
Stepfather's Employer: \_\_\_\_\_  
Father's Occupation: \_\_\_\_\_  
Father's Employer: \_\_\_\_\_  
Stepmother's Occupation: \_\_\_\_\_  
Stepmother's Employer: \_\_\_\_\_

List brothers and sisters:

Name	Relationship	Age	Live at home? Y or N
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe fully and specifically the behavior(s) and reason(s) that lead you to want to place your daughter at Main Place Youth: (Use an additional sheet if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did these activities start occurring? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comment on any factors that may have influenced these problems with your child. Please be specific and frank: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have been divorced, please describe the dynamics that may have had an impact on your child:

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If you have been divorced, please describe your daughter's relationship with her step family:

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If you are married, what is the condition of your marriage? \_\_\_\_\_

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Has she ever accused anyone or been accused herself of any type of abuse? Yes

If yes, who, when and what was done about it: \_\_\_\_\_

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Have either parent undergone any psychiatric treatment or psychological counseling? Yes

If so, which parent(s) \_\_\_\_\_

Dates: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment results: \_\_\_\_\_

Have any of your other children undergone any psychiatric treatment/psychological counseling? Yes

If so, who? \_\_\_\_\_

Dates: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment results: \_\_\_\_\_

Will she be restricted from communication or visitation with a family or step family member? Yes

If so, please describe relevant particulars and provide the appropriate documentation: \_\_\_\_\_

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In your opinion, is your daughter suicidal? Yes

Describe any suicide threats or attempts (what happened and when): \_\_\_\_\_

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If police or other authorities were involved, what was the result and include any reports or findings:

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Has she ever self harmed? yes no If yes, please describe the circumstances in detail, the number of times it has happened, the date(s) it has occurred and include any police or hospital reports and/or necessary medical treatment that was required: (Use an additional sheet if necessary)

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Has she ever affiliated herself with the occult or witchcraft? yes no

If yes, describe her activity and when it began: \_\_\_\_\_

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In the last three years has there been any major transitions in her life such as a death of a close family member or friend, moving, puberty, or a major relationship breakup that was a significant crisis for her?

If yes, please explain: \_\_\_\_\_

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List 3 or more goals you have pertaining to your daughter's treatment at Main Place Youth:

- 1) \_\_\_\_\_
  - 2) \_\_\_\_\_
  - 3) \_\_\_\_\_
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What are your plans for your daughter if she is dismissed or leaves Main Place Youth?

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## TREATMENT HISTORY

*Please list any types of treatment that the applicant has been involved with including but not limited to previous programs, counselors/psychologists, psychiatrists, hospitalizations, etc.*

Agency or Program: \_\_\_\_\_

Physician, Counselor or Contact: \_\_\_\_\_

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

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Type of Treatment (choose one):

<input type="checkbox"/> In-patient	<input type="checkbox"/> Individual Counseling
<input type="checkbox"/> Out-patient	<input type="checkbox"/> Residential Placement
<input type="checkbox"/> Rehab	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Group Counseling	

Date and length of treatment: \_\_\_\_\_

Medications prescribed: \_\_\_\_\_

Treatment outcome: \_\_\_\_\_

Agency or Program: \_\_\_\_\_

Physician, Counselor or Contact: \_\_\_\_\_

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

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Type of Treatment (choose one):

<input type="checkbox"/> In-patient	<input type="checkbox"/> Individual Counseling
<input type="checkbox"/> Out-patient	<input type="checkbox"/> Residential Placement
<input type="checkbox"/> Rehab	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Group Counseling	

Date and length of treatment: \_\_\_\_\_

Medications prescribed: \_\_\_\_\_

Treatment outcome: \_\_\_\_\_

**(COPY THIS PAGE AS NEEDED)**

## STUDENT PROFILE

Please indicate all that apply with an O, M, or S for occasional, moderate, or severe.

Substance abuse: \_\_\_\_\_ Drugs \_\_\_\_\_ Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_ Pornography  
\_\_\_\_\_ Other: \_\_\_\_\_

Please give some background on her substance abuse such as types/names and duration of usage:

\_\_\_\_\_

\_\_\_\_\_

Family conflicts with: \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Stepparent(s): \_\_\_\_\_  
\_\_\_\_\_ Siblings: \_\_\_\_\_ \_\_\_\_\_ Grandparent(s): \_\_\_\_\_

Excessive attention seeking:

\_\_\_\_\_ Demands center of attention with: speech, dress, behavior, appearance

\_\_\_\_\_ Sexually seductive \_\_\_\_\_ Other: \_\_\_\_\_

Self-destructive: \_\_\_\_\_ Self harm (please indicate how) \_\_\_\_\_  
\_\_\_\_\_ Suicide attempts \_\_\_\_\_ Suicide threats \_\_\_\_\_ Other: \_\_\_\_\_

Behavior problems:

\_\_\_\_\_ Loses temper, throws temper tantrums, or destructive

\_\_\_\_\_ Argumentative or refuses to comply with adult's requests

\_\_\_\_\_ Blames others, or circumstances for mistakes or misbehavior

\_\_\_\_\_ Deliberately annoys others \_\_\_\_\_ Often angry

\_\_\_\_\_ Manipulative or demanding \_\_\_\_\_ Resentful or spiteful

\_\_\_\_\_ Unforgiving or holds grudges \_\_\_\_\_ Proudful or feels invincible

\_\_\_\_\_ Sneaky, secretive, or walled off \_\_\_\_\_ Profanity

Depression: \_\_\_\_\_ Mild \_\_\_\_\_ Major \_\_\_\_\_ Long-term

Negative self-image:

\_\_\_\_\_ Expresses hopelessness, lack of future, no one loves or likes her

\_\_\_\_\_ No expectations of making friends

\_\_\_\_\_ Lack of self-worth or self identity

Attention deficit: \_\_\_\_\_ Inattentive \_\_\_\_\_ Hyper \_\_\_\_\_ Impulsive

Aggressive behavior: \_\_\_\_\_ Bullies, threatens, intimidates: verbally, physically, emotionally, or cyber

\_\_\_\_\_ Violates rights of others: (how/why) \_\_\_\_\_

\_\_\_\_\_ Fighting

Runs away:

\_\_\_\_\_ Incidental - short periods, stays with known friends

\_\_\_\_\_ Chronic - gone for long periods, associates with persons involved with deviant behavior

Eating Disorders: \_\_\_\_\_ Anorexia \_\_\_\_\_ Bulimia \_\_\_\_\_ Binge Eating

**Student Profile Continued:**

**Please indicate all that apply with an O, M, or S for occasional, moderate, or severe.**

Promiscuity:  Infrequent, casual  Long history  Many different partners  
 Same Sex  Large age gap  Other: \_\_\_\_\_  
 Experimentation or close friendships with those who have same sex attractions

Has the applicant ever been pregnant before?  If yes, what was the result of the pregnancy:  
\_\_\_\_\_

Does she or has she ever had any STD's or communicable diseases?  If yes, please explain:  
\_\_\_\_\_

Is your daughter currently on birth control?  Yes  No

Abuse victim:  Verbal  emotional  neglect  physical  sexual (molestation or rape)

Reliability:  Not trustworthy  Steals or hides items

Other (please describe): \_\_\_\_\_  
\_\_\_\_\_

**Legal History:**

Has your daughter ever been arrested or investigated by law enforcement or have a police record?  
 If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is your daughter on probation?  yes  no  
Probation officer's name: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Has the applicant or any other member of your family been involved/supervised by a social service agency such as Dept. of Children & Families?  If yes, please explain:  
\_\_\_\_\_

**Academic History:**

School Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Last grade completed: \_\_\_\_\_  
Reading skills level:  good  average  poor  
Writing skills level:  good  average  poor

Has she ever been expelled?  If yes please explain: \_\_\_\_\_

**Academic History Continued:**

Does she have a learning disability of any kind, or has she been placed in any special education programs? If so, or if she is more than one grade behind in school, please explain what sort of problem and provide copies of school counseling reports or school psychological information you may have.

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Does she have an educational or behavioral IEP or a 503 plan? \_\_\_\_\_ If yes, please explain:

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What are you expectations regarding her grades: A's & B's / B's & C's / C's & D's

**Spiritual History:** Other: \_\_\_\_\_

In your understanding, what is a Christian? \_\_\_\_\_

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Are you a Christian?  
Why or why not? \_\_\_\_\_

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Is there anyone who is not a Christian in your home? \_\_\_\_\_

Has your daughter been raised to be a Christian? \_\_\_\_\_

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From your perspective, is your daughter a Christian?  
Why do you feel this way about your daughter's faith? \_\_\_\_\_

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Has your daughter previously been water baptized? \_\_\_\_\_

Name of the church you last regularly attended: \_\_\_\_\_

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

Phone number: \_\_\_\_\_

Name of the Pastor: \_\_\_\_\_ Denomination: \_\_\_\_\_

Any other major influences upon her spiritually be it a family member, teacher, pastor, or friend?

Name	Relationship	Age	Positive Impact?	Negative Impact?
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**Medical History:**

*Does she have or has she had any of the following (please check all the at apply):*

- Allergies: Please list all types (food, meds, animal, seasonal, etc.) \_\_\_\_\_
- Asthma or respiratory related issues: \_\_\_\_\_
- Digestive related issues: \_\_\_\_\_
- Auditory related issues: \_\_\_\_\_
- Visual related issues including glasses/contacts: \_\_\_\_\_
- Last eye appointment date and doctor's name: \_\_\_\_\_
- Dental related issues including braces: \_\_\_\_\_
- Last dental/ortho appointment date and doctor's name: \_\_\_\_\_
- Other: \_\_\_\_\_

Is she taking any prescriptions for anything?  If so, please give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is she taking any OTC medicines, vitamins, homeopathics, herbal medicines, or supplements?  
\_\_\_\_\_

Does your daughter have any physical limitations that would hinder her from participating in rigorous exercise or recreational activities?  If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Is the applicant currently undergoing medical treatment?  If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Is she on a special diet?  If yes, was this prescribed by a doctor?  
Doctor's name and phone number: \_\_\_\_\_  
Reason: \_\_\_\_\_

Has she been diagnosed with an eating disorder, or treated for one by a physician?  If yes:  
Doctor's name and phone number: \_\_\_\_\_  
Reason: \_\_\_\_\_

List all past surgeries or hospitalizations (include dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide any other pertinent information: \_\_\_\_\_  
\_\_\_\_\_

**MAIN PLACE YOUTH**  
**Insurance Information (not usable for tuition payments)**

**Student's Full Name:** \_\_\_\_\_

S.S.#: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

**Student's Current Address:** \_\_\_\_\_  
\_\_\_\_\_

**Person Providing Insurance:** \_\_\_\_\_

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

D.O.B.: \_\_\_\_\_

S.S.#: \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_

Policy Number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

**Billing Address for Insurance Company:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone#: \_\_\_\_\_

**Insurance Coverage Includes:**     Medical  
    Dental  
    Optometrist  
    Mental Health

**IMPORTANT INFORMATION FOR PARENT/GUARDIAN:**

**Prior to enrollment: Please contact your Insurance Company (i.e. medical, dental, etc.) to establish Providers in the Kingman, KS area. For prescriptions, please call Kingman Drug at (620) 532-5113 with a Visa or M/C to set up an account. Main Place Youth will not be responsible for making these changes.**

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