Appalachian Teen Challenge, Inc.
Training Center

Student Medical Exams and History Questionnaire: CONFIDENTIAL

The applicant and his or her doctor shall complete these forms. *On page 2*, there is information for the doctor to complete and sign. Please have your doctor sign and return with your test results. Also, be sure to fill out and sign the **"Release of Information"** on the bottom of the page. –**THIS IS A MUST, OR YOUR APPLICATION WILL BE RETURNED TO YOU FOR A DOCTOR'S SIGNATURE.**

1. Please read carefully the following instructions.
2. The enclosed questionnaire provides Teen Challenge with a student's health, medical, psychological, and substance abuse history.
3. Copies of the results of the following examination and/or lab test items checked below shall be completed and mailed to: **Appalachian Teen Challenge, Inc., PO Box 980, Athens, WV 24712.** ***(Test results must be current.)***

   [X] Physical examination to rule out contagious diseases or significant mental or physical impairment—similar to a sports physical—**(*use Doctor's forms*)**;

   [X] Tuberculosis test: **PPD** or chest x-ray or other tests as recommended by doctor;

   [X] Pregnancy test (female applicants only);

   [X] Genital exam—***if indicated*** for sexual transmitted diseases;

   [X] HIV test;

   [X] Hepatitis Panel—Complete (includes A, B, and C screening lab test); and,

   [X] If you will be taking a particular medication while in the Teen Challenge program, please make sure the attending physician has sufficient information to verify it and state the prescribed medication and dosage on page 2. ***This is a must*** or you may not be allowed to take the medication.
4. Non-prescription Items—Students are permitted to bring non-prescription items into the program or receive them from outside the program (aspirin, etc.) if, and only if, they are enclosed in the manufacturer's original package and the wrapping seal is unbroken—***NO EXCEPTIONS***.

RELEASE OF INFORMATION AUTHORIZATION

I, (please print name) ____, authorize the above listed tests to be completed and the results and information sent to: Appalachian Teen Challenge, Inc., PO Box 980, Athens, WV 24712.

____

Applicant's signature | Applicant's printed name | Date

Witness Information: (This authorization must be witnessed. The witness must be at least 18 years of age.)

____

Street | City | State | Zip | Relationship to applicant

____

Witness' signature | Witness' printed name | Date

PHYSICIAN TO SIGN

Upon examination of the prospective student named herein, I find him or her to be:

Physically: [ ]Good [ ]Average [ ]Poor

Mentally: [ ]Good [ ]Average [ ]Poor

Emotionally: [ ]Good [ ]Average [ ]Poor

In my opinion this person is physically, mentally, and emotionally capable to participate in a long-term residential program involving classroom and work experience, taking on responsibilities and strict discipline to help produce a self-disciplined lifestyle. **If No**, or **if restrictions apply**, please use the space below to explain:

____

____

____

____

____

____

MEDICATION AUTHORIZATION BY PHYSICIAN

I also verify that the following medication/s are prescribed and needed for his well-being (if applicable):

Medication to be taken	**Reason to be taken**
1.________________________________	________________________________
2.________________________________	________________________________
3.________________________________	________________________________
4.________________________________	________________________________
5.________________________________	________________________________

By my signature below, the above-mentioned medication (if applicable) is not habit forming and this information is true to the best of my knowledge, as determined by the information provided by the prospective student.

Physician's name (print):____

Phone number: (___)________________ Fax number: (___)__________________

Address:____

Street City State Zip

____

Physician's signature Date

Please return this and all test results and information to:

Appalachian Teen Challenge, Inc.—PO Box 980, Athens, WV 24712

PERSONAL DATA AND INFORMATION

Applicant Name:____
Last First Middle Initial

Sex: [ ]Male [ ]Female Date of Birth ___/___/___ Age____ Height_______ Weight_______

Married: [ ]Yes [ ]No How Long? _________ Nationality______________________________

BLOOD TYPE:__________

1. List your present physician's name____

   Phone Number: (___)____________________

   Address:____
   Street City State Zip

2. If you entered our program, what provisions would be made for the following expenses? (please indicate)

   Medical:____

   Dental:____

IN CASE OF EMERGENCY NOTIFY:

Name________________________________ Relationship__________________________

Address____
Street City State Zip

Phone number: Home (___)______________________ Work (___)______________________

FOR WOMEN ONLY

1. Age at time of first period: _____ Days between periods: _____ Length of period: _____
2. Flow (please check appropriate box): [ ]Heavy [ ]Average [ ]Slight
3. Any bleeding between periods (please explain)? ________________________________

   ____

   ____

   ____

   ____

   ____

   (Use the back of this page if additional space is required.)

4. Do you have normal menstrual cycles? [ ]Yes [ ]No If No, please explain: ___________

   ____

   ____

(Use the back of this page if additional space is required.)

FOR WOMEN ONLY (continued)

5. When was your last pelvic exam? ________________ Were there any adverse findings? [ ]Yes [ ]No

   If Yes, please explain: ____

   ____

   ____

   (Use the back of this page if additional space is required.)

6. List number of pregnancies: _____ Number full-term: _____ Number of miscarriages: _____

7. Have you ever experienced any of the following problems?

   Abortions: [ ]Yes [ ]No If Yes, please explain: ________________________________

   ____

   ____

   ____

   (Use the back of this page if additional space is required.)

   Miscarriages: [ ]Yes [ ]No If Yes, please explain: ________________________________

   ____

   ____

   (Use the back of this page if additional space is required.)

   Other problems (please specify): ____

   ____

   ____

8. Menopause (change of life): [ ]Yes [ ]No When?________ If yes, please explain in detail, including treatment received for problem: ________________________________

   ____

   ____

   ____

   (Use back of this page if additional space is required)

9. Do you think you are pregnant now? [ ]No [ ]Yes [ ]Maybe If Yes or Maybe, please explain why you think so: ____

   ____

   ____

   (Use back of this page if additional space is required)

10. Have you ever experienced an eating disorder, for example anorexia, bulimia, etc.? [ ]Yes [ ]No

    If Yes, please explain in detail, including treatment received for problem: ______________________

    ____

    ____

____

(Use the back of this page if additional space is required.)

MEN AND WOMEN
PERSONAL MEDICAL HISTORY

1. Describe any illness, injury, symptom, or medical care that you are currently experiencing or for which you are being treated. Please give in detail the full explanation of any problems that you are experiencing. **In the event you enroll into Teen Challenge with existing problems that are not listed on this form you will be promptly dismissed from the program.**

   Name of Physician: ______________________ How long? ______________

   Address: ____

   Phone: (   ) ______________

   ____

   ____

   ____

   ____

   (Use the back of this page if additional space is required.)

2. Describe any serious injuries or broken bones: ______________________

   ____

   ____

   ____

   (Use the back of this page if additional space is required.)

3. Describe treatment and/or medicine you are currently receiving for illnesses, injuries, or symptoms noted in items (1) and (2) above:

   ____

   ____

   ____

   ____

   (Use the back of this page if additional space is required.)

4. Please list all medication that you would be required to take while in the Teen Challenge program (Bring medication with you):

   ____

   ____

   ____

   ____

   (Use the back of this page if additional space is required.)

5. Describe any allergies (hay fever, asthma, hives, etc.) or reactions to medication (i.e., novocain, penicillin, aspirin, sulfanilamide, or other antibiotics), foods, bee stings, or other substances:

   ____

   ____

   ____

(Use the back of this page if additional space is required.)

PERSONAL MEDICAL HISTORY (continued)

6. Describe any illness and developmental problem/concern that you experienced as a child:

____

____

____

____

(Use the back of this page if additional space is required.)

7. Do you have epilepsy or seizures? [ ]Yes [ ]No Type: ______________________________

Medication and frequency used? ____

____

____

8. Do you have Diabetes? [ ]Yes [ ]No Medication and frequency used? ________________

____

____

9. List any major operation (start with your most recent operation):

Month/Year	Reason for Operation
____________________	____
____________________	____
____________________	____
____________________	____

(Use the back of this page if additional space is required.)

10. Do you have any special diet requirements or food allergies? [ ]Yes [ ]No If Yes, please explain:

____

____

____

11. When were your eyes last examined? ___________ Results: [ ]Excellent [ ]Good [ ]Fair [ ]Bad

Explain any present problems with your eyes: ______________________________________

____

Do you wear prescription glasses? [ ]Yes [ ]No Are you wearing glasses now? [ ]Yes [ ]No

12. When were your teeth last examined? ___________ Are you currently experiencing problems with your teeth? [ ]Yes [ ]No If Yes, please explain: ______________________________

____

____

13. If you drink coffee/tea or smoke cigarettes, please list the amount that you consume per day:

Coffee: ___________cups consumed per day

Tea: ______________cups consumed per day

Cigarettes: _packs consumed per day

14. How would you rate your present health? [ ]Good [ ]Fair [ ]Poor

Have you ever experienced or presently have a physical ailment, injury, handicap, or medical problem that would prevent you from performing manual work related tasks while enrolled in any Teen Challenge program? [ ] YES [ ] NO

If Yes, please explain: ____

____

____

____

____

____

(Use the back of this page if additional space is required.)

PLEASE CONTINUE ON TO NEXT PAGE

PERSONAL MEDICAL HISTORY (continued)

15. Please check any of the following illnesses or symptoms that you have experienced.

PROVIDE AN EXPLANATION FOR EACH ITEM CHECKED "YES".
PLEASE USE A SEPARATE PIECE OF PAPER.

RESPIRATORY	YES	NO
Coughing blood		
Asthma		
Night Sweats		
Wheezing		

G.I.	YES	NO
Poor appetite		
Nausea		
Vomiting		
Stomach ulcer		
Vomiting blood		
Frequent indigestion		
Stomach pain		
Yellow jaundice		
Gas pain		
Belching		
Diarrhea		
Piles or hemorrhoids		
Constipation		
Black stools		
Intestinal parasites		
Persistent weight gain		
Weight loss		

NEUROMUSCULAR	YES	NO
Arthritis		
Blackout spells		
Convulsions		
Backache		
Fatigue		
Dizziness		
Excessive fatigue		

INTEGUMENTARY	YES	NO
Excessively dry skin		
Excessive sweating		
Frequent rash		
Frequent boils		
Severe itching		

G.U.	YES	NO
Frequent urination		
Excessive thirst		
Blood in urine		
Pus in kidneys		
Frequent urination at night		
Burning during urination		
Loss of control of bladder		
Frequent kidney infections		
Do you strain to urinate		
Kidney stones		

NEUOPSYCHIATRIC	YES	NO
Are you nervous?		
Are you depressed often?		
Do you worry?		
Do you have trouble sleeping?		
Are you excessively sleepy?		

PERSONAL MEDICAL HISTORY (continued)

HEENT	YES	NO	If Yes, note when PAST	PRESENT
Severe or persistent headache				
Blurred vision				
Double vision				
Blindness				
Pain in the eyes				
Red or inflamed eyes				
Watery eyes				
Hearing loss				
Runny ears				
Ringing in ears				
Frequent sneezing				
Hay fever				
Sinus trouble				

Place an "X" and write in age when you had:

PAST HISTORY	YES	NO	AGE
Scarlet fever			
Measles			
Chicken pox			
Mumps			
Whooping cough			
Small pox			
Typhoid fever			
Cancer			
Anemia			
Gonorrhea			
Aids			
Herpes			
Syphilis			
Diphtheria			
Hepatitis			
Tuberculosis			
Pneumonia			
Nervous breakdown			

CARDIAC	YES	NO
High blood pressure		
Low blood pressure		
Severe chest pains		
Racing of heart		
Shortness of breath		
Swelling of ankles		
Leg cramps		
Rheumatic fever		
Heart trouble		

Goiter			

FAMILY MEDICAL HISTORY

1. Please check the appropriate box for any family member that has experienced any of the following problems:

	Grandparent	Father	Mother	Wife	Brother	Sister	Child
Drug Abuse							
Alcoholism/alcohol related problems							
Physical problems							
Mental health problems							

2. Family medical history (List tuberculosis, diabetes, heart disease, asthma, chronic kidney trouble, high blood pressure, etc.) If deceased, write **D** under **Age**.

Relative	Age	Age at Death	Present state of health, or cause of death if deceased
Mother			
Father			
Sisters			
Brothers			

PERSONALITY AND MENTAL HEALTH HISTORY

1. Is it easy for you to express your feelings? [ ]Yes [ ]No [ ]Sometimes

2. Do you enjoy being around people? [ ]Yes [ ]No, Or would you rather be alone? [ ]Yes

3. Has a family member or someone close to you ever attempted suicide? [ ]Yes [ ]No

   If Yes, please explain: ______________________________

   ____

   ____

   ____

(Use the back of this page if additional space is required.)

4. Have you ever thought about committing suicide? [ ]Yes [ ]No

5. Have you ever attempted suicide? [ ]Yes [ ]No If Yes, please explain: ________________

____

____

____

(Use the back of this page if additional space is required.)

PERSONALITY AND MENTAL HEALTH HISTORY (continued)

6. Have you ever received mental health treatment **not related** to drug or alcohol use? [ ]Yes [ ]No
   If Yes, please list:
   a. Date: ________ Name of Clinic: ____________________ Outcome: __________________

      Reason for mental health treatment: ____

   b. Date: ________ Name of Clinic: ____________________ Outcome: __________________

      Reason for mental health treatment: ____

   c. Date: ________ Name of Clinic: ____________________ Outcome: __________________

      Reason for mental health treatment: ____

   d. Date: ________ Name of Clinic: ____________________ Outcome: __________________

      Reason for mental health treatment: ____

   (Use back of this page if additional space is required.)

7. Would you as a student of our program be willing to authorize doctors or agencies involved in previous treatment to release the above mentioned confidential information (6a, 6b, 6c, and 6d) to Teen Challenge? [ ]Yes [ ]No

PLEASE CONTINUE ON TO NEXT PAGE

SUBSTANCE ABUSE AND TREATMENT HISTORY

1. Why did you become involved with (check those that apply)? [ ]Drugs [ ]Alcohol
____
____
____
____
____
____

2. Cost to support substance abuse per day: ______________________________

3. Longest time period clean: ______________________________

4. Method of supporting substance abuse: ______________________________
____
____
____
____

5. Previous occurrence of overdose, withdrawal, or adverse drug reactions:

DRUG USED	REACTION (EXPLAIN)	FINAL OUTCOME	APPROXIMATE DATE

6. Alcohol, drug, and medical counseling (Start with your most recent treatment experience):

Date Admitted & Discharged	Program/Facility	Reason for Leaving

(Use the back of this page if additional space is required.)

SUBSTANCE ABUSE AND TREATMENT HISTORY (continued)

7. Please use the chart below to describe your use of alcohol and drugs. Complete the "YES" and "NO" boxes for each drug listed, and if "YES", answer the remaining questions on that line for that drug.

   When answering the question of ***HOW OFTEN TAKEN**—in the chart below, please use the following symbols:

   1) If taken once, use an **O**. 2) If taken several times, use an **ST**.

   3) If taken regularly, use an **R**. 4) If continually strung-out, use an **SO**.

ALL DRUG TYPES USED: (include street drugs, alcohol, illegal prescriptions, over the counter & other drugs)	**CURRENTLY USING**		**PRESCRIBED BY A PHYSICIAN**		**IF YES, AGE WHEN FIRST USED**	**AGE WHEN LAST USED**	*** HOW OFTEN TAKEN**	**CHECK USUAL METHOD OF ADMINISTRATION**				
	YES	NO	YES	NO				ORAL	SMOKE	SNORT	IM	IV
Alcohol												
Amphetamines/speed (Uppers Benzedrine, Dexedrine, etc.)												
Anti-depressants (Elavil, Sinequan, Triavil, etc.)												
Barbituates/downers (Seconal , Nembutal, etc.)												
Chew-Tobacco												
Cocaine/crank												
Codeine												
Darvon												
Diladud												
Hallucinogens (LSD, Acid, Mescaline, etc.)												
Heroin												
Inhalents (Glue, Paint, Gasoline, etc.)												
Marijuana, hashish												
Methadone—non-legal												
Opiates (Percodan,												

Opium, Morphine, etc.)												
PCP (Angel Dust, etc.)												
Ritalin												
Tobacco-smoking												
Tranquilizers (Thorazine, Mellaril, etc.)												
Valium, Librium												
Other (specify)												

The undersigned student applicant fully acknowledges that the information provided herein is accurate and true to the best of his or her knowledge, and that the application form has been completed and filled out by the student applicant in his or her own handwriting. The student applicant further understands that any false or incomplete information may cause and result in disqualification from admittance into the program, whether a student is just entering into or is already in the program.

____

Student Applicant, signature Student Applicant, printed name Date

IF THIS APPLICATION FORM HAS BEEN COMPLETED OR FILLED OUT BY ANYONE OTHER THAN THE STUDENT APPLICANT, PLEASE PROVIDE THE FOLLOWING:

1. Name of person completing and filling out application form:

   ____

   Other person, signature Other person, printed name Date

2. Relationship to applicant ____

3. Explain why the student applicant was unable to complete or fill out the enclosed application form:

   ____

   ____

   ____

   ____