STUDENT APPLICATION

This application must be completed in its entirety.

Return by Regular Mail, E-Mail or Fax together with the following documentation:

1. **Physician - signed Medical Records Form.**
2. **Copies of all Reports from Mental Health Providers, if any.**
3. **Financial Form**
4. **$50.00 non-refundable Application Fee to:**

New Life
P O Box 149
Canada, Ontario
K0K 1T0
Attention: New Applications
Fax:613.394.0940

APPLICATION FORM

Date of Application: ____

Date available for Trial period/Program entry: ________________________

PERSONAL INFORMATION

Last Name: ____

First Name: ____

Address:

____

____

Date of Birth: ________________________________

Phone number Home: ____

Cell: ____

Email Address: ____

Marital Status: ____

Number of Children: ____

PERSONAL SUMMARY

☐ALCOHOL

☐DRUGS - PRESCRIPTION & STREET

☐SELF HARM

☐SMOKING

☐SEXUAL PROBLEMS

☐LAW BREAKING

☐EATING DISORDER

☐ADD/ADHD

☐PERSONALITY DISORDER

☐PANIC DISORDER

☐COMPULSIVE BEHAVIOUR

☐PHOBIAS

☐FINANCIAL PROBLEMS

☐SUICIDAL

☐BI-POLAR

Health Card #: ________________________ Social Insurance #: ___________________________

Marital status: _____________________________________

Emergency Contact person: _________________________

Relationship to you: ________________________________ Phone # __________________________

Address:

____

____

EDUCATION INFORMATION

Please describe your reading and writing skills:

Reading: ☐Fair ☐ Good ☐ Excellent Writing: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Is English your primary language: ☐ Yes ☐ No

If not what is your primary language: ____

What is the last school year completed?: ____

College or University, (please list diploma or degree received):

____

How would you describe your academic skills? ____

MARRIAGE / PARENTING INFORMATION NOT APPLICABLE ☐

Spouses name: _______________________ Date of marriage: _________________________

Occupation: ____

Address:____

Contact #'s: ____

If divorced or separated please give brief explanation: ______________________________

Do you have children: ☐Yes ☐No

If yes, please provide details:

Name: ____ Age: __________

Name: ____ Age: __________

Name: ____ Age: __________

Who will take care of your children while you are at New Life: ______________________________

Name: ____

Relationship: ____

Phone #: ________________________________

Address: ____

Family History

For the purpose of this application, please consider "family" to be the group of people you were raised with, including any stepparents, half-siblings, adoptive parents and long term foster parents.

Are your parents still alive? Father: ☐Yes ☐No

Mother: ☐Yes ☐No

Are your parents still living together? ☐Yes ☐No

If not, what is the nature of their relationship and where are they living?

____

Did someone other than your natural parents raise you? If yes, whom and why.

____

Do you have brothers and or sisters? ☐Yes ☐No

Brothers: ___________________________ # Sisters: ____________________________

What is your parents' religious affiliation? ____

Do your parents attend church regularly? ______________________________________

Is your family supportive of you coming to New Life? ☐ Yes ☐No

Are any of your family member's currently using/abusing drugs or alcohol? ☐Yes ☐No

Religious Background

Denominational affiliation (if any): ____

How often do you attend church? ____

Do you believe in God? ______________

Do you believe in Jesus? _____________

Do you believe in the Holy Spirit? ______________

Have you surrendered your life to Jesus? _____________ If so, when? ________________

Do you believe the Bible is God's inspired word? __________________________________

Are you now, or have you ever been involved in a cult or the occult? _________________

Please check if you have been involved with or participated in the following:

☐Horoscopes	☐White Magic	☐Astral Projection
☐Black Magic	☐Meditation	☐ESP
☐Witchcraft	☐Ouija Boards	☐Séances
☐Tarot Cards	☐Satanism	☐Other

Background on illegal activity

Have you ever been in jail or prison? If yes, please explain.

____

List all past charges (felonies or misdemeanours). ____________________________________

Do you have any charges pending? If yes, explain. ____________________________________

Are you currently on probation? ____

If yes, please provide the name and contact info of your parole officer.

____

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Girls' Home (Canada)

Abuse History

Where you abused in any way as a child? ______________________________

If yes, please identify who abused you and for how long:

Physically: ____

Sexually: ____

Mentally: ____

Emotionally: ____

Have you ever abused yourself in any way? ____

If yes, how, why and when? ____

Have you ever been abused as an adult? ____

If yes, when, how and by whom? ____

Have you ever raped? ____

If yes, when and by whom? ____

Have you ever participated in same sex activities? ____

If yes, please explain. ____

Have you ever been involved in prostitution? ____

If yes, when and for how long? ____

Drug History

Have you used illegal drugs or prescription drugs illegally? _____________________________________

If yes, when was your first experience with drugs and what did you use? _________________________

Why did you become involved with drugs? ____

Please fill in the chart below:

DRUGS USED	AGE FIRST TRIED	HOW OFTEN USED	USING NOW? Yes/No
ALCOHOL			
MARIJUANA			
BARBITUARATES			
COCAINE			
HEROIN			
LSD			
PCP			
OPIUM			
MORPHINE			
HASHISH			
QUAALUDES			
SOLVENTS			
CIGARETTES			
PRESCRIPTION			
OTHER			

As a result of your substance abuse have you ever experienced any of the following:

Health problems ____________________

Legal problems ______________________

Financial Problems ___________________

Being Abusive _______________________

Difficulty completing tasks __________________

Blackouts, forgetting, difficulty thinking _________

Mood/personality changes, flashbacks __________

Relationship Problems ________________________

Emotional Health

WE REQUIRE COPIES OF ALL REPORTS FROM ALL MENTAL HEALTH PROVIDERS

Do you suffer from or have you even been diagnosed for depression? ________________

If yes, please explain

____

Do any immediate family members have a history of depression? ________________________________

If yes, please explain.

____

Have you ever had a major emotional upset? If yes, when, why and for how long?

____

Did you receive therapy or treatment for it? ____

Where you hospitalised for it? ____

Did you participate in Psychiatric Group Therapy? ____

If yes, did you respond to these treatments? ____

Have you ever been diagnosed with a mental illness? ____

If yes, name of illness. ____

Have you ever been institutionalised? ____

If yes, why, how often and for how long? ____

What institutions were you in? Please give dates. ____

Have you ever tried to commit suicide? ____

If yes, how many times, when and why? ____

Medical History

Doctor's Name: ______________________________ Phone #: _________________________

Address: ____

Do you have any type of medical insurance? If so, please give details: ____________________________

Are you on any type of disability or welfare assistance? ____

What is the date and results of you last medical examination? __________________________________

How would you describe your current physical health? ____

Have you had any recent weight changes? ____

If yes, describe the changes: ____

Height: __________________ Natural Hair colour: ______________________ Eye colour: ________________________

Please list all present/past illnesses, injuries and physical challenges that hinder you from enjoying an average physical lifestyle.

____

How have you been sleeping? ____

How many hours per night (average) have you been sleeping? __________________________________

How is your appetite? ____

Please list all your allergies. ____

When was your last tetanus shot? ____

Have you ever had an abortion? If so, how many, what type and when? __________________________

Have you ever had syphilis, gonorrhea or any other venereal disease? If so, which one (s), when, for how long did you receive medical treatment? ____

When was your last menstrual period? ____

Have you ever had a miscarriage? If yes, when? ____

Have you had a V.D, T.B. or pregnancy test in the past two weeks? If yes, please explain:

____

Please list ALL medication (including vitamins) that you are currently taking, and for what reason?

____
____
____

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Additional Information