

FAMILY INFORMATION

PARENT(S) **BIOLOGICAL** **ADOPTIVE**

Father		Date of Birth	Occupation	
Home Phone Number	Work Phone Number	Cell Phone Number	Involved with Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address				
Email Address	SSN	Highest Grade Completed	Yearly Income	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widower		If Remarried – Spouse Name		Years Married
Spouse's Email Address	Spouse's Work Phone Number	Spouse's Cell Phone Number	Spouse's SSN	
Mother		Date of Birth	Occupation	
Home Phone Number	Work Phone Number	Cell Phone Number	Involved with Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address				
Email Address	SSN	Highest Grade Completed	Yearly Income	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		If Remarried – Spouse Name		Years Married
Spouse's Email Address	Spouse's Work Phone Number	Spouse's Cell Phone Number	Spouse's SSN	

SIBLING(S)

Name	Age	Relationship to Student	Living With?
Name	Age	Relationship to Student	Living With?
Name	Age	Relationship to Student	Living With?
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FAMILY HISTORY

Describe the relationship between your daughter and her biological father –

Describe the relationship between your daughter and her biological mother –

Describe the relationship between your daughter and her step or adoptive father (if applicable)

Describe the relationship between your daughter and her step or adoptive mother (if applicable)

Describe the relationship between your daughter and her siblings –

Describe the history of the marriage or marriage relationship(s) –

If there has been a divorce or separation, describe the history and your daughter's reaction. How old was she?

TREATMENT HISTORY

Has your daughter ever received counseling, psychological or psychiatric services? Yes No

If Yes, list counselor, outpatient therapy, family therapy, acute in-patient hospitalizations, etc.	
Provider Name	Dates
Diagnosis	Discharge Status
Address	
Provider Name	Dates
Diagnosis	Discharge Status
Address	
Provider Name	Dates
Diagnosis	Discharge Status
Address	
Has your daughter had any previous residential placements? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provider Name	Phone Number
Address	
Treatment Dates	
BEHAVIORAL & EMOTIONAL CONCERNS	
Has your daughter been diagnosed with a mental disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain and give diagnosis.	
Has your daughter had any suicide attempts or ideation?	
Please list dates and describe -	
Describe any history of self harm, bizarre or unusual behaviors.	
Describe any depressive features, mood swings, or periods of isolation.	
Describe the way in which your daughter expresses anger.	
Is your daughter insecure or lacking in confidence? Please explain.	
Is your daughter bright but unmotivated? Please explain.	

Describe your daughter's positive traits -
Describe your daughter's weaknesses -
Is your daughter sexually active? Please note any inappropriate behaviors.
Does your daughter have any special needs related to religion, ethnic identity or sexual orientation?
Has your daughter demonstrated aggressive behaviors toward self, others, property, etc.?
Describe any cruelty to animals -
Describe any violence, bizarre activity, gang affiliation, or cult activity -
Describe any run-away history (style, length, where, contact, home, friends, etc.) -
Describe any history of Lying/Stealing -
Describe any eating disorders -
Describe any trauma your daughter has experienced (physical or sexual abuse, rape, violence, etc.)
Describe any delusional thoughts or experiences -
Describe any juvenile/adult judicial history (shoplifting, burglary, curfew violations, court action, etc.)
Does your daughter have any felony convictions or pending felonies? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain.

Is she court-ordered into treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, presiding court / location –	
Probation Officer	Phone Number
Address	
SUBSTANCE ABUSE	
Please indicate frequency and intensity of use of any drugs/alcohol -	
What age did the use begin? When is the last known date of use and description of substance used?	
Under what circumstances or stresses?	
Are there other family members who have drug and alcohol problems? Explain.	
SOCIAL	
How many very close friends does your daughter have?	
Describe your daughter's general social skills (outgoing, less/more mature, mean to friends, socially isolated, etc.)	
Describe your daughter's main peer group –	
Describe a general history of her social life (especially if there have been recent changes) -	
Does your daughter have a history of fighting with peers?	
EDUCATIONAL	
Describe your daughter's school performance in three phases (grades, teacher relationship, classroom behavior)	

Kindergarten through 5 th Grade –	
6 th through 9 th Grade –	
9 th Grade through 12 th Grade–	
College –	Number Completed Hours
Address	Phone Number
Has your daughter ever been suspended / expelled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain –	
Level of functioning (IQ) -	
Favorite Classes –	
Least Favorite Classes –	
Hobbies / Special Interests –	
What do you perceive as your daughter's current academic needs?	
MEDICAL HISTORY	
Physician Name	Phone Number
Address	

Dentist Name		Phone Number
Address		
Has your daughter been treated for any chronic illness, fractures, surgery, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide the following (include dates, physician, diagnosis, medications, etc.)		
Physician		Phone Number
Date(s)	Diagnosis	Medication(s)
Physician		Phone Number
Date(s)	Diagnosis	Medication(s)
Physician		Phone Number
Date(s)	Diagnosis	Medication(s)
Is your daughter currently taking any medication(s) / prescriptions(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please explain (name, prescribing physician, dosage, etc.)		
Does your daughter have any other medical / physical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please explain –		
Does your daughter have / need any of the following?		
Allergies	Sexually Transmitted Disease	
Special Needs (glasses, contacts, hearing aid, braces, etc.)	Hallucinations	
Other	Other	
Has your daughter attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please explain –		
Has your daughter ever had a serious illness or head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please explain –		

Describe your daughter's general health –

Date of last medical exam	Date of last eye exam
Date of last dental exam	Date of last hearing exam
Date of last tetanus inoculation	Date of last menstrual period

Does your daughter have any conditions, which would prevent her from participating in the daily academic program, recreational activities, physical education, etc.? Yes No

If Yes, please explain –

Does your daughter have any special dietary needs? Yes No

If Yes, please explain –

Has your daughter had any of the following?

<input type="checkbox"/> Ear Infection(s)	<input type="checkbox"/> Migraines	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Chronic Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Long-Measles
<input type="checkbox"/> 3-Day Measles	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Polio	<input type="checkbox"/> Mumps
<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Positive PPD	<input type="checkbox"/> Pregnancy(s)	<input type="checkbox"/> Abortion(s)	<input type="checkbox"/> HIV AIDS

Provide information about conditions selected (date(s), physician(s), diagnosis, medication(s), etc.)

PARENT(S) / GUARDIAN(S) EXPECTATIONS

What life goals do you desire in / for your daughter?

Expectations for involvement in our process at Fulshear Ranch Academy?
What is your expectation for your daughter upon discharge from Fulshear Ranch Academy?

HOLD SPOT INFORMATION

A deposit of \$1,000 is required to secure a spot at Fulshear Ranch Academy for your daughter. This is a non-refundable deposit will be credited to your first tuition payment upon enrollment.

<input type="checkbox"/> M/C <input type="checkbox"/> VISA <input type="checkbox"/> AMEX	Credit Card Number	Security Code
Amount Authorized	Billing Address	Billing Zip Code
Name on Card	Signature	Date