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**Student Enrollment Packet**

**Regenesis is at a minimum 9 month residential personal development program. Regenesis is a rigorous working program with 24 hour a day supervision. The counseling at Regenesis is biblically based and the rules and standards are rooted in the Christian faith, The use of nicotine products or psychotropic medications are not permitted at Regenesis.**

**PERSONAL DATA AND INFORMATION**

Name: Inmate # (If applicable): Date:

Address: Detention Facility (If applicable):

City: State: Zip Code:

Sexual Orientation: 🗌Heterosexual 🗌Gay 🗌Lesbian 🗌Bi-Sexual

Telephone:
 Residence Cell Work

Social Security Number: Birth Date: Age:

Do you have a valid driver’s license?  Yes  No  Valid  Expired  Suspended
State: DL Number: Expiration Date:

**NEXT OF KIN/IN CASE OF EMERGENCY**

**1St Person Name**: Relationship:

Address: City: State:

 Zip Code:

Telephone: Cell:

**2nd Person Name:** Relationship:

Address: City: State:

Zip Code:

Telephone: Cell:

**WHO HAS REFERRED YOU TO REGENESIS?**

Name: Relationship:

Address: City: State: Zip Code:

Telephone: Cell:

**PERSONAL FAMILY HISTORY**

***Please list parent/parenting figures, spouse, girl/boyfriend, brothers & sisters (do NOT list your children)***

 **Name Relationship Age Residence**

1.

2.

3.

4.

**PERSONAL & FAMILY MEDICAL HISTORY**

**Do you have or have you ever had any of the following:**

Asthma Back problems Diabetes Epilepsy TBHeart problemsHepatitis VD High Blood Pressure HIVOther

**Please explain if you answered any of the above with a yes answer. If you have any problems not listed above, please explain**:

**Do you have any diet requirement**s?  Yes  No **If yes, please explain:**

**Are you presently taking medication or have open prescriptions? Yes No (List Below)**

|  |  |
| --- | --- |
| Medication | Dosage |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |

**List your present physician’s name:**

Address:

City: State: Zip Code:

Phone:

**MARITAL/INTIMATE RELATIONSHIP HISTORY**

Marital Status: Married Single Engaged Separated Divorced Re-married Widowed

Current spouse (full name):

Address:

City: State: Zip Code:

Telephone:

 Residence Cell Work

**Do you have any children?** Yes  No **If yes, please list below.**

 Name of child Age Where they are living

**SIGNIFICANT LIFE EVENTS**

**Describe any of the follow that you are experiencing or have recently experienced:**

Death:

Sexual abuse/rape:

Physical abuse/neglect:

Other (specify):

**WORK AND EDUCATION HISTORY**

|  |
| --- |
| Circle last year of education completed: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 5+ |
| Describe other training, certificates, and diplomas: |
|  |
|  |
|  |
| **Describe your skill or employment history (what have you done):** |
|  |
| (Cont.) **Describe your skill or employment history (what have you done):** |
|  |

Can you write?  Yes  No  Good Average  Poor

Can you read?  Yes  No  Good  Average  Poor

**PSYCHOLOGICAL HISTORY**

**Have you ever received mental health treatment?** Yes  No **If yes, please list:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Name of Clinic** | **Reason for Mental Health Treatment** | **Outcome** |
|  |  |  |  |
|  |  |  |  |

Have you ever thought about committing suicide?  Yes  No

Are you currently thinking about committing suicide?  Yes  No

Have you ever received psychiatric care?  Yes  No

Have you ever cut yourself?  Yes  No

Have you ever had an eating disorder?  Yes  No

If yes, please explain:

Will you be willing to authorize doctors or agencies involved in previous treatments to release your medical records?

 Yes  No

**SPIRITUAL HISTORY**

Are you born-again? Date: Place:

Are you a member of any church?  Yes  No Denomination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you, your parent or grandparents ever been involved in any occult, cultic, new age or any other non –Christian practices? Yes  No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGAL HISTORY**

Are you legally mandated to participate in a residential program?  Yes  No

If yes, by whom?  Parole Board  Court  Other Explain:

If answer is court, please list County of origin:

Are you currently or will you be under legal supervision?  Yes  No

Method of reporting:  Phone  Letter In person  Other (explain)

How often do you report? How long? Time remaining?

List your probation/parole officer’s name:

Agency: Phone number:

Address:

City: State: Zip Code:

Are you required to attend any classes?

How much do you owe in fees, costs, and restitution?

Are any of the following pending against you? (Please check those that apply)

 Arrest warrant  Court appearance  Criminal charges  Sentencing Other: (explain)

If you have checked any of the above, please explain:

**List all arrests and major convictions other than traffic violations:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Charges** | **ConvictionYes No** | **Sentence** | **Time in Jail** | **Was Alcohol (A) of Drugs (D) Involved?** |
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Please list all upcoming court dates below:

|  |  |
| --- | --- |
| **Court Date** | **Locality/Jurisdiction of Case** |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Attorney Information** |
| Name:  | Phone: |
| Name: | Phone: |
| Name: | Phone: |
| Name: | Phone: |

**FINANCIAL STATUS**

Are you eligible for and/or receiving the following:  Welfare  Disability payments  Unemployment compensation

 Workman’s compensation Other income (please explain)

Have you ever applied for food stamps?  Yes  No Where?

**THE PROBLEM**

What is your main problem, as you see it?

Have you ever been in treatment before? Was it religious or secular (non-religious)?

What are you expecting (believing) God to do in your life through this program?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drug**If you did not use drug listed leave blank. | **First Time**How old were you or what month/year? | **Last Time**Please list approximate date. | **Frequency**How often did you use: occasionally, monthly, weekly, daily, etc. | **Amount Used**How much did you use per day/week/month? |
| Alcohol |  |  |  |  |
| Barbiturates |  |  |  |  |
| Benzodiazepines |  |  |  |  |
| Cocaine/Crack |  |  |  |  |
| Glue/Paint |  |  |  |  |
| Heroin |  |  |  |  |
| Inhalants (Snuffing) |  |  |  |  |
| K2/Spice |  |  |  |  |
| Marijuana |  |  |  |  |
| MDMA (Ecstasy) |  |  |  |  |
| Meth |  |  |  |  |
| Mushrooms |  |  |  |  |
| PCP |  |  |  |  |
| Prescription Drugs |  |  |  |  |
| Speed |  |  |  |  |
| Tobacco |  |  |  |  |
| Other |  |  |  |  |

**\*If the enclosed application form has been completed or filled out by anyone other student applicant, please provide the following:**

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

 (Print Name)

 (Signature) (Date)

2. Relationship to applicant:

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