TEEN CHALLENGE NORTH EAST SCOTLAND
Sunnybrae. Woodhead, Fyvie, Turriff, Aberdeenshire. AB53 8LS

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APPLICATION FORM

(Please print in BLOCK CAPITALS)

FIRST NAME……………………………………………….. MIDDLE NAME……………………………………………………

LAST NAME:………

TELEPHONE NUMBER (Inc. Area Code)………………………………….. Mobile:……………………………………………

PRESENT ADDRESS (Inc. Postal Code)………………………………………………………………………………………

………

DATE OF BIRTH………………………………………………. NATIONALITY…………………………………………………

Contact Information (Eg. Family/Friend/Agency) if not contactable at current address:

CONTACT NAME………

ADDRESS (Inc. Postal Code)………………………………………………………………………………………………

TELEPHONE NUMBER (Inc. Area Code)……………………………………………………………………………………

ACCOMMODATION: Alone ☐ Spouse ☐ Parents ☐ Friends ☐ Other……………………………………………………

DO YOU OWN A HOUSE OR FLAT? No ☐ Yes ☐ ARE YOU A COUNCIL TENANT? No ☐ Yes ☐

MARITAL STATUS: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

ARE YOU CURRENTLY EMPLOYED? No ☐ Yes ☐ If yes, with whom?..

NATIONAL INSURANCE NUMBER……………………………………………….

BENEFITS CURRENTLY RECEIVED (If Any)……………………………………………………………………………

……..

PLEASE GIVE BRIEF SUMMARY OF EMPLOYMENT HISTORY:

……..

……..

……..

……..

……..

GP'S NAME………………………………………………TELEPHONE NUMBER……………………………………………....

ADDRESS:…….
(If you don't have a G.P, put your last Doctor's name and address)

DO YOU SMOKE? No ☐ Yes ☐ If yes, how many per day?...

DO YOU DRINK? No ☐ Yes ☐ If yes, amount per day?........................ Type of Alcohol……………………………..

DO YOU USE DRUGS? No ☐ Yes ☐ If yes, what is your primary drug?...

DAILY AMOUNT…………………………………….. AGE STARTED………….. PRESCRIBED No ☐ Yes ☐

OTHER DRUGS USED: Crystal Methamphetamine ☐ Crack Cocaine ☐ Cannabis ☐ Ecstasy ☐ LSD ☐

Heroin ☐ Methadone ☐ Temazepam ☐ Amphetamines ☐

Other………………………………………………………………………………………

ARE YOU TAKING ANY PRESCRIBED MEDICATION? No ☐ Yes ☐

IF YES, WHAT MEDICATION?...

HAVE YOU RECEIVED ANY PREVIOUS TREATMENT FOR DRUG OR ALCOHOL ABUSE? No ☐ Yes ☐

IF YES, WITH WHOM?..

DO YOU HAVE ANY HEALTH PROBLEMS IN THE FOLLOWING AREAS:

Mobility ☐ Hearing ☐ Visual Impairment ☐

HAVE YOU EVER SEEN A PSYCHIATRIST? No ☐ Yes ☐

HAVE YOU EVER EXPERIENCED MENTAL OR EMOTIONAL HEALH PROBLEMS? No ☐ Yes ☐

IF YES, WHEN?...

NAME OF PSYCHIATRIST OR MENTAL HEALTH PRACTITIONER………………………………………………………

TELEPHONE NUMBER (Inc. Area Code)……………………………………………………………………………………

ADDRESS (Inc. Postal Code)……

………

DO YOU HAVE A CRIMINAL RECORD? No ☐ Yes ☐ Ever been to prison? No ☐ Yes ☐

DO YOU HAVE ANY OUTSTANDING WARRANTS? No ☐ Yes ☐

HAVE YOU EVER BEEN PROSECUTED FOR A VIOLENT OFFENCE? No ☐ Yes ☐

HAVE YOU EVER BEEN PROSECUTED FOR A SEXUAL OFFENCE? No ☐ Yes ☐

HAVE YOU EVER BEEN PROSECUTED FOR ARSON? No ☐ Yes ☐

ARE YOU SUBJECT TO ANY FORM OF STATUTORY SUPERVISION OR PROBATION? No ☐ Yes ☐

ARE YOU PRESENTLY INVOLVED IN A COMMUNITY SERVICE ORDER? No ☐ Yes ☐

References

Please give the name and address of a referee (Excluding Doctor) who has known you for more than six months. Eg. Minister of Religion, Church or Social Worker, Family Member or Friend.

NAME:……………………………………………….. ADDRESS……………………………………………………………..

……………………………………………………………………………. POSTAL CODE………………………………………..

TELEPHONE NUMBER………………………………………. PROFESSION………………………………………………..

Declaration

I have completed this application form truthfully and to the best of my knowledge. I understand that any misleading information could jeopardise my entrance into the programme or my remaining on it.

Print Name……

Signed……

Date………

CONSENT FORM

This information will be kept confidential

In order to make a decision about your admission to Teen Challenge we must contact your G.P. In order for us to do this, we would be grateful if you would complete and sign this consent form.

I,…………………………………………………………………….. Date of Birth………………………

Of (Present Address)…………………………………………………………………………………

……………………………………………………………………… Post Code…………………………

Give my consent for Teen Challenge Staff to obtain written / verbal information from my G.P. For the purpose of assisting in my application assessment for Teen Challenge.

G.P's Name……………………………………… G.P's Address…………………………………………..

………………………………………………………………………… Post Code………………………..

GP's Phone Number……………………………………………………………………………………...

SIGNED………………………………………………………………..

DATE………………………………