



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 HEALTH 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.....**