

NEW HORIZONS YOUTH RANCH
6442 West Kootenai Road – Rexford, Montana – 59930
(406) 889-5995
Student Profile

The following questions are designed to assist us in working most effectively with your son and your family. Please take as much time as needed to complete them in their entirety. Feel free to continue your answers on an additional sheet of paper when needed.

Date: _____

Anticipated Date of Enrollment: _____

Escort Service Needed? No _____ Yes _____ If yes, why? _____

Run Away Risk? No Yes If yes, please explain:

SECTION 1: STUDENT & FAMILY INFORMATION

Students First Name: _____ Middle: _____

Last: _____ Nickname: _____

Age: _____ Grade: _____ Date of Birth: _____

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____

Citizenship: _____ SSN# _____

SECTION 2: STUDENT'S ACADEMIC RECORD

Highest grade completed: _____ Current GPA _____

Name, address of school child is currently or last attended:

School Name: _____

Address: _____

Telephone: _____

What level of school is this? Middle School ___ High School _____

IQ _____ IQ Testing Date: _____

Has your child ever been held back a grade? No ___ Yes ___

If yes, when did this happen and what was the reason? _____

How has this affected your child? _____

Has your child ever skipped a grade? No ___ Yes ___

If yes, when did this happen and what was the reason? _____

How has this affected your child? _____

Is the student behind in academic credits? No ___ Yes ___ How far behind? _____

Is your child on a 504 Plan, or IEP? No ___ Yes ___ If yes, last updated: _____

Expulsions / Suspensions: No ___ Yes ___ When? _____

Why?

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What kind of testing/evaluations has your child had within the last 6 months?

Are these available for review? ? No ____ Yes ____

What learning disabilities, if any, does your child struggle with? _____

When did you first become concerned about your child's school performance? _____

Favorite Subjects: _____

Least favorite subjects: _____

Awards/Honors: _____

Career or College Goals: _____

Interests, Skills, Talents, & Hobbies: _____

SECTION 3: FATHER'S INFORMATION

Name: _____

Social Security # _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Fax: _____ Occupation: _____

Employer: _____

Stepmother's Name: _____ **How long in child's life?** _____

Social Security # _____

Email: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Occupation: _____

Employer: _____

SECTION 4: MOTHER'S INFORMATION

Name: _____

Social Security # _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Fax: _____ Occupation: _____

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Employer: _____

Stepfather's Name: _____ How long in child's life? _____

Social Security # _____

Email: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Occupation: _____

Employer: _____

SECTION 5: LEGAL GUARDIAN'S INFORMATION (If not a parent)

Social Security # _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Work Phone: _____ Cell Phone: _____

Fax: _____ Occupation: _____

Employer: _____

Relationship to Child: _____ How long in child's life? _____

SECTION 6: FAMILY STATUS

Are parents divorced / separated? _____ If yes, when? _____

Are there any special circumstances? _____

Who has legal custody of the child? _____

Who has physical custody of the child? _____

What are the legal custody arrangements? _____

Can the non-custodial parent or other relatives have access to information about the child's treatment? No ___ Yes ___

If yes, please list their name and relationship to child: _____

Special Communication or Visitation Instructions: _____

SECTION 7: REFERRAL INFORMATION

How did you hear about New Horizon Youth Ranch?

Conference _____ Educational Consultant _____ Internet Search _____

Other _____

SECTION 8: OBJECTIVES

What specific event precipitated consideration of enrollment to a program? _____

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What are your specific objectives for your son in a program? (i.e., anger adjustment, living arrangements, school, substance abuse assistance, therapy) _____

SECTION 9: CHILD / PARENT RELATIONSHIP

Describe the relationship of your son to you and other family members.

Relationship with **Father** at home and outside the home:

Relationship with **Mother** at home and outside the home:

Relationship with **Stepfather** at home and outside the home:

Relationship with **Stepmother** at home and outside the home:

Relationship with **Legal Guardian** at home and outside the home:

Describe your son's relationship with his siblings (including half and step siblings)

<u>Name</u>	<u>Age / Sex</u>	<u>Type of Relationship at Home</u>

Additional people living in the home: _____

Any special circumstances? _____

Additional family information (i.e., significant family illnesses or issues) _____

Describe current concerns: _____

Has anyone in your family been incarcerated? No___ Yes___ If yes, please explain:

Have there been any physical confrontations between child and parent? If yes, please give detailed:

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Is your son adopted? No ___ Yes ___ At what age? _____

What this an out of country adoption? No ___ Yes ___ What country? _____

Were there any special circumstances? Explain: _____

Does adoption appear to be an issue? Explain: _____

What information do you have about the birth parents? _____

SECTION 10: EMOTIONAL CONCERNS

Describe any major traumatic changes or events in your child's life (abuse, death, injury, illness, rape, runaway experiences, etc):

Has your child witnessed domestic violence? Yes ___ No ___ If yes, please explain: _____

Have there been any difficult moves to a new home or school? _____

Has your child ever heard voices or seen visual hallucinations? No ___ Yes ___

Describe the circumstances: _____

Has your child ever been hospitalized for psychiatric / psychological reasons and / or been diagnose with a mental disorder (i.e. depression, PTSD, schizophrenia, suicide attempts)? No ___ Yes ___

Diagnosis: _____

Describe circumstances, dates, etc:

Has your child had any suicide attempts or ideation? No ___ Yes ___ Dates: _____

Describe circumstances: _____

Describe any history of bizarre or unusual behavior or self-harm: _____

Describe any depressive features, mood swings or periods of isolation: _____

Describe the way in which your child expresses anger: _____

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Has your child ever held a paid or volunteer job? No___ Yes___ If yes, was it successful? No___ Yes___ Please list who your child worked for, when they held the job, what their responsibilities were and how long the job lasted:

Is your child bright but unmotivated? Explain: _____

Is your child insecure or lacking confidence? Explain: _____

Does your child have any special needs related to ethnic identity, nationality, race, religion or sexual orientation? If yes, please explain: _____

Is it important that your child be able to attend religious services on a regular basis?

Yes___ No___ If yes, please give us some information: _____

SECTION 11: BEHAVIORAL CONCERNS

Describe any problems your son has had in the following areas:

Trouble with the law; include any arrests or convictions? No___ Yes___ If yes, please describe including dates:

Is your child currently on probation? No___ Yes___ If yes, please give the probation officer's name and phone number:

Does your child have any pending court dates? No___ Yes___ If yes, please describe:

Has your child displayed Aggressive or Violent behavior? No___ Yes___ If yes, please describe:

Is your child sexually active? No___ Yes___ If yes, please explain any inappropriate behavior:

Has your child been involved with Arson or other forms of Property Damage? No___ Yes___

If yes, please describe: _____

Cruelty to animals? No___ Yes___ If yes, please describe: _____

Delusional thoughts or experiences? No___ Yes___ If yes, please describe: _____

Eating Disorders? No___ Yes___ If yes, please describe: _____

Excessive and/or inappropriate use of computer/video games, television, telephone.

No___ Yes___ If yes, please describe: _____

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Excessive Lying? No___ Yes___ If yes, please describe: _____

Running away? No___ Yes___ If yes please specify when, where, how long, and whether or not your child contacted you after running away: _____

Stealing? No___ Yes___ If yes, please describe _____

SECTION 12: PEER RELATIONSHIPS

Is your child involved in unhealthy peer relationships? No___ Yes___

Describe your son's friends and social relationships: _____

SECTION 13: SUBSTANCE ABUSE

To your knowledge, does your child smoke cigarettes? No___ Yes___ How often? _____

To your knowledge has your child used or abused drugs and/or alcohol? No___ Yes___

If yes, please describe and indicate frequency of any use of alcoholic beverages or over the counter (OTC) and /or street drugs (cocaine, crystal, huffing, heroine, marijuana, meth, speed) by your child recently or in the past:

If yes, at what age did you know your son was abusing alcohol and drugs? _____

Alone or socially? _____ How often? _____

How much? _____

Are there other family members who have alcohol and/or drug problems? Explain:

Other family history /information that you feel is valuable: _____

SECTION 14: TREATMENT HISTORY - Interventions

Describe all professional and/or personal efforts that have been made to address your son's behavioral, emotional, or substance abuse problems (i.e. hospitalization, outplacement programs, placement programs, local public school programs, therapy, treatment programs, wilderness programs, etc.) Describe the most current treatment first, including addresses and telephone numbers.

Reason: _____

Contact: _____

Address: _____

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City _____ State _____ Phone: _____

Frequency of visits: _____

Duration of treatment: _____

Psychological Testing: Yes ___ No ___ Date last tested: _____ Is copy available for review? Yes ___ No ___

Are you attaching to this Intake now? No ___ Yes ___

Reason for testing: _____

Contact: _____

Address: _____

City _____ State _____ Phone: _____

Frequency of visits: _____

Duration of treatment: _____

Psychological Testing: Yes ___ No ___ Date last tested: _____ Is copy available for review? Yes ___ No ___

Are you attaching to this Intake now? No ___ Yes ___

If there were other interventions, please describe them below:

SECTION 15: MEDICAL HISTORY

Does your child currently have any health problems? No ___ Yes ___

If yes, please describe: _____

Does your child use an inhaler? _____ Type: _____

Please provide the date of the last physical exam and name/phone of that physician:

Please provide the date of the last dental examination: _____

Does your child require corrected vision? No ___ Yes ___ Contacts ___ Glasses ___

Are they required for Reading ___ In the classroom ___ All the time ___

Does your child have any dietary restrictions? No ___ Yes ___ If yes, please describe these restrictions:

Has your son fathered a child? No ___ Yes ___ If yes, what are the current circumstances:

SECTION 16: MEDICATIONS

Is your child taking any medications? No ___ Yes ___ Do you have a current 30 day supply? ___

Name of medication _____ Dosage _____ Purpose _____

Length of time on medication _____

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Name of medication _____ Dosage _____ Purpose _____

Length of time on medication _____

Name of medication _____ Dosage _____ Purpose _____

Length of time on medication _____

Has your child been taking the medication(s) long enough for it to be stabilized? _____

Please explain your child's history with regards to medications (e.g., hordes, irregular resists, sells, etc.) _____

Has your child recently been taken OFF any medications? If yes, please explain types and circumstances: _____

Is your child allergic to any medications? No ___ Yes ___ If yes, please list medications: _____

Please indicate allergic reactions: _____

Are there any potential risks such as dehydration or irregular food intake associated with medications your child is taking, including prolonged exposure to the sun?

No ___ Yes ___ If yes please explain: _____

Are there any physical reasons why your child might have difficulty participating in our program? No ___ Yes ___

If yes, please explain: _____

Is your child current wearing braces or using a retainer? No ___ Yes ___ If yes, what needed follow up will need to be scheduled while in their program? _____

Is your child up to date on all vaccinations? No ___ Yes ___

Please check ALL that apply to your child:

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Alcohol chemical abuse | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back injuries | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Birth defect | |
| <input type="checkbox"/> Bladder/kidney infections | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Bone conditions | <input type="checkbox"/> Bowel problems | |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Coughing | <input type="checkbox"/> Cysts/tumors | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty lifting | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Eating disorder | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eczema | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Fatigue | |
| <input type="checkbox"/> Fetal Alcohol syndrome | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Frequent constipation | | |
| <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Gastro difficulties | <input type="checkbox"/> German measles | |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Heart trouble/disease | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | | |

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- | | | | | | |
|---|---|--|--|--|---------------------------------|
| <input type="checkbox"/> Hives / skin allergies | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Headaches/migraines | | | |
| <input type="checkbox"/> Impulse control disorder | <input type="checkbox"/> Knee or ankle injury | <input type="checkbox"/> Lupus | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Moles | |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Mental condition | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mood disorder | | |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Mumps | <input type="checkbox"/> Muscle weakness | | | |
| <input type="checkbox"/> Neck injuries | <input type="checkbox"/> Neurological condition | <input type="checkbox"/> Obesity | <input type="checkbox"/> OCD | <input type="checkbox"/> ODD | |
| <input type="checkbox"/> Pneumonia/bronchitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Prosthetic devices | <input type="checkbox"/> PTSD | | |
| <input type="checkbox"/> RAD | <input type="checkbox"/> Respiratory condition | <input type="checkbox"/> Rheumatic Fever | | | |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seeing difficulties | <input type="checkbox"/> Seizures | | |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Speech difficulties | | |
| <input type="checkbox"/> STD's | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Sun sensitive | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> TMJ/jaw joint | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Urination problems | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Whooping cough | | |
- Any other health information that is vital for us to know
-
-

If your child is currently using alcohol / drugs, is detoxification needed? No Yes

Immunization records must be received within one week of enrollment. Montana law requires evidence of immunizations or a medical or religious exemption.

Students without proper immunization records must be excluded from school attendance when records are not received within 30 days.

I certify that I/we have completed all of the information to the best of my ability.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date