STRAP, Inc.

Juvenile “At Risk” Intervention Program Application

Procedures, Questionnaire & Application Materials

Mr. Steven H. Cooley – Preside
4/8/2013

Application Procedures

Do NOT use a pencil to complete this application.

In order for an applicant to be considered for the "Pilot" enrollment decision, the application must be complete and accurate.

The following documents MUST be submitted:

- **Questionnaire (3 pages)**
- **Medical History (3 pages)**
- **Application (3 pages)**
- **Birth Certificate (please provide a copy)**
- **Medical Insurance Card (please provide a copy)**
- **Immunization Record (please provide a copy)**

All applications must be mailed or delivered to the U.S. Postal or email address below!

STRAP, LLC

2704 Duluth Highway

Duluth, Ga. 30096

(770)-978-0918

Straplc@att.net

Mail To:

STRAP, LLC

PO Box 1669

Snellville, Ga. 30078

Troubled-Teen Questionnaire

Many times as parents, we wonder whether or not our teenager is in need of help. The following survey is designed to give you an idea of the seriousness of your teenager's level of behavioural problems. Please answer the following questions regarding your teen.

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1. Does your troubled teen fail to complete tasks that require effort regardless of the future importance of the task?
   (e.g. school work)

   Yes ○ No ○

2. Does your troubled teen attempt to negotiate and/or manipulate in order to avoid consequences and problems?

   Yes ○ No ○

3. Does your troubled teen justify negative behaviors by blaming others?

   Yes ○ No ○

4. Is your troubled teen unwilling to recognize the impact of his/her behavior on family and friends?

   Yes ○ No ○

5. Does your troubled teen use manipulation and deception in order to change others' points of view?

   Yes ○ No ○

6. Does your troubled teen have weekly outbursts or mood swings?

   Yes ○ No ○

7. Does your troubled teen avoid participating in family activities and social events?

   Yes ○ No ○

8. Does your troubled teen become impatient or easily agitated with others?

   Yes ○ No ○

9. Does your teen have an intense fear of gaining weight or becoming fat?

   Yes ○ No ○

10. Has there been a recent drop in your teen's performance at school?

    Yes ○ No ○

11. Is it difficult for your teen to relate with others or make friends?

    Yes ○ No ○

12. Does your teen frequently fail to finish schoolwork, projects or chores?

    Yes ○ No ○

13. Does your teen fail to follow through with responsibilities or instructions?

    Yes ○ No ○

14. Is your teen forgetful or often viewed as lazy?

    Yes ○ No ○

15. Does your teen argue with adults and authority figures?

    Yes ○ No ○

16. Is your teen failing one or more courses in school?

    Yes ○ No ○

17. Have your teen undergone therapy and/or counselling without results?

    Yes ○ No ○

18. Does your teen do dangerous things without considering the consequences, "a daredevil"?

Yes ○ No ○

19. Has your teen been physically abusive to animals?

Yes ○ No ○

20. Is your teen extremely self-conscious?

Yes ○ No ○

21. Does your teen appear depressed, sad, tearful or irritable nearly every day?

Yes ○ No ○

22. Has your teen run away from home? (More than twice)

Yes ○ No ○

23. Is your teen sexually active?

Yes ○ No ○

24. Does your teen engage in self-injurious behaviours and/or threaten to inflict self-harm?

Yes ○ No ○

25. Does your teen use illegal drugs and/or alcohol?

Yes ○ No ○

26. Is your teen currently enrolled in school (Middle, High, Alternative, etc.)?

Yes ○ No ○ Grade: _____ School: _____

27. Please provide the name of the school in the box.

Medical History

Applicant Name	Social Security Number	Age	
Height	Weight	Right Handed◯	Left Handed◯
Do you or have you ever had:	Yes	No	If yes, please explain
Household contact with anyone who has tuberculosis	◯	◯	
Tuberculosis or positive TB test	◯	◯	
Blood in saliva or when coughing	◯	◯	
Excessive bleeding after injury or dental work	◯	◯	
Suicide attempt or plans	◯	◯	
Sleeping walking	◯	◯	
Wear corrective lenses	◯	◯	
Eye surgery to correct vision	◯	◯	
Lack vision in either eye	◯	◯	
Wear hearing aid	◯	◯	
Stutter or stammer	◯	◯	
Wear a brace or back support	◯	◯	
Scarlet fever	◯	◯	
Rheumatic fever	◯	◯	
Swollen or painful joints	◯	◯	
Frequent or severe headaches	◯	◯	
Dizziness or fainting spells	◯	◯	
Hearing loss	◯	◯	
STD/syphilis/gonorrhea, etc.	◯	◯	
Recent gain/loss of weight	◯	◯	
Loss of finger/toe	◯	◯	
Bed wetting since age 12	◯	◯	
Kidney stone/blood in urine	◯	◯	
Diabetes or hypoglycemia	◯	◯	
Recurrent ear infections	◯	◯	

Severe tooth or gum trouble	◯	◯	
Shortness of breath	◯	◯	
Chronic cough	◯	◯	
Palpitation or pounding heart	◯	◯	
Heart trouble	◯	◯	
High or low blood pressure	◯	◯	
Frequent cramp in legs	◯	◯	
Frequent indigestion	◯	◯	
Stomach , liver, intestinal trouble	◯	◯	
Gallbladder trouble or gallstones	◯	◯	
Jaundice or hepatitis	◯	◯	
Broken bones	◯	◯	
Skin diseases	◯	◯	
Tumor, grow, cyst or cancer	◯	◯	
Hernia	◯	◯	
Hemorrhoids or rectal disease	◯	◯	
Frequent or painful urination	◯	◯	
Eating disorder	◯	◯	
Thyroid trouble or goiter	◯	◯	
Arthritis, rheumatism or bursitis	◯	◯	
Bone, joint or other deformity	◯	◯	
Painful or “trick” shoulder or elbow	◯	◯	
Recurrent back pain or any back injury	◯	◯	
Trick or locked knee	◯	◯	
Foot trouble	◯	◯	
Nerve injury	◯	◯	
Paralysis	◯	◯	
Epilepsy or seizures	◯	◯	
Car , train or air sickness	◯	◯	
Chronic depression	◯	◯	
Loss of memory or amnesia	◯	◯	
Period of unconsciousness	◯	◯	
X-ray or any radiation therapy	◯	◯	
Chemotherapy	◯	◯	
Sinusitis or hay fever	◯	◯	
Asthma	◯	◯	

Tire easily	◯	◯	
Pain or pressure in chest	◯	◯	
Sensitivity to chemicals, dust, sunlight, etc	◯	◯	
Inability to perform certain motions	◯	◯	
Inability to assume certain positions.	◯	◯	
Have you ever been treated for a mental condition?	◯	◯	
Been advised to have any operations?	◯	◯	
Been a patient in any in any type of hospital?	◯	◯	
Ever had any illness or injury other than those already noted?	◯	◯	
Been exposure to asbestos or toxic chemicals	◯	◯	
Been diagnosed with a learning disability	◯	◯	
Do you used illegal substance	◯	◯	
Do you use tobacco	◯	◯	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete.

Parent or Guardian Signature & Date

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Date: Month _____ Day ____ Year _____	Social Security Number								

Name: _____ GA Resident: Yes € No €

(First) (Middle) (Last)

Mailing Address where you want to receive correspondence concerning your application:

_____

(Street) (Apt or Lot#) (City) (County) (State) (Zip Code)

Home Phone (____)_____ Additional Contact # (_____)_____

Age: _____ Date of Birth: ____/_____/_____ Gender: Male € Female €

MM DD YY

RACE: Black € White € Asian € Hispanic € Native American Other €

List two personal accomplishments:

1. _____
2. _____

Parent or Legal Guardian Mailing Address:

Name: _____ Relationship: _____

(First) (Mid) (Last)

Address:

____

(Street) **(Apt or Lot #)** **(City)** **(State)** **(Zip Code)**

Home Phone: (___)____________________ Work: (___)____________________

E-mail Address: ____

Recommended By (If applicable): ______________________________________

Telephone Number: (______)____________________________

STRAP - Juvenile “At Risk” Intervention Program Application

In 200 words or less, tell us why “I should be accepted into the 20 weeks STRAP – Juvenile Intervention Program.” Please be sure to include in the essay your future plans and goals beyond the program. **Note: The essay must be in the applicant’s handwriting and any attempts of forgery will forfeit the applicant’s chance to participate in the program.**

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I understand the aim and purpose of the STRAP Juvenile Intervention program. All statements made by me in this application have been made with every attempt to be truthful and factual. Currently, I am in good health, drug free, and do not have an alcohol problem. I understand that all STRAP activities will be conducted in a “Smoke Free” facility.

_____ Date: _____
(Applicants Signature)

_____ Date: _____
(Parent or Legal Guardian’s Signature)