



**In order to help TLC's THP get to know and understand you better, please fill out this form as completely and honestly as possible. All information you provide us with is strictly confidential and private; no one outside this agency will be allowed to see any information that you give us except when you say it's okay!**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Cell#: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Gender:**  Male  Female  Transgender  non-Conforming

**Do you identify within the LGBTQI community?**  Yes  No  Decline to state

**Preferred Pronoun:** \_\_\_\_\_

**Race/Ethnicity:**

African American  White  Mexican American  Asian American  Latino

Native American  Other: \_\_\_\_\_

**Do you have children:**  Yes  No How many? \_\_\_\_\_

Child 1 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child 2 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Religious Preference:** \_\_\_\_\_

**Who Referred you to this program:**

Social Worker  ILSP  Probation Officer Other: \_\_\_\_\_

Are you enrolled in ILSP?  Yes  No What day and time do you attend? \_\_\_\_\_

**Current Placement:**

Residential treatment center: \_\_\_\_\_

THPP: \_\_\_\_\_  Foster Home: \_\_\_\_\_

SILP: \_\_\_\_\_  Other: \_\_\_\_\_

**Social Worker / Probation Officer Information:**

Name: \_\_\_\_\_ Phone# \_\_\_\_\_

**County:**

Sonoma  Marin  Mendocino  Alameda  Humboldt  Other: \_\_\_\_\_

## Education

1. Are you enrolled in a High School diploma or GED program?  Yes  No  
 If yes, what school? \_\_\_\_\_  
 How many credits do you need to graduate? \_\_\_\_\_
- If no, have you graduated with a high school diploma or GED?  Yes  No  
 Graduated from: \_\_\_\_\_ Graduation date: \_\_\_\_\_
2. Are you enrolled or currently attending college?  Yes  No  
 If yes, what college? \_\_\_\_\_  
 How many completed units? \_\_\_\_\_
3. Do you have a learning disability?  Yes  No  
 If yes, please explain: \_\_\_\_\_
4. Do you have an IEP?  Yes  No
5. I am interested in the following: (*check all that apply*)  
 Beauty College  Technology  Vocational  Military  Childcare  
 Automotive  Junior College  State/University  Other: \_\_\_\_\_

## Employment

Are you currently working?  Yes  No

Employer Info	Start Date	End Date	Hourly Wage	Full/Part Time	Reason for leaving

Do you have an updated resume?  Yes  No

## **Emancipating Planning**

Do you have a bank account?  Yes  No

If yes, what bank? \_\_\_\_\_

Do you currently have?

California Identification Card	Yes	No
Birth Certificate (not a copy)	Yes	No
Social Security Card	Yes	No
Passport	Yes	No
CA Driving Permit	Yes	No
CA Drivers License	Yes	No
Immunization Record	Yes	No
School Photo Identification	Yes	No

Do you have any reason to suspect that you might have bad credit?  Yes  No

Please explain: \_\_\_\_\_

\_\_\_\_\_

Has anyone ever put bills (phone, PG&E, water, or cable) in your name?  Yes  No

## **Wellness/Health**

Do you have Medi-Cal?  Yes  No

Number: \_\_\_\_\_

Do you have any other insurance?  Yes  No

Name: \_\_\_\_\_ Number: \_\_\_\_\_

Are you experiencing any physical pain?  Yes  No

Are you under a Physicians Care?  Yes  No

When was your last Medical/Doctor's Visit: \_\_\_\_\_

Are you experiencing any dental problems?  Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

When was your last Dental Visit: \_\_\_\_\_

Are you pregnant right now?  Yes  No  Possibly Expectant Due Date: \_\_\_\_\_

Are you currently using any form of birth control?  Yes  No

Have you ever seen a Counselor/Therapist?  Yes  No

How often do you see them?  Daily  Weekly  Monthly

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list all medications (prescriptions) you may have ever taken?

Medication Name	Reason/Purpose	Length Taken
	Physical Health Mental Health Other:	30 days 1-3 months 1-2 years On-going
	Physical Health Mental Health Other:	30 days 1-3 months 1-2 years On-going
	Physical Health Mental Health Other:	30 days 1-3 months 1-2 years On-going

Have you been hospitalized in the last 2 years?  Yes  No

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following questions**

- |   |                                |                                    |                                 |                                |
|---|--------------------------------|------------------------------------|---------------------------------|--------------------------------|
| 1.) I am doing great                          | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 2.) I feel helpless                           | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 3.) I feel angry                              | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 4.) I feel good                               | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 5.) I feel sad                                | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 6.) It feels like things don't go my way      | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 7.) I struggle with depression/anxiety        | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 8.) Medication helps me feel better           | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 9.) I have wanted to hurt myself              | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 10.) I cut myself, to make myself feel better | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 11.) I have felt suicidal                     | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| 12.) I have thought of hurting others         | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |

13.) I get aggressive when people push me to far  Often  Sometimes  Rarely  Never

**Please fill in the following chart**

Substance	On the average, how often have you used this substance in the last 6 months?			
	Never	Once	Daily	Weekly
Alcohol				
Marijuana				
Downers				
Uppers				
Cocaine				
Inhalants				
Psychedelics				
Heroin				
Crystal Meth				
Crack				
Ecstasy				
Cigarettes				
Vape/E-Cig				

Have you ever been in a treatment program for substance abuse?  Yes  No

Name of program and length of stay? \_\_\_\_\_

Have you ever been a survivor of domestic violence?  Yes  No

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have people in your life that you can rely on?  Yes  No

Please explain who: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been arrested?  Yes  No

If yes, what was the reason?

- |   |  |
|---|--|
| <input type="checkbox"/> Drinking alcohol                   | <input type="checkbox"/> Truancy (skipping school)           |
| <input type="checkbox"/> Possession or use of illegal drugs | <input type="checkbox"/> Running away from placement or home |
| <input type="checkbox"/> Theft                              | <input type="checkbox"/> Vandalism                           |
| <input type="checkbox"/> Driving violation                  | <input type="checkbox"/> Curfew violations                   |
| <input type="checkbox"/> Violence (fighting or battery)     | <input type="checkbox"/> Other: _____                        |

Are you currently on probation?

Yes  No

Are you enrolled in any court-mandated programs?

Yes  No

If yes, please list them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any outstanding traffic tickets/violations?

Yes  No

Do you have any unpaid fines and restitutions due to the court?

Yes  No

Please explain why: \_\_\_\_\_

\_\_\_\_\_

### **Nutrition**

1.) Do you have any food allergies?

Yes  No

If yes, what are they? \_\_\_\_\_

2.) Do you require an Epi-Pen for this food allergy?

Yes  No

3.) Have you experienced weight **loss** of 10 pounds or more in the last 3 months?

Yes  No

4.) Have you experienced weight **gain** of 10 pounds or more in the last 3 months?

Yes  No

5.) Have you decreased your food intake, or experienced a lack in appetite?

Yes  No

6.) How many meals per day do you eat? \_\_\_\_\_

7.) Do you currently, or have you ever been diagnosed with an eating disorder?

Yes  No

If yes, when were you diagnosed \_\_\_\_\_

8.) Do you experience eating habits or behaviors that may be indicators of an

Yes  No

eating disorder, such as bingeing or induced vomiting?

### **Personal Effectiveness**

List your top 3 goals

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

Tell us 2 things about yourself, that you are most proud of

1.) \_\_\_\_\_

2.) \_\_\_\_\_

Why do you want to participant in the THP program?

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What areas do you feel you need the most support in?

- Education*    *Counseling*    *Job Training/Skills*    *Time Management*  
 *Employment*    *Cooking*    *Money Management*    *Emancipation Planning*

What skills/strengths do you already have that will make you successful in the THP program?

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Below are the basic program expectations:

- 1.) Attend a school program regularly
- 2.) Meet at least once a week with a THP Social Worker; Transitions Advocate
- 3.) Work or volunteer at least 10 hours per week
- 4.) Comfortable riding the bus

***I have answered the questions to the best of my knowledge and understand that any false or misleading information can hinder my acceptance into the THP program. I understand that if I am accepted into the THP Program, I will be required to meet the basic program expectations.***

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**Program Applicant Signature**

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**Date**