



Student Enrollment Packet

Regenesis is at a minimum 9 month residential personal development program. Regenesis is a rigorous working program with 24 hour a day supervision. The counseling at Regenesis is biblically based and the rules and standards are rooted in the Christian faith, The use of nicotine products or psychotropic medications are not permitted at Regenesis.

PERSONAL DATA AND INFORMATION			
Name:	Inmate # (If applicable):		
Date:			
Address:	Detention Facility (If applicable):		
City:	State:	Zip Code:	
Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bi-Sexual			
Telephone: _____			
Residence	Cell	Work	
Social Security Number:		Birth Date:	Age:
Do you have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Valid <input type="checkbox"/> Expired			
<input type="checkbox"/> Suspended			
State: _____ DL Number: _____ Expiration Date: _____			

NEXT OF KIN/IN CASE OF EMERGENCY			
1st Person Name:		Relationship:	
Address:		City:	State:
Zip Code:			
Telephone:		Cell:	
2nd Person Name:		Relationship:	
Address:		City:	State:
Zip Code:			
Telephone:		Cell:	

WHO HAS REFERRED YOU TO REGENESIS?

Name:	Relationship:		
Address:	City:	State:	Zip
Code:			
Telephone:	Cell:		

PERSONAL FAMILY HISTORY

Please list parent/parenting figures, spouse, girl/boyfriend, brothers & sisters (do NOT list your children)

Name	Relationship	Age	Residence
1.			
2.			
3.			
4.			

PERSONAL & FAMILY MEDICAL HISTORY

Do you have or have you ever had any of the following:

- | | | | | |
|---|--|-----------------------------------|--|-----------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> TB |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> VD | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Other | | | |

Please explain if you answered any of the above with a yes answer. If you have any problems not listed above, please explain: _____

Do you have any diet requirements? Yes No **If yes, please explain:** _____

Are you presently taking medication or have open prescriptions? Yes No (List Below)

Medication	Dosage
1.	
2.	
3.	
4.	

List your present physician's name: _____

WORK AND EDUCATION HISTORY

Circle last year of education completed: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3
4 5+

Describe other training, certificates, and diplomas:

Describe your skill or employment history (what have you done):

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(Cont.) Describe your skill or employment history (what have you done):

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Can you write? Yes No Good Average Poor

Can you read? Yes No Good Average Poor

PSYCHOLOGICAL HISTORY

Have you ever received mental health treatment? Yes No **If yes, please list:**

Date	Name of Clinic	Reason for Mental Health Treatment	Outcome

Have you ever thought about committing suicide? Yes No

Are you currently thinking about committing suicide? Yes No

Have you ever received psychiatric care? Yes No

Have you ever cut yourself? Yes No

Have you ever had an eating disorder? Yes No

If yes, please explain: _____

Will you be willing to authorize doctors or agencies involved in previous treatments to release your medical records?

Yes No

SPIRITUAL HISTORY

Are you born-again? _____ Date: _____ Place: _____

Are you a member of any church? Yes No Denomination

Have you, your parent or grandparents ever been involved in any occult, cultic, new age or any other non-Christian practices? Yes No If yes, explain: _____

LEGAL HISTORY

Are you legally mandated to participate in a residential program? Yes No

If yes, by whom? Parole Board Court Other Explain: _____

If answer is court, please list County of origin: _____

Are you currently or will you be under legal supervision? Yes No

Method of reporting: Phone Letter In person Other (explain) _____

How often do you report? _____ How long? _____ Time remaining? _____

List your probation/parole officer's name: _____

Agency: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Are you required to attend any classes? _____

How much do you owe in fees, costs, and restitution? _____

Are any of the following pending against you? (Please check those that apply)

Arrest warrant Court appearance Criminal charges Sentencing Other: (explain) _____

If you have checked any of the above, please explain: _____

List all arrests and major convictions other than traffic violations:

Date	Charges	Conviction		Sentence	Time in Jail	Was Alcohol (A) of Drugs (D) Involved?
		Yes	No			

Please list all upcoming court dates below:

Court Date	Locality/Jurisdiction of Case

Attorney Information	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Name:	Phone:

FINANCIAL STATUS

Are you eligible for and/or receiving the following: Welfare Disability payments Unemployment compensation

Workman's compensation Other income (please explain) _____

Have you ever applied for food stamps? Yes No Where? _____

THE PROBLEM

What is your main problem, as you see it? _____

Have you ever been in treatment before? _____ Was it religious or secular (non-religious)? _____

What are you expecting (believing) God to do in your life through this program? _____

Drug If you did not use drug listed leave blank.	First Time How old were you or what month/year?	Last Time Please list approximate date.	Frequency How often did you use: occasionally, monthly, weekly, daily, etc.	Amount Used How much did you use per day/week/month?
Alcohol				
Barbiturates				
Benzodiazepines				
Cocaine/Crack				
Glue/Paint				
Heroin				
Inhalants (Snuffing)				
K2/Spice				
Marijuana				
MDMA (Ecstasy)				
Meth				
Mushrooms				
PCP				
Prescription Drugs				
Speed				
Tobacco				
Other				

***If the enclosed application form has been completed or filled out by anyone other student applicant, please provide the following:**

1. Name of person completing and filling out application form: _____
(Print Name)

(Signature) _____ (Date)

2. Relationship to applicant: _____

3. Explain why applicant was unable to complete or fill out the enclosed application form: _____
