PARTICIPANT INFORMATION FORM

Fight 4 Change Inc.

Date of Intake:_____/_____/ _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth:_____/_____/ _____

Primary Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address (if applicable): _____

City: _____ State: _____ Zip Code: _____

Phone #1:_____-_____- _____

- ❑ Home
- ❑ Cell
- ❑ Other _____

Phone #2:_____-_____- _____

- ❑ Home
- ❑ Cell
- ❑ Other _____

Race/Ethnicity (check all that apply):

- ❑ Asian/Pacific Islander
- ❑ African American/Black
- ❑ Hispanic/Latino
- ❑ Native American/American Indian
- ❑ White
- ❑ Other _____

With whom do you live? (Check all that apply)

- ❑ Alone (or with child)
- ❑ Mother/Stepmother
- ❑ Father/Stepfather
- ❑ Other Relatives
- ❑ Child's Father/Mother
- ❑ Parent/Guardian of Child's Father
- ❑ Other Relative of Child's Father
- ❑ Friend
- ❑ Foster Home
- ❑ Group Home or Shelter
- ❑ Other _____

Parent/Legal Guardian Information

First Name:_____Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #1:_____-_____- _____

- ❑ Home
- ❑ Cell
- ❑ Other _____

Phone #2:_____-_____- _____

- ❑ Home
- ❑ Cell
- ❑ Other _____

Emergency Contact Information
Enter if different from Parent/Legal Guardian listed above.

First Name:_____Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #:_____-_____- _____

- ❑ Home
- ❑ Cell
- ❑ Other

Relation to you:

- ❑ Father
- ❑ Sister
- ❑ Grandparent
- ❑ Other relative
- ❑ Non-relative
- ❑ Mother
- ❑ Other guardian
- ❑ Brother

Resources

What services do you currently receive? (Check all that apply)

- ❑ TANF/Work First
- ❑ Food Stamps
- ❑ Unemployment Benefits
- ❑ WIC
- ❑ Day Care Subsidy
- ❑ Mental Health Services
- ❑ Child Protective Services
- ❑ Health Department
- ❑ Drug Treatment
- ❑ Juvenile Services
- ❑ Medicaid
- ❑ Health Choice
- ❑ SSI/SSA
- ❑ Foster Care
- ❑ Child Support
- ❑ Child Services Coordination (CSC)
- ❑ Resources from Church
- ❑ Public Housing
- ❑ After School Program
- ❑ Other _____
- ❑ None
- ❑ Not Sure

What assistance or services do you need? (Check all that apply)

- ❑ Care package
- ❑ Personal trainer
- ❑ Mentoring/counseling
- ❑ Weight management/dieting
- ❑ Job Preparation
- ❑ Academic Support
- ❑ Strength and conditioning for sports
- ❑ Transportation
- ❑ Self defense/bully prevention
- ❑ Financial Assistance
- ❑ Community service hours
- ❑ Loaner laptop
- ❑ Other _____
- ❑ Other _____

Education

What type of educational program are you enrolled in?

- ❑ Not Currently Enrolled (you must enroll within the next 60 days to participate in APP)
- ❑ Regular Education (includes charter schools & homebound)
- ❑ GED or Alternative Education Program (night school, virtual school, home school)

Name of School or Program: _____

What grade are you currently in?

- ❑ Not Currently Enrolled
- ❑ Ungraded School
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10
- ❑ 11
- ❑ 12

What level of grades did you achieve on your most recent report card?

- ❑ Above Average (mostly A's and B's)
- ❑ Average (mostly C's and D's)
- ❑ Below Average (F's)

What is your educational goal? (Check all that apply)

- ❑ Graduate from High School or earn GED
- ❑ Attend Vocational or Trade School
- ❑ Attend 2-year College Program
- ❑ Attend 4-year College Program
- ❑ Attend more than 4 years of college

Parents and Siblings

How old was your mother when she had her first child?

- ❑ 14 or younger
- ❑ 15-19
- ❑ 20 or older
- ❑ Not Sure

Did any of your brothers or sisters become parents before graduating from high school?

- ❑ Don't have any brothers or sisters
- ❑ No
- ❑ Yes
- ❑ Not Sure

Did any of your brothers or sisters drop out of school before graduating?

- ❑ Don't have any brothers or sisters
- ❑ No
- ❑ Yes
- ❑ Not Sure

What was the highest grade completed by your mother?

- ❑ 8th Grade or lower
- ❑ 9th Grade
- ❑ 10th Grade
- ❑ 11th Grade
- ❑ 12th Grade
- ❑ GED
- ❑ Some College
- ❑ College Degree or higher
- ❑ Not Sure

What was the highest grade completed by your father?

- ❑ 8th Grade or lower
- ❑ 9th Grade
- ❑ 10th Grade
- ❑ 11th Grade
- ❑ 12th Grade
- ❑
- ❑ GED
- ❑ Some College
- ❑ College Degree or higher
- ❑ Not Sure

Employment

Do you currently have a job?

- ❑ Yes

  How many hours per week do you work?

  - ❑ 1-10 hours
  - ❑ 11-20 hours
  - ❑ 21-30 hours
  - ❑ 30 or more hours

  Do you think you are learning skills at your current job that could help you get a better job?

  - ❑ Yes
  - ❑ No
  - ❑ Not sure

  Do you think you will have good chances for promotions at your current job?

  - ❑ Yes
  - ❑ No
  - ❑ Not sure

- ❑ No

  Have you ever had a job?

  - ❑ Yes
  - ❑ No

Are you looking for a job (or a better job) right now?

- ❑ Yes
- ❑ No

  What is/are the reason(s)? (Check all that apply)

  - ❑ Like my current job
  - ❑ Too young to work
  - ❑ There are no jobs available that I want
  - ❑ Cannot find a job
  - ❑ Not sure where/how to get a job
  - ❑ Do not have the necessary training, skills, or experience to get a job
  - ❑ Cannot arrange childcare
  - ❑ Do not have time to work due to other responsibilities
  - ❑ Parent/guardian will not allow me to work
  - ❑ Do not have transportation
  - ❑ Do not feel well enough to work due to pregnancy
  - ❑ Not interested in working

Legal Issues

Have you ever been arrested?

- ❑ No
- ❑ Yes

  Have you ever been sentenced to spend time in a correctional institution (jail, prison, youth detention center, etc.)?

  - ❑ Yes
  - ❑ No

  Have you ever been on probation?

  - ❑ Yes

    Are you currently on probation?

    - ❑ Yes

      Name and Contact Information of Probation Officer:

      _____

    - ❑ No
  - ❑ No

Have you ever been reported to Child Protective Services for suspected child abuse or neglect?

- ❑ Yes
- ❑ No

Experience with Abuse/Assault

Have you ever experienced physical abuse (hitting, pushing, and choking)?

- ❑ Yes

  By whom? (Check all that apply)

  - ❑ Current Partner (boyfriend/girlfriend)
  - ❑ Former Partner
  - ❑ Parent/Guardian
  - ❑ Sibling
  - ❑ Other
- ❑ No

Have you ever experienced emotional abuse (name calling, put-downs)?

- ❑ Yes

  By whom? (Check all that apply)

  - ❑ Current Partner (boyfriend/girlfriend)
  - ❑ Former Partner
  - ❑ Parent/Guardian
  - ❑ Sibling
  - ❑ Other
- ❑ No

Have you ever witnessed a sibling being physically or emotionally abused?

- ❑ Yes
- ❑ No

Have you ever witnessed a parent being physically or emotionally abused?

- ❑ Yes
- ❑ No

Have you ever been forced to have sex (vaginal, anal, or oral) against your will?

- ❑ Yes

  By whom? (Check all that apply)

  - ❑ Current Partner (boyfriend/girlfriend)
  - ❑ Former Partner
  - ❑ Parent/Guardian
  - ❑ Other relative
  - ❑ Other
- ❑ No

Have you ever experienced any unwanted sexual situation?

- ❑ Yes

  By whom? (Check all that apply)

  - ❑ Current Partner (boyfriend/girlfriend)
  - ❑ Former Partner
  - ❑ Parent/Guardian
  - ❑ Other relative
  - ❑ Other
- ❑ No

Do you currently smoke?

- ❑ Yes
- ❑ No

Do you currently drink alcohol?

- ❑ Yes

  How many drinks per week?

  - ❑ 0-1
  - ❑ 2-3
  - ❑ 4-5
  - ❑ More than 5
- ❑ No

Have you ever drunk alcohol in the past?

- ❑ Yes
- ❑ No

Do you currently use illicit or prescription drugs or other substances to get high?

- ❑ Yes

  How often?

  - ❑ Less than once per month
  - ❑ 1-2 times per month
  - ❑ 3-4 times per month
  - ❑ More than once per week
- ❑ No

Pregnancy

Are you currently pregnant?

- ❑ Yes (Continue with questions below.)
- ❑ No (Stop Here.)

When is your due date?_____/_____/_____

How many times have you been pregnant (including current pregnancy and any abortions, miscarriages, or still births)?

- ❑ 1
- ❑ 2
- ❑ 3 or more

Would you like to have another child?

- ❑ Yes
  How soon? _____
- ❑ No

Which of the following do you currently suffer from? (Check all that apply)

- ❑ Pre-eclampsia/Toxemia
- ❑ Pre-term Labor
- ❑ Gestational Diabetes (diabetes during pregnancy only)
- ❑ Multiple Births
- ❑ Pregnancy and Lupus
- ❑ Pregnancy and Sickle Cell Anemia
- ❑ Pregnancy and Epilepsy
- ❑ Ectopic Pregnancy
- ❑ Fibroids and Pregnancy
- ❑ Infectious Disease and Pregnancy
- ❑ Back pain
- ❑ Grinding your teeth
- ❑ Headaches

- ❑ Eating disorder
- ❑ Feeling bad about myself
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Take prescription medication
- ❑ Depression
- ❑ Anxiety
- ❑ Asthma
- ❑ Recurrent sexually transmitted infections
- ❑ Other _____
- ❑ None
- ❑ Hard time sleeping
- ❑ Unable to concentrate
- ❑ Feeling grouchy
- ❑ Sleeping too much
- ❑ Loss of appetite
- ❑ Wanting to hurt myself
- ❑ Indigestion or gas pains
- ❑ Shaking hands
- ❑ Upset stomach
- ❑ Pounding heart
- ❑ Muscle tension
- ❑ Ringing in ears
- ❑ Eating too much

Have you received any prenatal care yet?

- ❑ Yes
  - When did you begin receiving prenatal care?
    - ❑ 1st Trimester
    - ❑ 2nd Trimester
    - ❑ 3rd Trimester
  - How many prenatal visits have you had?
    - ❑ 0
    - ❑ 1-3
    - ❑ 4-6
    - ❑ 7 or more
- ❑ No

Have you been hospitalized during your pregnancy?

- ❑ Yes
- ❑ No

Do you currently have a health care provider who you can see on a regular basis?

- ❑ Yes. Name of Practice/Provider: _____
- ❑ No

Do you have health insurance?

- ❑ Yes
  - ❑ Medicaid
  - ❑ Health Choice
  - ❑ Other
- ❑ No

Fight 4 change intake form