

TEENS LEARNING CONTROL (TLC) PROGRAM ASSESSMENT

PLEASE READ EACH QUESTION CAREFULLY. IF A QUESTION DOES NOT APPLY, PLEASE WRITE N/A.

(Please **PRINT** all information)

Name: _____

Current Address: _____

City, State, Zip: _____

E-Mail Address: _____

Telephone:

Home: _____ Cell: _____

Date of Birth: _____ Age: _____

Sex: _____ Race : _____

Employed? Yes No

Place of Employment: _____ Occupation: _____

Are you currently in school? Yes No

(If yes, list name of school) _____

Classification (year in school): _____

If not currently in school, highest level completed: _____

If not in school or employed, how do you spend your time on a daily basis?

Do you have any dependants? _____ If so, how many? _____

Are you your only financial support? _____

Emergency (additional) contact, if we are unable to reach you at number(s) provided above.

Name: _____ Relationship: _____

Telephone:

Home: _____ Work/Cell: _____

What do you expect to gain from the TLC program? _____

Name of Judge who placed you in the TLC program: _____

Please list the citation (s) by name that you are in the TLC program for: (If speeding how fast?)

- 1.
- 2.
- 3.
- 4.

Was your license suspended for this charge? _____

Are you currently participating with another court program? _____

If yes, what program? _____

Contact name and number of individual supervising your progress:

Date of TLC sentencing (court date): _____

Car driven at time of citation: Own _____ Parents: _____ Other: _____

What were the events that led up to the current citation that placed you in the TLC program?

Were you listening to music at the time the violation occurred? Yes No

Were you using a cell phone at the time the violation occurred? Yes No

Have you had any other legal charges or traffic citations before? Yes No (Do not include this citation/charge):

Do you have any history of probation for traffic or criminal charges? Yes No

How often do you wear your seatbelt as a driver or passenger? (Circle only one below)

Never Sometimes Often Always

Have you ever tried alcohol? Yes No If yes, at what age? _____

What type? _____

Do you consume alcohol currently? Yes No What type? _____

How much alcohol do you consume? per day _____ per month _____

Occasions in which you normally consume alcohol:

Have you ever tried drugs? Yes No If yes, at what age? _____

Which drugs? _____

Do you currently use drugs? Yes No If yes, Which
drugs? _____

How much drugs do you consume? per day _____ per month _____

Drug (s) of choice: _____

Occasions in which you normally use drugs:

Do you have any immediate family members who suffer from alcohol/drug abuse?

Have you ever been diagnosed with ADD/ADHD? _____

Have you ever been diagnosed with a mental health issue? _____

If yes, please describe:

Are you currently taking any prescribed medication? _____

If yes, please list all medications:
