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)   Citation # _____

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?
_____

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

Name: _____   Relationship: _____

Telephone:
Home: _____   Work/Cell: _____

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.

Was your license suspended for this charge?   Yes   No

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? _____

Do you consume alcohol currently? Yes   No

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

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

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:

_____