



College *Living* Experience

# Application for Admission *Student Questionnaire*

## Student Information

This is your chance to tell us about you. Please answer questions with as little assistance as possible.

_____	_____	_____	_____
First Name	Middle Name	Last Name	Preferred Name
Male / Female (Please Circle One)	_____	_____/_____/_____ Date of Birth	_____
	Age	Country of Birth	Citizenship
_____-_____-_____ Social Security Number	_____	_____	_____
	Telephone		Cell Phone

Email: \_\_\_\_\_

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

Do you wish to attend a church or synagogue while at College Living Experience ? Yes / No

### *Educational Background*

Have you ever taken any college courses? Yes / No

If yes, did you receive college credit for these courses? Yes / No

Please list all colleges or vocational schools you have attended where you have earned credit:

_____	_____	_____
Name of School:	Date Attended	Credit Earned

_____	_____	_____
Name of School:	Date Attended	Credit Earned

_____	_____	_____
Name of School:	Date Attended	Credit Earned

## Student Information Continued

What courses in high school have you enjoyed? (Check all that apply)

- |   |   |                                    |                                  |
|---|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> English          | <input type="checkbox"/> Math               | <input type="checkbox"/> History   | <input type="checkbox"/> Science |
| <input type="checkbox"/> Foreign Language | <input type="checkbox"/> Physical Education | <input type="checkbox"/> Computers | <input type="checkbox"/> Other   |

What courses have you had the most difficulty with? (Check all that apply)

- |   |   |                                    |                                  |
|---|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> English          | <input type="checkbox"/> Math               | <input type="checkbox"/> History   | <input type="checkbox"/> Science |
| <input type="checkbox"/> Foreign Language | <input type="checkbox"/> Physical Education | <input type="checkbox"/> Computers | <input type="checkbox"/> Other   |

What academic challenges do you have in the classroom? \_\_\_\_\_

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What would you like your teacher or tutor to know about how you learn? \_\_\_\_\_

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What accommodations have you had in the classroom in the past? \_\_\_\_\_

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What does College Living Experience program provide, which you feel will benefit you the most?  
(Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Academic Support Services    | <input type="checkbox"/> Financial Skills Assistance | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Cooking and Meal Preparation | <input type="checkbox"/> Social Program              | <input type="checkbox"/> Other           |

If other, please explain: \_\_\_\_\_

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## General Information

What do you consider your greatest asset as a person? \_\_\_\_\_

In what areas do you feel that you have the most room for growth as a person? \_\_\_\_\_

Have you ever lived away from your parents? Yes / No

If yes, explain the circumstances: \_\_\_\_\_

Have you ever lived with a roommate? Yes / No

If yes, please tell us about your experience(s): \_\_\_\_\_

Describe the ideal roommate you would like to have: \_\_\_\_\_

What is at least one habit that you would not like in a roommate? (Examples: plays loud music, smokes, very messy) \_\_\_\_\_

Have you ever had a credit card? Yes / No

Have you ever had your own checking account? Yes / No

Have you ever paid your own bills? Yes / No

Do you have a computer? Yes / No

Will you have internet access in your apartment? Yes / No

Do you have a desktop computer or a laptop computer? Desktop / Laptop

## Driving

Do you presently have a driver's license? Yes / No

Have you ever lost your license due to violations? Yes / No

If yes, please explain the circumstances: \_\_\_\_\_

Are you planning on bringing a car? Yes / No

Do you have auto insurance? Yes / No

Have you ever used public transportation? Yes / No

What types? (Examples: buses, subway, local trains, tramways, cabs, etc) \_\_\_\_\_

Do you feel confident in using public transportation? Yes / No

Do you think your parents would like you using public transportation? Yes / No

## Social Activities

What sports activities have you participated in? (Sports activities could include school sports i.e. football, basketball and sports outside of school i.e. karate, dance, skiing, etc.) \_\_\_\_\_

What sports activities would you like to continue to participate in while attending College Living Experience?

What types of clubs/organizations interest you the most? \_\_\_\_\_

Do you belong to any social organizations or groups? Yes / No

If yes, list and describe them: \_\_\_\_\_

Check which of the following do you like best?

- Doing an activity on your own
- Participating in an activity with only one or two others
- Participating in an activity with a group larger than three others

## Social Activities Continued

What type of activities do you like to do when you are by yourself? \_\_\_\_\_

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Do you make friends easily? Yes / No

Which best describes your relationships with your friends/peers (check all that apply)

- |                                    |                                   |                                    |
|------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Confident | <input type="checkbox"/> Leader   | <input type="checkbox"/> Talkative |
| <input type="checkbox"/> Insecure  | <input type="checkbox"/> Follower | <input type="checkbox"/> Quiet     |

Do you have difficulty in social situations? Yes / No / Sometimes

If yes, check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Shy                   | <input type="checkbox"/> Fearful of rejection | <input type="checkbox"/> Difficulty trusting others |
| <input type="checkbox"/> Lack of assertiveness | <input type="checkbox"/> Teased often         | <input type="checkbox"/> Lonely                     |
| <input type="checkbox"/> Angered easily        | <input type="checkbox"/> Ignored by others    | <input type="checkbox"/> Difficulty making friends  |
| <input type="checkbox"/> Fight when angry      | <input type="checkbox"/> Disappointed easily  | <input type="checkbox"/> Often alone                |

Do you have a hard time getting along with others? Yes / No

If yes, check all that apply:

- |   |                                   |                                    |                                |
|---|-----------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> parents/step-parents | <input type="checkbox"/> teachers | <input type="checkbox"/> employers | <input type="checkbox"/> peers |
|---|-----------------------------------|------------------------------------|--------------------------------|

Please explain why you have a hard time getting along with this group of people: \_\_\_\_\_

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Which of your family members do you feel most understands you? \_\_\_\_\_

Explain: \_\_\_\_\_

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Which of your family members do you feel least understands you? \_\_\_\_\_

Explain: \_\_\_\_\_

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## Employment History

Are you employed or have you ever been employed?  
If yes, please provide the following:

Yes / No

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Name of Employer Job Title Period of employment

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Duties Why did you leave?

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Name of Employer Job Title Period of employment

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Duties Why did you leave?

Have you received any vocational or special job training?  
If yes, please provide the following information:

Yes / No

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Name of Program Type of Training

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Duties Period of Enrollment

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Name of Program Type of Training

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Duties Period of Enrollment

## Personal Habits and Behaviors

Have you ever smoked? Yes / No

Do you presently smoke? Yes / No

Do you drink alcohol? Yes / No

If yes, which of the following best describes your drinking of alcoholic beverages (circle all that apply):

- Monthly       Weekends Only       Usually when I'm alone       Weekly  
 Daily       Usually with friends       Celebrations/Occasions

Have you ever tried any illegal drugs? Yes / No

If yes, explain: \_\_\_\_\_

## Personal Habits and Behaviors Continued

When you get angry, how do you manage it (what do you tend to do)?

Explain: \_\_\_\_\_

Have you every been arrested?

Yes / No

If yes, explain: \_\_\_\_\_

Do you have any behaviors/habits you would like to change?

Yes / No

Explain: \_\_\_\_\_

Do you have any behaviors/habits that you feel others would like you to change?

Yes / No

Explain: \_\_\_\_\_

## Goals

Do you know what you would like to study? \_\_\_\_\_

What are your career goals? \_\_\_\_\_

What would you like to get out of CLE? \_\_\_\_\_

## Signature

Please indicate which College Living Site(s) you are interested in attending:

- Austin, Texas       Denver, Colorado       Fort Lauderdale, Florida

I am applying to the College Living Experience program (CLE). I grant my permission for CLE to contact any person, organization, or school (including, without limitation, any healthcare provider or educational provider) listed in the student or parent questionnaire, both of which constitute "this application." I consent to the release of any and all information about me by any person, organization, or school (including, without limitation, any healthcare provider or educational provider) listed in this application. I grant my permission for CLE and any person, organization, or school (including, without limitation, any healthcare provider or educational provider) listed in this application to discuss anything about me. This consent shall continue until withdrawn in writing by me

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**Please attach a recent picture of yourself to this application.**