Volunteers of America®

The Life House
3322 Strahan Parkway
Sheridan, WY 82801

# The Gathering Place and The Life House
# Application/Screening Sheet

Admissions: 307.672.2044 / Fax: 307.674.6867
www.voanr.org

**For Office Use Only:**
**Date of First Contact: _____**

**BLACK INK ONLY – NO PENCIL OR BLUE INK**

**Date**_____

## Personal Information:

First Name: _____ Middle: ____ Last:_____

Maiden: _____

Sex: M or F Race ____ Combat Veteran: Yes No WY Resident: Yes No

SSN: _____ Age: _____DOB:_____

Tribal Affiliation _____

Current Mailing Address: _____

City: _____State: _____ Zip Code: _____

Home Mailing Address: _____

City: _____State: _____Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

E-mail address: _____

Marital Status: Married___ Single___ Divorced___ Separated___ Widowed_____

Children: Y___ N___ (**if yes list ages**: _____) Pregnant: Yes No

Contact Person: _____Relationship: _____

Phone Number (s): _____

## Chemical Use History:

Substances Used on a Regular Basis:

| Substance | Route of Administration | Date of Last Use |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Treatment History:**

| Facility Name | Dates of Attendance | Nature of Discharge |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Psychological History:**

Mental Health Diagnosis:

| Diagnosis/Date of diagnosis Diagnosed by whom? | Medication Prescribed | Date Medication Last Used |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

If taking medications, how do/will you pay for them? _____

Have you been prescribed medications that you are not taking: Y___ N ___

History of Suicidal Thoughts: Last 30 Days: ___ Lifetime: ___ Attempts: ___

If yes, did you have a plan? _____

History of Homicidal Thoughts: Last 30 Days: ___ Lifetime: ___ Attempts: ___

If yes, did you have a plan? _____

Do you hear voices or see things that other people don't see? Y___N___

If yes, please describe: _____

**Medical History:**

Current Medical Conditions

| Diagnosis/Date of Diagnosis Diagnosed by whom? | Medications Prescribed | Date Medication Last Used |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

If taking medications, how do/will you pay for them? _____

Have you been prescribed medications that you are not taking? Y___ N ___

Physician's Name, Facility, City: _____

-Date of last appointment? _____For:_____

Date of Last Physical: _____

Date of Last Hospitalization: _____For:_____

**Who is filling out this screening sheet?** Self ___ Family ___ Friend___Counselor ____

**Do you have a Living Will?** Y ____ N ____

If yes, have you provided a copy of your Living Will? Y ____ N ____

**Legal Status**

Are you currently in Drug Court? Y___ N___ If yes, where? _____

Are you currently in jail?: Y___N___

-If yes, where? _____

-If yes, when were you incarcerated? _____

-If yes, how long will you be there? _____

-Upon leaving treatment will you be required to return to jail? Y___N___

Are you on probation/parole? Y___ (unsupervised, supervised, ISP) N___

-If yes, where? : _____

-If yes, agent's name: _____

Are you court ordered to treatment? Y___N___

Are you ordered to have a substance abuse evaluation? Y ___ N ___

-If yes, have you provided a copy of your court order? Y___N___

Are you awaiting sentencing? Y___N___

-If yes, for what charges? _____

Will you be on furlough to attend treatment? Y___ N___

-If yes, from what jail will you be coming? _____

Do you have any outstanding warrants that you are aware of? Y___ N___

-If yes, out of what county and for what? _____

Do you have an attorney? Y ____ N ____

-If yes, name and address _____

**Financial Status**

Are you currently employed? Y___ N___ If yes, where? _____

Household income for last quarter (3 months): _____

Number of Dependents: _____

How will treatment be paid for? Self___ Insurance___ Drug Court _____Other_____

Do you have: Medicare? Y ___ N___ Do you have Medicaid? Y ___ N___

Do you have insurance? Y___ N___

-Insurance company's name: _____Policy #:_____

*If you have insurance you must obtain pre-authorization prior to your bed date *

When a bed becomes available, we will attempt to contact you at the last phone number and address you provided. If we are unable to contact you, your name will be removed from our waiting list.

If you are incarcerated and transferred to another facility, you must notify us.

**Name _____ Date_____**

# Adverse Childhood Experience (ACE) Questionnaire

## Finding your ACE Score 10 24 06

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you? **OR**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you? **OR**
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way? **OR**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special? **OR**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her? **OR**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **OR**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

**Now add up your "Yes" answers:_____This is your ACE Score**

**PLEASE INCLUDE THIS QUESTIONNAIRE WITH YOUR ADMISSIONS PACKET.**