Admission Contact for
The Life House - Sheridan
The Gathering Place - Sheridan
Recovery Homes - Sheridan
3322 Strahan Parkway (82801)
p. 307.672.2044
f. 307.674.6867

Admission Contact for
Center of Hope – Riverton
223 W Adams Ave (82501)
p. 307.856.9006 f. 307.856.8205
Pingora Behavioral Health – Riverton
625 East Madison, Ste 1 (82501)
p. 307.463.0337 f. 307.463.0041

Screening Sheet/Application for Treatment

For Office Use Only - Date of First Contact: _____

Today's Date: _____

I AM APPLYING FOR TREATMENT AT:
(Select all that may apply):

☐ **Sheridan Residential** ☐ **Sheridan Recovery Homes**
☐ **Center of Hope Transitions** ☐ **Pingora Behavioral Health**

_____ _____
Name of Person Completing Form ***Relationship to Patient***

Patient Personal Information:

First Name:_____Middle: _____Last: _____ Maiden: _____

Sex: M or F SSN: _____ Age: _____ DOB:_____

Race: _____ Combat Veteran: **Yes No** WY Resident: **Yes No**

Tribal Affiliation: _____

Current Mailing Address:_____

City:_____ State: _____ Zip Code: _____

Home Mailing Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone:_____ Cell Phone: _____Work Phone: _____

Marital Status: Married ___ Single ___ Divorced ___ Separated ___ Widowed ___

Children: **Yes No** *(if yes list ages:* _____*)* Who has legal custody? _____

Are you Pregnant? Yes No N/A

Contact Person: _____ Relationship: _____

Home Phone (s): _____ Cell Phone: _____

Chemical Use History:

Substances Used:

Drug of Choice	Substance(s)	Route of Administration	Frequency of Use	Date of Last Use

Treatment History:

Are you currently participating in Medication Assisted Treatment (MAT)? **Yes** **No**

Facility Name, City, State	Dates of Attendance	Nature of Discharge

Psychological History:

Mental Health Diagnosis:

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

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? **Yes** **No**

-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? **Yes** **No**

-If no, Name of Medication_____Reason not taking: _____

-If no, Name of Medication_____Reason not taking: _____

Are you allergic to any medications? **Yes** **No**

-If yes, Name of medication _____Date of last use: _____

-If yes, Name of medication _____Date of last use: _____

Physician's Name, Facility, City, State:

-Date of last appointment? _____ For: _____

Date of Last Physical: _____

Date of Last Hospitalization: _____For:_____

Legal Status

Do you have an Attorney? **Yes** **No**

-if yes, (name of attorney & company, city, state)? _____

_____

Are you currently in Drug Court? **Yes** **No** If yes, where? _____

Are you currently in jail? **Yes** **No**

-if yes, where (facility, city, state)?_____

-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? **Yes** **No**

Are you on probation/parole? **Yes** *(unsupervised, supervised, ISP)* **No**

-if yes, where? _____

-if yes, agent's name: _____

Are you court ordered to treatment? **Yes** **No**

Are you ordered to have a substance abuse evaluation? **Yes** **No**

-if yes, have you provided a copy of your court order? **Yes** **No**

Are you awaiting sentencing? **Yes** **No**

-if yes, for what charges? _____

_____

Will you be on furlough to attend treatment? **Yes** **No**

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

Do you have any outstanding warrants, that you are aware of? **Yes** **No**

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

Financial Status

Are you currently employed? **Yes** **No** If yes, where? _____

Household income for last quarter (3 months): _____Dependents: _____

How will treatment be paid for? Self _____ Insurance_____ Other _____

Do you have insurance? **Yes** **No**

Are you covered under someone else? **Yes** **No** *(If yes, please complete)*

Who is covering you?

Name _____ Relationship to you: _____

DOB Insured _____Phone: _____

-Insurance company's name: _____ Policy #: _____

* If you have insurance you must obtain pre-authorization and provide a claim form *

Do you have Wyoming Medicaid? **Yes** **No** Number: _____

* Please know Wyoming Medicaid does not cover Residential Treatment, only Outpatient Treatment *

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 to remain on our waiting list.

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 _____

This is your ACE Score… Now add up your "Yes" answers: ___

PLEASE INCLUDE THIS QUESTIONNAIRE WITH YOUR ADMISSIONS PACKET.