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
223 W Adams Ave (82501)
p. 307.463.0337 f. 307.856.8205

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:* _____*)* Are you Pregnant? **Yes or No N/A**

Contact Person: _____ Relationship: _____

Home Phone (s): _____ Cell Phone: _____

Chemical Use History:

Substances Used:

Drug of Choice	Substance(s)	How did you take?	How often did you use?	Date of Last Use

Treatment History:

Please list previous residential and outpatient treatments you have attended:

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

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

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 _____ Reaction: _____

-If yes, Name of medication _____ Reaction: _____

Are you ***allergic to any foods***? **Yes** **No** *If yes, doctor's note required*

-If yes, Name of food _____ Reaction: _____

-If yes, Name of food _____ Reaction: _____

-If yes, Name of food _____ Reaction: _____

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 _____

If 'Other' is marked, documentation is needed from that source to ensure that they are covering treatment costs

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 or No** Number: _____

Do you have Wyoming Medicare? **Yes or No** Number: _____

*** Wyoming Medicaid/Medicare does not cover Residential Treatment ***

Dependent(s)

Have your parental rights been suspended or terminated? **Yes or No**

Who has temporary parental rights? _____

Do you have legal custody? **Yes or No**

Who has legal custody? _____

I, _____ agree that the information that has been provided on this form is true and accurate to

(signature)

my knowledge.

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 in order 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.

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HEALTH CARE SERVICES
1876 South Sheridan Ave.
Sheridan, WY 82801

Physical Examination Form **(Provider MUST fill out)**

Name						Date			
Allergies						DOB		Age	
Height		Weight		Blood pressure		Pulse		LMP	

Medical conditions	Medications	Dosage/Frequency

Physical Exam Testing/Immunizations

Head		Heart		TB skin test	[ ] Positive [ ] Negative
Eyes		Lungs		Date	
Ears		Breasts		Hepatitis C	[ ] Positive [ ] Negative
Nose		Abdomen		Date	
Throat		Extremities		Hepatitis B	[ ] Positive [ ] Negative
Thyroid		RLE		Date	
Nodes		RUE		HIV	[ ] Positive [ ] Negative
Adnexae		LLE		Date	
Skin		LUE		Other	[ ] Positive [ ] Negative

ROS			
	☐ HEENT	☐ Gastrointestinal	☐ General
	☐ Cardiovascular	☐ Genitourinary	☐ Psychiatric
	☐ Respiratory	☐ Neuromuscular	☐ Dermatological

Notes regarding Physical Exam, Testing/Immunizations, and ROS

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HEALTH CARE SERVICES
1876 South Sheridan Ave.
Sheridan, WY 82801

***Please include:**

Basic Assessment		
1.	Is the patient independent in their activities of daily living?	
2.	Can the patient ambulate independently?	
	Any ambulatory aids used?	
3.	Does the patient need or use visual or hearing aids?	
	If so, are they wearing them?	
4.	Does the patient have special nutritional needs?	
	If so, which ones?	
5.	Does the patient have conditions which will impact their program?	
	If so, how?	
6.	Has the patient had an infectious disease in the last year?	
7.	If an infectious disease in the last year, was it treated?	
	How?	
	What medications were used?	
	Where?	
8.	Does the patient currently have any open wounds?	
	If so, where?	
	How long has the patient had the wound?	
	Is any drainage present? What type of drainage?	
9.	Has the patient had labs in the last 60 days?	
	If so, please include copies of lab work	
10.	Is the patient medically stable to participate in a residential treatment program?	
	If not, what issues add to medical instability?	

Additional Comments regarding basic assessment and medical status

***Please include:**

1. **Prescriptions for a 90-day supply for any medications needed through treatment.**
2. **A prescription medication record for the last 3 years.**
3. **Copies of labs done in the last 60 days.**

Signed:_____Date:_____

Practitioner Name and Address **Phone Number**