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: _____

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 Name: _____

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: _____

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

Children: Y___ N___ (if yes list ages: _____) 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)? Y___ N ___

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? 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 ___

-If no, Name of Medication_____Reason not taking:_____

-If no, Name of Medication_____Reason not taking:_____

Are you allergic to any medications? Y___ N ___

-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? Y___ N ___

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

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

Are you currently in jail? Y___ N ___

-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? 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? _____

Financial Status

Are you currently employed? Y___ N ___ If yes, where? _____

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

How will treatment be paid for? Self _____Insurance_____Other_____

Do you have insurance? Y___ N ___

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

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

Do you have Wyoming Medicaid? Y ____ N _____ Number: _____

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

Occasionally we have un-anticipated openings. Would you be interested and/or available to come on short notice? Y___ N ___ (If you are in jail this does not apply as the Court needs time to arrange release)

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.