



RCM Recovery Centers of Montana

390 Hodgson Road, Columbia Falls, Montana 59912

Date: _____

Full Legal Name: _____ Gender: M F

Physical Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

County of Residence: _____ DOB: _____ Age: _____

SS# _____ - _____ - _____ Employed: Y N Employer: _____

Cell Phone: _____ Home/Other Phone: _____

Education Completed: High School/Grade _____ College _____ Post Graduate _____ Other GED _____

Marital Status: Married Unmarried Divorced Committed/cohabitating

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Are you a Veteran: Y N Homeless: Y N

Race/Ethnicity: White Native Indian Asian Indian Black Alaskan Native Hispanic

Other: _____ Enrolled as Tribal Member: Y N Tribe: _____

Health Insurance: ****MEDICARE does not cover treatment. If you have Medicare/Medicaid, call your insurance company as you may qualify for treatment*

Medicaid None Other: _____ Insurance ID# _____

Name of Insured: _____ Relationship: _____

Substance Use History:

Substances used in the past 30 days: _____



Do you experience withdrawal symptoms when you stop using substances? Y N

If Yes, What symptoms? _____

Date of Last use: _____

****IMPORTANT - On the day of admission, you need to be sober, not intoxicated, or you will have to wait to be admitted and perhaps sent to the emergency room.**

Legal History:

Are you currently on Probation? Y N If so, PO's county/name: _____

Do you have dependent children under the age of 18? Y N How many? _____

Who has legal custody? _____ DFS Case? Y N Case worker: _____

Medical:

List current medical conditions if any _____

STD's ____ Hep-C ____ HIV ____

Do you have a history of seizures? Y N If yes, how many in lifetime? _____

Do you have a history of falls? Y N Do you have a history of DT's? Y N

Past withdrawal symptoms are typically: MILD MODERATE SEVERE

Current withdrawal symptoms are: MILD MODERATE SEVERE

Current withdrawal symptoms include:

List all health conditions: _____

List any dietary restrictions: _____



List any allergies: _____

Are you on a MAT (medication assisted treatment) Program? If so, what medication? List ALL medications:

Medication	Dose	Frequency	I have a refill	I am out of this med

Medical Continued:

Who is your primary physician? _____ City/Clinic? _____

What pharmacy do you get your medications from? _____ City: _____

Any special needs/accommodations (*wheelchair, hearing, vision*) _____

Are you pregnant or do you think it is possible that you are pregnant? Y N

If yes, how many weeks? _____ Have you seen a physician for your pregnancy? Y N

Mental Health:

Mental Health Diagnoses: None Depression Anxiety PTSD BPD BiPolar Schizophrenia

Other: _____

Do you have history of suicidal ideation and/or attempts? Y N

Have you ever been hospitalized for Mental Health? Y N If so, when/where _____



Treatment History:

Number of prior treatments: Inpatient _____ Outpatient _____ Date of last treatment _____

Name of Treatment Facility	Dates	Completed Yes or No	Aftercare Program	Length of sobriety following treatment

I have attended the Prime for Life Program? Y N

I have completed the DUI ACT Program Y N

I am involved with NA or AA groups? Y N Do you presently have a sponsor? Y N

Do you have a Peer Support? Y N If so, who/where? _____

Legal History:

Do you have an attorney? Y N If so, who/city? _____

Have you been incarcerated in the past 30 days? Y N How many days? _____

Are you required to register as a violent/sex offender? Y N

List any upcoming required court appearances or pending charges:

County/Court	Date/Time	Charge



List any scheduled or need-to-schedule doctor/dental appointments:

Doctor/Clinic	Date/Time	Procedure

What is the immediate follow up plan to this inpatient treatment stay?

On a scale from 1-10, with 10 being 100% committed to achieve and maintain sobriety, what number would you assign to describe your readiness to change your life? _____

TREATMENT PAYMENT PLAN OPTION

PROSPER

Visit: www.prosper.com

To see if you qualify

Signature of applicant: _____ Date: _____