Date: _____

390 Hodgson Road, Columbia Falls, Montana 59912

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: _____

Substances used in the past 30 days: _____

_____

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

If Yes, What symptoms?_____

_____

390 Hodgson Road, Columbia Falls, Montana 59912

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? _____

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: _____