SCREENING/APPLICATION FOR TREATMENT

Admission Contact for Chrysalis Treatment Center
125 S. Division Street, P.O. Box 847, Powell, WY 82435
p. 307.254.2321 (Admissions) f. 307.333.0470

For Office Use Only - Date of First Contact: _____

Today's Date: _____

_____ _____

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

Patient Personal Information:

First Name: _____Middle: _____Last: _____ Maiden: _____

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

Race: _____ 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: _____

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

Who has legal custody? _____

Are you Pregnant? **Yes No N/A**

Contact Person: _____ Relationship: _____

Home Phone (s): _____Cell Phone: _____

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 _____

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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: _____

Has your son/daughter ever been discharged from another program due to sexual or violent behavior?

Yes ***No***

Has your son/daughter ever been convicted of a sexual or violent crime?

Yes ***No***

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

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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

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If taking medications, how are they paid for? _____

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 incarcerated? **Yes** **No**

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

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-if yes, when were you incarcerated? _____

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

-if yes, where? _____

-if yes, who is your probation officer? _____

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

Have you completed a substance abuse evaluation? **Yes** **No**

-if yes, was it court ordered? **Yes** **No**

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

-if yes, for what charges? _____

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

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

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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