

IHS ABERDEEN AREA
NEBRASKA URBAN INDIAN HEALTH COALITION AND INTERTRIBAL
 2240 Landon Court
 Omaha, NE 68102

Pre-Admission Application
 For
 Residential Behavior Health Services

Today's Date: _____

I. GENERAL INFORMATION

NAME – PLEASE PRINT LAST: _____ FIRST: _____ MI _____	SOCIAL SECURITY NUMBER _____
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CURRENT ADDRESS Address: _____ City: _____ State: _____ Zip _____ Present Living Arrangements: I currently live _____	PHONE NUMBERS Work (____) _____ Home (____) _____ Cell (____) _____
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Tribe	Enrollment #	Degree of Blood	DOB: _____ Current Age: _____
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Sex Male _____ Female _____	Height / Weight Height _____ Weight _____	Marital Status Single _____ Married _____ Divorced _____	Dependents
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Source of Income	Medical Insurance
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EMERGENCY CONTACT

Name: _____ Phone: (____) _____ Relationship to you _____

Address: _____ City: _____ State: _____ Zip: _____

II. REASON FOR REFERRAL

Who suggested or is requiring you to seek treatment? Their name: _____

Address: _____ City: _____ State: _____ Zip: _____

Why? _____

III. OTHER CONTACT INFORMATION

Attorney Name: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Probation or Parole Officer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

IV. MILITARY EXPERIENCE

Are you a veteran? _____ Yes _____ No If yes, were you involved in active duty? _____ Yes _____ No

Type of Discharge Received: _____

V. EDUCATIONAL EXPERIENCE

CIRCLE HIGHEST GRADE COMPLETED

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Degree _____

Have you had additional training or technical education? _____ Yes _____ No If yes, what kind? _____

VI. LEGAL HISTORY

List legal problems/charges that are the direct result of alcohol and /or drugs that you have experienced:

Have you been charged with driving under the influence? _____ Yes _____ No How many times were you charged with this offense? _____

Is there a legal action of any kind pending against you at the present time? _____ Yes _____ No If yes, Explain: _____

VII. MEDICAL HISTORY

Are you presently under a doctor's care? _____ Yes _____ No

If yes, for what condition? _____

_____ Are

you currently on any prescribed medication of any kind? _____ Yes _____ No If yes, please specifically list each medication you are on: _____

Physician's Name: _____

Hospital or Clinic: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

List current/past medical problems: _____

Do you have allergies? _____ Yes _____ No If yes, please explain: _____

Do you have: Diabetes Type I ____ Type II ____ Controlled ____ Uncontrolled ____ No Diabetes ____

Do you have any **Special Dietary Needs** because of a health condition? ____ Yes ____ No

If yes, please explain: _____

Have you ever been diagnosed with HIV/AIDS? ____ Yes ____ No

Have you ever been diagnosed with Hepatitis B? ____ Yes ____ No

Have you ever been diagnosed with Hepatitis C? ____ Yes ____ No

Have you ever been diagnosed with Tuberculosis? ____ Yes ____ No

Have you ever been told you have Fetal Alcohol Syndrome or Fetal Alcohol Effects? ____ Yes ____ No

Have you ever received Tobacco Cessation classes? ____ Yes ____ No If yes, Were you successful at stopping tobacco use? ____ Yes ____ No

VIII. PSYCHIATRIC / PSYCHOLOGICAL INFORMATION

Are you presently or have you recently been thinking or suicide? ____ Yes ____ No If yes, explain:

Have you ever heard voices saw things that other people do not see or hear? ____ Yes ____ No

If yes, were these experiences a result of alcohol / drug usage or during withdrawal? Please explain:

Have you seen a counselor, psychiatrist or other professional person for mental or emotional difficulties? ____ Yes ____ No If yes, please give dates and describe details: _____

Have you ever experienced depression or anxiety or received some other diagnosis such as bipolar, depression, Anxiety, schizophrenia, etc. ____ Yes ____ No If yes, please explain _____

Have you ever been on medication for any of these conditions? ____ Yes ____ No If yes, please give the following
MEDICATION DATE DURATION REASON NAME OF PRESCRIBING DOCTOR

How would you describe your anger? ____ I don't feel angry ____ I feel angry ____ I am angry most of the time

_____ I am so angry and hostile all of the time that I can't stand it

Tell us more about your anger _____

Have you ever been a victim or a perpetrator of domestic violence? _____Yes _____No

Please Explain: _____

If you answer yes to above question, have you ever received victim counseling? _____Yes _____ No.

Have you ever been emotionally, sexually, or physically abused? _____ Yes _____ No. If yes, please briefly describe

SUBSTANCE ABUSE HISTORY

Please answer the following questions. Have you ever . . .

- _____Yes _____ No 1. Tried to cut-down on your use of alcohol / drugs?
- _____Yes _____ No 2. Felt annoyed by someone talking to you about your alcohol or drug use?
- _____Yes _____ No 3. Felt guilty about your drinking or drug use?
- _____Yes _____ No 4. Drank shortly after waking up (eye-opener)?
- _____Yes _____ No 5. Experienced a blackout?
- _____Yes _____ No 6. Are you currently receiving counseling for substance abuse?

What areas of your life have been affected by your use of alcohol or drugs? (Check all that apply)

- | | |
|------------------|--------------------|
| _____ Education | _____ Legal |
| _____ Employment | _____ Recreational |
| _____ Family | _____ Social |
| _____ Financial | _____ Spiritual |
| _____ Health | _____ Other: _____ |

Are there other members of your family who have problems with alcohol/drugs? _____ Yes _____ No If yes, explain:

What influenced you to use alcohol / drugs? _____

How would you describe your use of alcohol / drugs? _____

What periods in your life have you used the most? _____

What is your favorite substance to use? _____

Have you ever over-dosed? ____ Yes ____ No

Were you ever admitted for detox services? ____ Yes ____ No If yes, how many times? _____

Do you believe that you have a problem with alcohol/drugs? ____ Yes ____ No

Have you ever been treated for chemical dependency before? ____ Yes ____ No If yes, ____ # times
How many times did you complete treatment? ____

What type of program did you enter? ____ Outpatient ____ Residential ____ Hospital-based program
____ Other: _____

How long were you abstinent from alcohol / drugs? _____ What helped you to maintain
sobriety? _____

What do you believe caused you to start using again? _____

List your most recent treatment experiences:

Names of Treatment Program	Mo/Yr	Completed?	Days Sober?
1. _____	/	Yes__ No__	_____
2. _____	/	Yes__ No__	_____
3. _____	/	Yes__ No__	_____

PATTERN OF USE

SUBSTANCE	HOW USED	HOW MUCH	HOW OFTEN	Age Started	Age Stopped
Gas, Paint, etc.	Inhale				
Nicotine	Smoke				
Caffeine	Oral				
Beer	Drink				
Wine	Drink				
Liquor	Drink				
Lysol	Drink				
Amphetamine/Crank	IV/Oral/Snort				
Barbiturates	IV/Oral/Snort				
Methaqualone	IV/Oral/Snort				
Tranquilizer	IV/Oral				
PCP	Oral/Smoke				
Cocaine	IV/Oral/Smoke				
Marijuana/Hash	Smoke/Oral				
LSD	IV/Oral				
Mescaline	IV/Oral/Smoke				
Psilocybin	IV/Oral				
Opium/Heroin/Morphine	IV/Oral/Smoke				
Prescription Drugs	IV/Oral/Smoke				
Other Substances	IV/Oral/Inhale				

APPLICANT'S SIGNATURE

DATE

THIS SECTION TO BE COMPLETED BY REFERRAL SOURCE

Referring Source: Caseworker, Counselor, Spouse or other Person(s) who have knowledge of the applicant.

How long have you worked with this individual before the referral?

Briefly describe this person's physical, emotional and mental state.

DSM-IVR Information: (If available)

How would you describe their motivation for treatment?

What areas of life or particular problems do you feel this individual needs to work on while in treatment?

Have tentative aftercare plans been made for this individual? ____ Yes ____ No If yes, please describe.

If the client is court-ordered to treatment, please provide us with a copy of the legal documents. Also briefly describe the situation including any pending court dates, or required visits by the Probation/Parole Office.

Is there any other significant information that we need to be aware of regarding this referral?

Name of Referring Agency: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone (____) _____

