

INPATIENT APPLICATION PROCESS

1. Complete BHS application form (needs to be specific as possible).
2. Complete History and Physical form (attached to application).
 - a. Needs to be completed and signed by a Physician. Must be medically stable.
 - i. Need PPD skin test. Or, copy of recent test results.
 - b. **Must** bring prescribed medication—enough to last 34 days. Failure to do so may delay admissions.
3. Supporting Documents: Court Orders, referrals, assessments, psychological evaluation, etc.
 - a. Need a copy of supporting documents.
 - i. Court Orders: not associated with the courts, however, we do take them into consideration. Need to make sure our services will satisfy the courts.
 1. Applicant needs to meet legal obligations (or, otherwise noted by all parties involved)
 2. Need a copy of Judgment and Sentence
 - ii. Incarcerated:
 1. Will work directly through Lawyer, Probation Officer, Case Worker, etc.
4. Payment Source:
 - a. Funding available for qualified applicants.
 - b. Do not let funding discourage you from seeking treatment. Allow us to help you with this.

Once we receive all required documents, our clinical staff will review the application. Upon approval, and most importantly--the applicant accepts our program--an admission date will be scheduled. This is on a first come, first serve basis.

Thank you.

Rehoboth McKinley Christian Health Care Services
Behavioral Health Services
650 VandenBosch Parkway, Gallup, NM 87301
Phone (505) 726-6900
Fax (505) 722-6192

Staff use only-- Do not write in this area.
Diagnosis: _____
Counselor: _____
Case Mgr: _____
Level of care: _____
Admit Date/Time: _____
Bill to: _____
Treatment Type: _____

Please return application to Ervin Tsosie

Please provide ALL information. Missing data may delay application process.

PART I: PERSONAL DATA:

DATE of Application: _____

Which program are you applying for? Inpatient (Approx. 28 days): **IOP**

Name: _____ Home Phone: _____

Address: _____ Message: _____

City: _____ State: _____ Zip: _____ County: _____

Birthdate: _____ Age: _____ Sex: Male Female

Soc. Sec. #: _____ Race/ Ethnicity: _____ Census #: _____

Preferred Language: _____ Religion: _____

Marital Status: _____ Number of Dependents: _____

Living Arrangement: Independent Dependent on others Homeless

Education Status: Full-time Part-time Not Enrolled Level of education: _____

Military Service: Yes No Branch and Dates: _____ Discharge Status:

Name of emergency contact: _____ Name of next of kin: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Referral Source:

Name: _____

Address: _____

Agency: _____

Phone: _____

Insurance Information:

Insurance Co: _____

Address: _____

Phone: _____

Policy #: _____

Group #: _____

Employment History: Employment Status: Full-time Part-time Not employed

Employer: _____ Occupation: _____

Address & Telephone: _____

PART II: ALCOHOL HISTORY:

1. Do you believe you are addicted to alcohol, or do you consider yourself an "alcoholic?" Yes__ No__
2. I am a "problem drinker" but not an alcoholic? Yes _____; No_____
3. How many times have you been in treatment for alcohol-related problems?_____
4. At what age did you have your first drink? _____
5. Do you use drugs and alcohol at the same time? Yes _____; No_____
6. How many years have you had problems related to drinking? _____
7. What is your drinking pattern? Daily _____; 2-3 times per week _____; Weekends only _____
Periodic _____; Binge Drinking_____
8. When did you have your last drink? _____
9. What do you drink: _____
10. On average, how much do you drink?_____
11. Do you drink more now than you did one year ago? Yes_____ No_____
12. Which of the following have you experienced? Blackouts _____ Age of first blackout_____
Shakes_____ ; Hallucinations/DT/s:_____ (Age of first hallucination or DT?_____
13. Have you experienced withdrawal problems related to alcohol? Yes_____ No_____
14. I am losing (or have lost) control of my drinking. Yes _____; No_____
15. I have accidents or fall while drinking and sometimes injure myself. Yes _____; No_____
16. My tolerance for drinking is decreasing. Yes _____; No_____
17. I need a drink when I wake up (or need one during the night). Yes_____ No_____
18. I have witnessed family members die from alcohol-related problems. Yes_____ No_____
19. What types of problems has alcohol caused in your life? School Problems_____ Marital
Problems_____ Physical Problems_____ Family Problems_____ Loneliness_____
Financial Problems_____ Job Problems_____ Legal Problems_____ Other: _____
20. Tell us anything else you'd like us to know about your drinking:_____

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES

BEHAVIORAL HEALTH SERVICES

ADDICTIONS PROGRAM

ADMISSIONS INTAKE

PART III: DRUG HISTORY

- 1. Do you believe you are addicted to or dependent on drugs? Yes _____ No _____
- 2. What are your drug(s) of choice? _____
- 3. What prescription drugs have you abused? _____
- 4. How many times have you been in treatment for drug-related problems? _____
- 5. At what age did you first abuse any drugs? _____
- 6. Do you use drugs and alcohol at the same time? Yes _____; No _____
- 7. How many years have you had problems related to drug use? _____
- 8. What is your pattern of drug use? Daily _____; 2-3 times per week _____; Weekends only _____
Periodic _____; "Binge Usage" _____
- 9. When did you last use? _____
- 10. What drug(s) did you use last? _____
- 11. On average, how much do you use? _____
- 12. Do you use more now than you did one year ago? Yes _____ No _____
- 13. Have you experienced withdrawal problems related to drugs? Yes _____ No _____
- 14. Have you lost control of your drug use? Yes _____; No _____
- 15. I have accidents or fall while using drugs, sometimes injuring myself. Yes _____; No _____
- 16. My tolerance for drugs has decreased. Yes _____; No _____
- 17. I must use when I wake up (or during the night). Yes _____ No _____
- 18. I have witnessed family members die from drug-related problems. Yes _____ No _____
- 19. Drugs have caused problems in each the following areas for me. School _____ Marital _____
Other: _____ Physical ___; Family ___; Loneliness ___; Financial ___; Work-Related _____
Legal _____
- 20. Tell us anything else you'd like us to know about your drug use:

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PART IV: MEDICAL HISTORY

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1. **List ALL medications you are taking:** _____
2. **Have you ever been hospitalized for any reason?** Yes_____ No_____
If you answered "yes," list the date(s) of hospitalization, the name of the hospital, and the reason: _____
3. **List any physical disabilities or handicaps you have:** _____
4. **Are you currently pregnant?** Yes_____ No_____
5. **Have you been gaining or losing weight?** Yes, Gaining_____ Yes, Losing_____ No_____
6. **How much weight have you lost or gained in the last 3 months?** _____
7. **How many meals do you eat per day?** _____
8. **Have you been on a diet in the last year?** Yes _____No _____. If yes, what type of diet were you on? _____
9. **Do you have HIV (AIDS)?** Yes___ No___; Don't know ___; When were you tested last? _____
10. **Are you a diabetic?** Yes_____ No_____. If yes, do you have a current doctor's order for insulin or other medication? Yes_____ No_____
11. **Have you ever had any of the following medical problems?** *Circle any that apply.*
Head Injury Neck Injury Cirrhosis Hepatitis Pancreatitis Liver Disease
Gastritis Tuberculosis (TB) Eating Disorder High Blood Pressure Heart Condition

PART V: PSYCHIATRIC/PSYCHOLOGICAL

1. **Have you ever been treated or hospitalized for a psychiatric or mental problem?** Yes_____ No_____
If yes, where and when? _____
2. **Were you ever sexually molested or raped?** Yes _____ No_____
3. **Have you ever been physically abused, abandoned, or neglected?** Yes_____ No_____
4. **Do you often get depressed or cry for no reason?** Yes_____ No_____

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BEHAVIORAL HEALTH SERVICES

ADDICTIONS PROGRAM

ADMISSIONS INTAKE

- 5. Do you think other people can hear your thoughts? Yes_____ No_____
- 6. Are people afraid of your temper? Yes_____ No_____
- 7. Have you ever seriously thought of killing yourself? Yes_____ No_____
- 8. Have you ever seriously thought about killing someone? Yes_____ No_____
- 9. Do you ever get so nervous or anxious that you cannot function? Yes_____ No_____

PART VI: LEGAL

- 1. Are you court-ordered for treatment? Yes_____ No_____
- 2. What legal charges do you have pending? _____

- 3. What have you been arrested and convicted of? _____

- 4. How many DUI's or DWI's have you had in your life? _____
- 5. How many times have you been arrested for public intoxication? _____
- 6. Have you lost your driver's license because of drug or alcohol-related offenses? Yes_____ No_____
- 7. Have you been convicted of a felony? Yes_____ No_____
- 8. Have you served time in prison or jail? Yes_____ No_____

PART VII: PERSONAL STATEMENT

Please explain why you want to enter treatment and your expectations?

Please list the family member(s) and phone number(s) that will be attending a mandatory family session(s) during your treatment: _____

*****RMCHCS is a SMOKE FREE FACILITY. NO SMOKING OR "CHEW" PERMITTED!!!!!!**

Sign _____ DATE _____

	REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES BEHAVIORAL HEALTH SERVICES ADDICTIONS PROGRAM ADMISSIONS INTAKE
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**REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES**

BEHAVIORAL HEALTH SERVICES

ADDICTIONS PROGRAM

ADMISSIONS INTAKE

HISTORY AND PHYSICAL EXAMINATION

Name _____ DOB: _____ SS# _____

Address: _____

Primary Care Provider: _____

Address: _____ IHS # _____

Occupation: _____

HISTORY OF ADDICTION

Main Drug: _____ How Long? _____ Date of last use: _____

Other Drugs: _____; _____; _____;

Tobacco: _____ How Much? _____

Previous Rehab? _____

How long sober and/or drug free? _____

HISTORY OR ALCOHOL/DRUG COMPLICATIONS

<input type="checkbox"/> Delirium Tremens	Comments: _____
<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Gastritis/Hematemesis	_____
<input type="checkbox"/> Acute/Chronic Liver Disease	_____
<input type="checkbox"/> Pancreatitis	_____
<input type="checkbox"/> ETOH Related Trauma	_____

IMMUNIZATIONS

PPD _____
Date given _____
Date Read _____

LABS



Behavioral Health Services
History and Physical Examination

Pilot 7-15-03

MEDICAL HISTORY

Drug Allergies _____

Acute/Recent Illnesses: _____

Current Medical Diagnoses: _____

Current Medications _____

Review of Systems

Heent _____	Cardiac _____
Dermatology _____	Hypertension _____
Pulmonary _____	Gastrointestinal _____
Uro-Genital _____	Diabetes Mellitus _____
Renal _____	Dental _____
Musculoskeletal _____	Neurological _____

Gynecological: LMP _____	Birth Control Method _____
Problems _____	Date of last Pap Smear _____
OB History _____ gravida _____ para _____	ab _____ Living Children _____

PHYSICAL EXAMINATION

Vital Signs: Temp _____ Pulse _____ Resp _____ BP _____ HT _____ WT _____

Visual Acuity O.D. 20/ _____ O.S. 20/ _____ O.U. 20/ _____

General Appearance: _____

_____ Heent	_____ Dental	_____ Neck
_____ Heart	_____ Lung	_____ Abdomen
_____ Genitalia	_____ Rectal	

Neuro-Muscular:

_____ Gait	_____ Motor Coordination
_____ Muscle Tone and Strength	_____ Sensory Function
_____ Cranial Nerves	_____ Mental Status
_____ Deep Tendon Reflexes	

SUMMARY OF MEDICAL PROBLEMS AND TREATMENT/MEDICATIONS

_____ Is able to participate in exercise	_____ Is able to participate in sweat lodge
_____ Is able to take over the counter medications	

Physician/Provider Signature/Title _____ Date _____

Physician Co-Signature for PA-C _____ Date _____



Behavioral Health Services
History and Physical Examination

