Central Texas Veterans Health Care System Mental Health Residential Rehabilitation Treatment Programs

Screening Form

DIRECTIONS: Please complete the following questionnaire, giving all the information requested.
If you have any questions regarding this questionnaire, call toll-free (in Texas) 1-800-423-2111, extension 42264,OR 254-743-2264.

Date:_____

A. Veteran's Information and Demographics

Name: _____ Race: _____

Full Social Security #: _____ Age: _____

Date of Birth: _____ Current marital status: _____

Religion: _____

Current Address: _____

City, St, Zip: _____

County of Residence:_____

Current Telephone Numbers:

Home :(_____)_____

Cell :(_____)_____

Work :(_____)_____

Someone Who Will Always Know How to Find You:
Do we have your permission to contact this person if we cannot find you? ___Yes, ___No

Name: _____

Relationship to You:_____Phone: (_____) _____ _____

B. What program are you applying?

_____Post Traumatic Stress Disorder (PTSD)
_____Serious Mentally Ill Empowerment (SMILE)
_____Women's Trauma Recovery Center (WTRC)
_____Substance Treatment Employment Program (STEP)
_____Reintegration Rehabilitation Treatment Program (RRTP)

Why are you applying for admission to that program?

_____
_____
_____

What do you plan to accomplish in the program?

_____
_____
_____

Have you ever been admitted to and discharged from any of the above residential programs? Yes _____ No _____

If yes, when were you last discharged from that program? (Give month and year) _____

Please go on to the next page

Name: _____

C. Treatment Concerns

1. Please list all medications you are currently taking, including over-the-counter supplements, including Home Oxygen therapy;

_____

_____

_____

2. Please list all medical problems:

_____

_____

_____

3. Do you have any problems in hearing? ___Yes ___No

4. Special problems/needs (*check in with PO, special diet, use electric scooter, etc.*):_____

_____

5. Do you have any nutritional problems?_____

6. Are you currently: _____on probation _____awaiting a court appearance
_____On parole _____awaiting sentencing
_____On bond _____facing charges
If yes, can you receive permission to leave your State/County? Yes____ No_____

Comments: _____

D. Referral Information

7. How were you referred to us?

Clinic and Provider: _____

How long were you working with him/her?_____

Did you see this provider individually or in groups? ___Ind, ___Group

8. Are there any problems at home?

___Verbal Abuse ___Finances ___Sleep in separate rooms
___Domestic violence ___Children ___Separated
___Substance Abuse ___Communication ___Divorced
___Bad Neighborhood

Other: _____

E. Drug/Alcohol Information

9. When was the last time you drank/used any alcohol? _____
What did you drink? _____How much? _____ how often? _____

Please go on to the next page

Name: _____

10. When was the last time you used any street/illicit drugs (e.g., cocaine marijuana, etc.)?_____
_____

11. Have you ever misused any prescription drugs? Yes_____ No_____
If yes, what drug(s) did you use? _____
How much? _____ how often do you use drugs? _____

12. Do you have a history of significant withdrawals from alcohol/drugs, i.e., shakes, DTs, etc.?
Yes_____ No_____ If yes, please describe: _____

13. Do you feel that you need treatment at this time for your use of alcohol and/or street/illicit/misuse of prescription drugs? Yes_____No_____

14. During your lifetime what street/illicit drugs have you tried. _____
_____

15. Have you ever received treatment for your alcohol and/or drug problems? Yes_____No_____
If yes, how many previous alcohol/drug treatment programs have you attended? _____

16. What was the longest period of sobriety you were able to achieve after any of these programs? _____

17. When was your last alcohol/drug program? _____ Where was this program? _____
Did you complete this program? Yes_____No_____

If no, why not? _____

18. What do you do to maintain your soberity?
_____
_____

F. Military Service History

19. Date of Service: _____
20. Military Occupation Specialty _____
21. Discharge date? _____

When?_____Where?_____

22. Rank achieved? _____

23. Disciplinary Actions? _____

24. Did you serve in combat? Yes_____ No_____ If yes, where were you deployed and for what time period?

_____

_____

25. During the above combat, please describe what injuries you received. (Write NA if you were not injured):_____

_____

26. Do you have a history of violence/sexual assault towards others? Yes_____ No_____

If yes, Explain_____

27. Tell us about any traumatic experiences before or since the Military:

a. History of childhood abuse? Yes____ No____ Age?_____

b. Physical? Yes____ No____ Perpetrator?_____

c. Emotional? Yes____ No____

Please go on to the next page

Name: _____

G. Vocational Issues

28. Usual Occupation:_____

Currently Employed? Yes ____ No ____

Last, Worked When?_____Where?_____

Number of Jobs since Military?_____

What kinds of problems have you had on the job?_____

_____

H. Mental Status:

29. Do you have any problems with memory that will interfere with treatment?_____

_____

30. Do you see or hear things that no one else does?_____

_____

31. What emotional problems have you ever been diagnosed? _____

_____

Were you ever hospitalized for your emotional problems?_____

32. In the past month are you/have you:

Feeling hopeless about the present/future? ( ) Yes ( ) No

Had thoughts about taking your life? ( ) Yes ( ) No

Do you have a plan to take your life? ( ) Yes ( ) No

Ever had a suicide attempt? ( ) Yes ( ) No

I. Discharge Planning: What is your total monthly income? $ _____

NOTE: If you receive SSI, your payments will stop on the day you are admitted. If you receive SSDI, your payments will continue.

33. Will you have a place to live when you finish this program? ___Yes, ___No

34. Where will you be living? _____

35. Will you have a means of transportation? ___Yes, ___No

36. How do you support yourself?

___Salary from working (self or spouse)
___VA SC Compensation
___VA NSC pension
___Retirement
___Supplemental Social Security
___Social Security Disability
___Unemployment
___I have a claim pending

Other:_____

37. What will be your follow-up treatment source?_____

Please go on to the next page

Name: _____

38. Do you have any existing appointments *(medical, mental health)*?_____

_____

J. Life Concerns/Needs: Self-Assessment

Please indicate (check) which problems below have affected you, and **describe** the impact each has had on your life:

☐ Nightmares - _____

☐ Vivid, Unwanted Memories - _____

☐ Difficulty Showing Emotions - _____

☐ Relationship Problems- _____

☐ Inadequate Social Support (friends, family, etc.) - _____

☐ Poor Communication Skills - _____

☐ Self-Esteem - _____

☐ Difficulty Trusting - _____

☐ Tension/Difficulty Relaxing - _____

☐ Sleep Problems - _____

☐ Authority Problems - _____

☐ Anger/Irritability - _____

☐ Violence - _____

☐ Thrill Seeking - _____

☐ Unresolved Grief - _____

☐ Spiritual Conflict - _____

☐ Unsure of Beliefs/Values - _____

☐ Substance Abuse - _____

☐ Employment Problems - _____

☐ (Other?) – _____

(NOTE: Out of all of the above, please circle the five that are most important to you.

WTRC Specific (Please complete the following section ONLY if you are applying to the Women's Trauma Recovery Center.)

☐ Rape.
☐ Attempted Rape.
☐ Non-Consensual Oral and/or Anal Sodomy or Attempt.
☐ Indecent Assault.
☐ Physical Assault.
☐ Childhood Sexual Abuse.
☐ Childhood Physical Abuse.
☐ History of Domestic Violence.
☐ Witness to a Traumatic Event (List): _____

Please go on to the next page

Name: _____

Military Trauma History Experienced by Applicant:

☐ Rape.
☐ Attempted Rape.
☐ Non-Consensual Oral and/or Anal Sodomy or Attempt.
☐ Indecent Assault.
☐ Physical Assault.
☐ History of Domestic Violence.
☐ Combat Trauma.
☐ Witness to a traumatic Event (List): _____
_____
_____

Family & Relationship

Are there minor children in the Veteran's care? ☐ Yes ☐ No
Can arrangements for care of children be made while Veteran is hospitalized? ☐ Yes ☐ No
Will family be able to meet financial obligations while Veteran is in care? ☐ Yes ☐ No

Please answer the following questions for your providers…

Name:_____ **Date:**_____

1.	When you were in the military, did you ever receive uninvited or unwanted sexual attention (i.e., touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?	YES	NO
2.	When you were in the military, did anyone ever use force or the threat of force to have sex with you against your will?	YES	NO

3.	Do you currently use tobacco?	Never used	Quit over 7 yrs	Quit over 1 year	Quit – less than a year	Currently use	
4.	I would like help quitting tobacco.	Don't use	Use and do NOT want to quit	Use, but want to quit	I'd like to learn how	I'd like medications	
5.	How often do you have a drink containing alcohol in the past year?	4 or more times a week	2 to 3 times a week	2 to 4 times a month	Monthly or less	Never	
6.	How many drinks containing alcohol do you have on a typical day when you are drinking in the past year?	10+	7-9	5-6	3-4	1-2	0
7.	How often do you have five or more drinks on one occasion in the past year?	Daily or almost daily	Weekly	Monthly	Less than monthly	Never	

Over the last 2 weeks have you had any of the following?

8.	Have you had little interest or pleasure in doing things?	Nearly every day	More than half the days	Several days	Not at all
9.	Have you been feeling down, depressed, or hopeless?	Nearly every day	More than half the days	Several days	Not at all

Have you <u>ever had</u> any experience that was so frightening, horrible, or upsetting that, <u>IN THE LAST MONTH</u>, you…

10.	Have had any nightmares about it or thought about it when you did not want to?	YES	NO
11.	Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	YES	NO
12.	Were constantly on guard, watchful, or easily startled?	YES	NO

13.	Felt numb or detached from others, activities, or your surroundings?	YES	NO

14.	Do you have current thoughts about killing someone or **hurting someone**?	YES	NO
15.	Do you have a specific plan for acting on these thoughts?	YES	NO
16.	Do you intend to act on these thoughts?	YES	NO
17.	Do you have the means to carry out this plan?	YES	NO
18.	Do you have current thoughts about **suicide or self harm**?	YES	NO
19.	Do you have a specific plan for acting on these thoughts?	YES	NO
20.	Do you intend to act on these thoughts?	YES	NO
21.	Do you have the means to carry out this plan?	YES	NO
22.	Do you have a prior history of past attempts?	YES	NO
23.	Are you feeling hopeless and/or helpless?	YES	NO

24. Do any of the following apply to you? **Check all that apply**

[ ] Older than 65 years?
[ ] Under 25 years?
[ ] Unmarried
[ ] White
[ ] Living alone
[ ] Current drug use
[ ] Current alcohol use
[ ] Chronic physical disorder/pain
[ ] Own a firearm
[ ] Past physical abuse
[ ] Past emotional abuse
[ ] Same sexual orientation

25. Are any of the following areas of concern for you? **Check all that apply**

[ ] Marriage
[ ] Home or family life
[ ] Employment
[ ] Finances
[ ] Health (worsening symptoms)
[ ] Health (new diagnosis or problem)
[ ] Legal

26. Are any of the following true for you? **Check all that apply**

[ ] Positive future plans
[ ] Positive social support
[ ] Children in your home
[ ] Responsibility to family
[ ] Responsibility to others
[ ] Pregnancy (yours or significant other)
[ ] Satisfied with life
[ ] Cultural beliefs against self harm
[ ] Religious/spiritual beliefs
[ ] Positive coping skills
[ ] Positive problem solving skills
[ ] Positive therapeutic relationship

IMPORTANT NOTICE:	**Recommended Limits:**	
Alcohol can interact with medications and worsen depression or other mental health conditions – please follow recommended limits.	Men: No more than 14 drinks a week, or 4 drinks a day	Women: No more than 7 drinks a week, or 3 drinks a day

27.	Would you like a referral for help to change your alcohol or drug usage?	YES	NO